

**STANDARDIZED MODEL FOR ASSESSING SUBSTANCE  
ABUSE AMONG OFFENDERS**

**SLIDE PRESENTATIONS**

**July 2002**

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## Nebraska Substance Abuse Task Force: An Overview & Summary of Progress

Presented by:

Denise C. Herz, Ph.D.

University of Nebraska—Omaha

Department of Criminal Justice

## Background

- In 1993, a technical review was prepared for Nebraska's Department of Public Institutions, which concluded:
  - The relationship between probation and treatment systems was 'ad hoc' and "dependent on the good will and energy of each individual probation officer and each individual treatment provider".
- In 1996, a group of justice practitioners began meeting to address problems related to substance abuse treatment.
- In 1997, this group named itself the Criminal Justice Coordinated Response and worked to:
  - Identify gaps in the criminal justice system related to treatment;
  - Eliminate fragmentation in services through the CJ continuum;
  - Identify effective treatment modalities for offenders; and
  - Integrate predictors of recidivism into substance abuse treatment.

## Background Continued

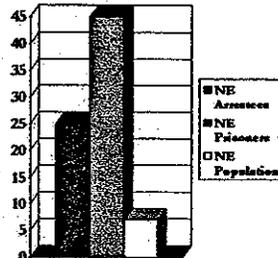
- Much of the Criminal Justice Coordinated Response work was based on the Colorado model, which used legislation to move the agenda forward
- Grassroots Results in Legislation: 1999
  - LB 865 (Co-Sponsors: Thompson, Hilgert, & Pederson)
  - Required Governor-appointed task force to complete a series of tasks and offer recommendations on how to improve justice system's response to substance abuse

## Summary of T/F Work: 1999-2000

- **T/F Vision:** Nebraska communities are safe, healthy, and free of substance abuse.
- **T/F Mission:** Enhance public safety and reduce criminal behavior by ensuring all governmental entities responsible for supervising individuals in the adult and juvenile justice systems have knowledge of and equal access to a full continuum of effective substance abuse services.

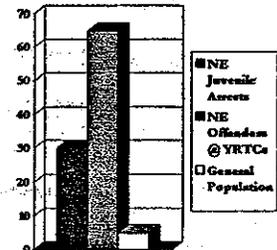
## Adult Offender Estimates of Need

- 25-40% of adult arrestees need substance abuse treatment.
- 65-85% of incarcerated adult offenders need substance abuse treatment.
- Only 7% percent of all adults in Nebraska need substance abuse treatment.
- Based on these estimates, between 13,900 to 22,241 adult arrestees needed some level of substance abuse treatment in 1997.



## Juvenile Offender Estimates of Need

- 30-40% of arrested juveniles in Nebraska need some level of substance abuse treatment.
- 65-80% of juvenile offenders at Nebraska YRTCs (Geneva and Kearney) need substance abuse treatment.
- Only 5% of juveniles in the general population need substance abuse treatment.
- Based on these estimates, an estimated 6,147 to 8,196 juvenile arrestees needed some level of substance abuse treatment in 1997.



## Funding for SA Treatment

- In Fiscal Year 1999/2000, the total amount of substance abuse treatment dollars was \$19,702,701.
- Of these dollars,
  - 4% was allocated to the adult criminal justice system via the Department of Corrections.
  - 1% was allocated to the juvenile justice system via the Office of Juvenile Services.
  - No substance abuse dollars were allocated to the courts or probation.
- Adjusting for inflation, substance abuse treatment dollars have decreased 16.5% since 1992.

## Criminogenic Need

- Criminogenic need is based in research and refers to factors that:
  - Increase the likelihood of recidivism (i.e., predictors)
  - Are dynamic and amenable to change
- Examples of criminogenic need include: Individual substance abuse, criminal or substance abusing peers, anti-social personality traits, and low achievement levels
- For treatment to be effective with offenders, criminogenic needs must be formally recognized by justice personnel and providers and incorporated into risk assessments and substance abuse evaluations.

## Effectiveness of Treatment

- Treatment of addiction is as successful as the treatment of other chronic diseases such as diabetes, hypertension, and asthma as long as treatment "best practices" are implemented (NIDA, 1999).
- It is estimated that for every \$1 spent on treatment, there is a \$4-\$7 reduction in drug-related crime and criminal justice costs (CALDATA Study, 1994).
- Coerced treatment works—Sanctions or enticements from the criminal justice system can significantly increase treatment entry, retention rates and the success of drug treatment interventions.

## Treatment "Best Practices"

- Matching treatment settings, interventions, and services to individual needs.
- Addressing multiple needs (e.g., medical, psychological, social, and criminogenic), not just substance use.
- Inclusion of counseling and other behavioral modification therapies.
- Recognition of relapse and viewing drug addiction as a long-term process.

## Gaps in the CJ/SA Provider Relationship

- Inconsistent coordination and communication
  - Lack of cross-training
  - Lack of information sharing
- Lack of criteria and accountability
  - Selecting offenders for evaluations (Justice)
  - Producing quality evaluations (Providers)
- Need to reexamine and update treatment approaches for offenders
- Limited system resources to pay for treatment
- Limited number of treatment & Certified Alcohol/Drug Abuse Counselors
  - 1 CADAC/3,068 NE Residents
  - 1 CADAC/12,500 Western NE Residents

## Summary of T/F Work: 2000-01

- Recommendations
  - 38 recommendations listed in the 2000 Report
  - Work was completed on 25 (66%) of these recommendations by the T/F, justice agencies and programs, the Division of MH/SA, the NE U.S. Attorney's Office, and other governmental units
- Standardization Subcommittee
- Risk Assessment Subcommittee
- Training Subcommittee

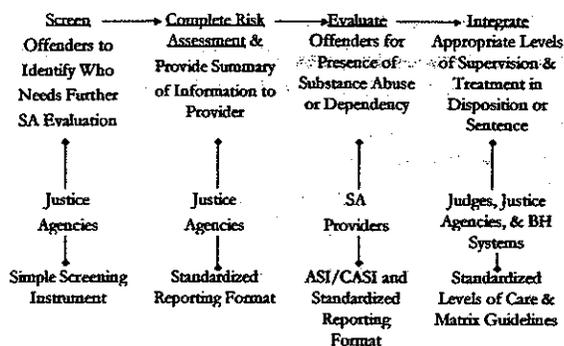
## Standardization Progress

- Completion of the Standardized Model
- Goals of this Model include:
  1. To ensure that all offenders are consistently and accurately screened and evaluated (when necessary) for substance abuse/dependency.
  2. To coordinate & formalize information sharing.
  3. To integrate levels of treatment care with offender accountability.

## Standardized Model Components

Component	Purpose	What & When
Screening (Justice)	To determine the presence of a current substance abuse problem and identify the need for further evaluation.	Simple Screening Instrument @ Jails, Detention Facilities, Diversion, Drug Treatment Courts, Probation, Corrections, Office of Juvenile Services
Risk Assessment (Justice)	To ensure that justice agencies consistently provide relevant risk information on offender to evaluators.	Standardized Risk Assessment Form completed using agency risk tool for all offenders sent for an evaluation (NOTE: This may be completed after the evaluation and used to update recommendations)
Evaluation (Providers)	To ensure consistent and accurate diagnoses and recommendations for treatment & formalize information sharing.	Addiction Severity Index (Adults) Comp. Adol. Severity Inventory (Juviles) One Additional Tool (Provider's Choice) Standardized Reporting Format

## Model Process & Requirements



## Other Standardization Developments

### ■ Approved Provider Criteria

1. Evaluations for justice clients must be completed by a certified alcohol and drug abuse counselor (CADAC), or a provisional CADAC (CPDAC) who is supervised by a CADAC, licensed psychologist or licensed physician with an addictions specialty.
2. Attend training and achieve competency on the ASI and/or CASI.
3. Attend training and achieve competency on the Standardized Model.
4. Formal agreement with justice agencies with regard to collateral contacts and the exchange of information within the rules of confidentiality.
5. Compliance with the Standardized Model evaluation and reporting process.
6. Successful completion of (#--TBD) continuing education credits in criminal behaviors and the criminal and juvenile justice systems.

## Other Standardization Developments

- Approved Provider Criteria Recommendations
  - Criteria 1-5 will be implemented by January 2003
  - Criteria 6 will be implemented by January 2004
- Standardized Levels of Care
  - Correlates all definitions used by different systems for similar levels of care
  - Provides one definition that overlays all terminologies used
  - Standardized definitions completed for both adult and juvenile services
  - Enables justice and providers to speak one language

## Risk Assessment Progress

- A summary and comparison of risk assessment factors currently collected by justice agencies
- Development of the Nebraska Standardized Risk Assessment Reporting Format for Substance Abusing Offenders
- Preliminary work on “hypothetical” models that provide guidelines on integrating substance abuse treatment levels of care with supervision levels of care

## Training Curriculum Progress

- Identified current agency training in this area
- Obtained agency commitment to use cross-training curricula within current agency training
- Developed cross-training curriculum outline and resources with assistance from the Lincoln Medical Education Foundation
- Worked with the Division of Mental Health & Substance Abuse to integrate cross-training concept into 2001 Annual Conference

## Next Steps: Training Model Implementation

### **T/F Implementation Plan 2001-02 Objectives**

- To provide training in the use of the Standardized Model of Assessment developed by the Substance Abuse Task Force.
- To finish the development of training curricula outline and resource materials.

### **Standardized Model Training**

- Develop a cross-training curriculum for the Standardized Model for justice personnel and providers.
- Coordinate and provide training on the Standardized Model of Assessment in three pilot sites across the state.
- Revise training modules based on recommendations from this training.

### **Development of Training Modules**

- Finish the development of cross-training curricula outlines and resource materials.
- Once fully developed into curricula, the substance abuse treatment modules will be integrated into justice agency training for new employees and continuing education for current employees.
- Once fully developed into curricula, the justice modules will be integrated into provider training for provisional CADACs and continuing education for current CADACs.

### **Modules for Justice**

- **Completed:**
  - ❑ Accessing Health and Human Services and Substance Abuse Services
  - ❑ Basic Knowledge of Addictions
  - ❑ Values, Attitudes and Beliefs about Drug Users: Confronting the Myths
  - ❑ Risks Associated with Drug Use

## Modules for Providers

- > Completed
  - Relationship between Treatment and Sentencing
- > In Progress
  - Overview of Nebraska's Criminal and Juvenile Justice Systems
  - Personality Development and Addictions
  - Best Practices for Offenders

## Modules for Both

- > Completed
  - Working Collaboratively: Partnerships between Substance Abuse Treatment & the Justice System
  - Screening, Assessment, and Evaluation
  - Mental Health Issues
- > In Progress
  - Criminogenic Need, Treatment Plans, and Public Safety
  - Levels of Care: Integrating Levels of Treatment and Graduated Sanctions

## Model Implementation

- > Governor and Senator Commitment
- > Justice Agency and Behavioral Health Commitment

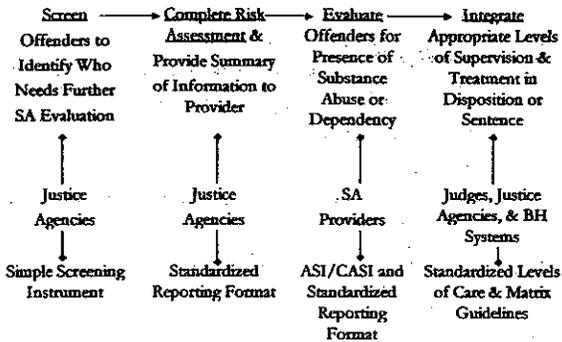
### Where do we go from here?

- > Moving from verbal commitment to implementation

## Necessary Steps to Success

- > Changing the "culture"
  - Cross-Training
  - Agency adoption
  - Judicial commitment in both theory & practice
  - Integrate services rather than simply "plugging into" them
  - Provider appreciation and acceptance of justice responsibilities and goals
- > Improving upon the Model—Making it Work for Nebraska
  - Monitoring implementation
  - Evaluating implementation
  - Integrating the Model into information systems

## Model Process & Requirements



## CONFIDENTIALITY

Presented by:  
Alice Schumaker, Ph.D.  
School of Public Administration  
University of Nebraska at Omaha

## CONFIDENTIALITY

- Protects the right of privacy of clients
- Allows the client to determine when and to whom AOD abuse information is disclosed
- Laws, mostly Federal, protect clients' AOD information
- Intent of laws was to attract AOD abusers into treatment

## Maintain Confidentiality When:

- gathering information from clients
- referring clients for assessment
- making diagnosis
- providing treatment
- communicating with other agencies working with clients

## **Federal Statutes and Regulations**

- Guarantee the strict confidentiality of information about all persons applying for or receiving AOD abuse prevention, screening, assessment, and treatment services and apply to any program that holds itself out as providing services for AOD abuse.

## **Requirements for Consent Form**

- Program making disclosure
- Program/individual receiving disclosure
- Client name
- Purpose/need for disclosure
- Description of information provided
- Signature of client or authorized person
- Date signed
- Revocation statement
- Date or condition for expiration of permission

## **Key Points of Disclosure**

- Be specific about purpose or need
- Expiration date no longer than reasonably necessary
- Must contain revocation statement

## **Exceptions to Disclosure Rule (a)**

- No client-identifying information is revealed (e.g. aggregate data)
- Communication does not include client status as AOD abuse (e.g. health clinic)
- Persons within the same program share information about client

### **Exceptions to Disclosure Rule (b)**

- Qualified service organization agreements
- Medical emergencies
- Crimes on program premises
- Court-ordered disclosures
- Research, audit, evaluation
- Clients right to their own records

### **Court-Ordered Disclosures**

- State or Federal courts issue order to permit disclosure about client
- Subpoenas, search warrants, or arrest warrants do not permit disclosure
- Court must notify program and client that order is sought
- Generally, fictitious names are used
- Court must find "good cause" for disclosure; and that information is not otherwise available

## **CULTURAL COMPETENCY**

**Presented by:**  
**Ethel Williams, Ph.D.**  
**School of Public Administration**  
**University of Nebraska at Omaha**

## **CULTURAL COMPETENCE**

- The information compiled in this module makes no assumptions regarding the abilities of justice professionals or the providers of substance abuse treatment to operate in a multicultural setting.

## CULTURAL COMPETENCE

- This unit provides information on how to more effectively respond to the challenges associated with obtaining information from, and providing services to a culturally diverse clientele

## Reasons For This Module

“Standardized assessments are highly problematic when used with individuals from other than mainstream United States culture” (Bonder, et al., 2001).

Differences in perception on the part of professional and clients may lead to inaccurate assessments.

## Defining Cultural Competency

- Cultural competency results from a sequence of actions that “leads to an ability to effectively respond to the challenges and opportunities posed by the presence of social-cultural diversity in a defined social system” (Cox and Beale, 1997).

## Defining Cultural Competency

- Cultural competence results from
  - *Recognizing that diversity has genuine effects on behavior within an organization and work outcomes*
  - *Understanding why competency is relevant to good performance*
  - *Taking steps to change non-productive actions*

### Cultural Competence in using the Standardized Model

- The administration of the Standardized Model bridges a number of organizations, therefore justice and substance abuse treatment providers must be especially aware that the barriers for each agency or organization may be different.

### Factors Affecting the Use of the Standardized Model

- Factors of assessment that appear most objective are subject to misinterpretation.
- The cultural issues present in all standardized assessments are
  - *Language*
  - *Conceptual Differences*

### Cross-Cultural Skills

- Developing skills that promote proficiency in communicating and interacting with a diverse clientele can be helpful. These skills include
  - *Developing a cultural awareness*
  - *Building a knowledge base*
  - *Determining the cultural salience of problems*

### Cross-Cultural Skills

- *Individualize clients within the context of community variations*
- *Recognize power differentials between clients and professionals*
- *Think comparatively*

### **Model for Developing Cultural Competence**

- **An awareness of one's limitations**
- **Openness to cultural differences**
- **A client-oriented systemic learning style**
- **Cultural competence as appropriate utilization of cultural resources**

### **Barriers to Cultural Competence**

- **Achieving cultural competency is hard work**
- **There is no blueprint for achieving competency**
- **Organization size and structure may complicate the process**

### **SCREENING FOR ALCOHOL AND OTHER SUBSTANCE ABUSE (AOD)**

**Presented by:  
Linda Wittmuss, P.A.  
Office of Mental Health, Substance Abuse and  
Addiction Services,  
Nebraska Department of Health and Human  
Services**

### **ALCOHOL AND OTHER DRUG ABUSE (AOD) SCREENING**

- **Never diagnostic by itself**
- **Preliminary assessment to identify key features of a problem area**
- **Usually a single event**
- **Based on a screening instrument that is highly sensitive**

### **Role of Screening in the Model**

- Used statewide
- Administered by criminal/juvenile justice personnel
- Completed early in process
- Information stays with offender throughout processing
- Information shared with providers when evaluation is complete

### **Qualities of an Effective Screening Instrument**

- For adults *and* juveniles
- Highly sensitive
- Detects all substances of abuse
- Administered in 10-15 minutes
- Simple to read, administer, score, and interpret
- Diverse group of personnel can use it
- Requires little background/training to administer
- Flexible and broadly applicable to diverse clients

### **What You Should Know About Screening**

- Reasons for screening
- Rationale for questions
- Comfortability in administering
- Results interpretation
- Referral actions
- Difference between screening and assessment
- False negative results
- Legal issues with confidentiality
- What information to keep and transfer

### **SSI Screening Instrument Selected**

- Samples of screening tools researched
- Reliability and validity
- Most used nationally
- Easiest to administer
- Nebraska version (adds gambling and frequency of use questions)

### **Administering the SSI: *Interviewing***

- Best Practice
- Improves quality of information gathered
- Consistency in data
- Requires observation comments
- Intervention opportunities
- Self administration less reliable

### **Administering the SSI: *How to Interview***

- Explain purpose to client
- Ask questions in straightforward manner
- Probe, listen, and empathize
- Pause between questions; allow time to discuss when appropriate
- Generally, adhere to the exact wording
- Feed back responses to client when appropriate
- Don't "lead" client into answers

### **SSI DOMAINS**

- 1. Alcohol & other drug consumption
- 2. Preoccupation and loss of control
- 3. Adverse consequences
- 4. Problem recognition
- 5. Tolerance and withdrawal

### **DOMAIN #1: *AOD Consumption***

- Pattern=frequency, length, and amount
  - 1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin, or other opiates, uppers, downers, hallucinogens, or inhalants.) (yes/no)
  - 10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
  - 11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)

**DOMAIN #2:**

***Preoccupation & Loss of Control***

- Refers to an individual spending inordinate amounts of time concerned with matters pertaining to AOD use.
  - Thinking about
  - Consuming
  - Recovering
  - Behavior changed
  - Loss interest in personal relationships
  - Less productive at work
- 11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)

**DOMAIN #2:**

***Preoccupation & Loss of Control***

- Loss of control over one's use of AOD or over one's behavior while using AOD
- Typified by consuming more of the substance than intended (amount, time spent)
  - 2. Have you felt that you use too much alcohol or other drugs? (yes/no)
  - 3. Have you tried to cut down or quit drinking or using drugs? (yes/no)

**DOMAIN #2:**

***Preoccupation & Loss of Control***

- Loss of inhibitions and by behaviors that are often destructive to oneself or others. (unnecessary risks, impulsive dangerous manner)
  - 9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
  - 12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

**DOMAIN #3:**

***Adverse Consequences***

- Physical
- Psychological
- Social

### **DOMAIN #3: *Adverse Consequences - Physical***

- Experiencing blackouts, injury & trauma, or withdrawal symptoms, or contracting an infectious disease associated with high-risk sexual behaviors
  - 5. Have you had any of the following?
    - Blackouts or other periods of memory loss
    - Injury to your head after drinking or using drugs
    - Convulsions or delirium tremens ("DTs")
    - Hepatitis or other liver problems
    - Feeling sick, shaking or depressed when you stopped drinking or using drugs
    - Feeling "coke bugs" or a crawling feeling under the skin, after you stopped using drugs
    - Injury after drinking or using drugs
    - Using needles to shoot drugs

### **DOMAIN #3: *Adverse Consequences - Psychological***

- Depression, anxiety, mood changes, delusions, paranoia, and psychosis
  - 13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

### **DOMAIN #3: *Adverse Consequences - Social***

- Social domain:
  - Loss of employment
  - Arguments and fights
  - Problem with intimate relationships
  - Relationships with friends
  - Legal problems: Criminal, Civil, and Family Court Issues

### **DOMAIN #3: *Adverse Consequences - Social***

- 6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
- 7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
- 8. Have you been arrested or had other legal problems? (bad checks, driving drunk, theft, or drug possession) (yes/no)
- 9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
- 12. When drinking or using drugs, are you more likely to do something you normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

#### **DOMAIN #4:**

##### ***Problem Recognition***

- Making a mental link between one's use of AOD and the problems that result from it.
- Indicators of Problem recognition
  - Past contacts with intervention and treatment services
  - Reporting negative consequences resulting from their AOD abuse
  - Insight and Recognition = Motivation and Contemplation

#### **DOMAIN #4:**

##### ***Problem Recognition***

- 2. Have you felt that you use too much alcohol or other drugs? (yes/no)
- 3. Have you tried to cut down or quit drinking or using drugs? (yes/no)
- 13. Do you feel bad or guilty about your drinking or drug use? (yes/no)
- 14. Have you ever had a drinking or other drug problem?
- 15. Have any of your family members ever had a drinking or drug problem? (yes/no)
- 16. Do you feel that you have a drinking or drug problem now? (yes/no)

#### **DOMAIN #5:**

##### ***Tolerance and Withdrawal***

- Tolerance—the need to use increasing amounts of a substance in order to create the same effect
  - 10. Are you needing to drink or use drugs more and more to get the effect you want?

#### **DOMAIN #5:**

##### ***Tolerance and Withdrawal***

- Withdrawal—if tolerance has developed and the individual stops using the substance of abuse, it is common for withdrawal effects to emerge.
- Equal to but opposite of the desired effect.
  - Stimulants and related drugs often include symptoms of depression, agitation, and lethargy
  - Depressants (including alcohol) often include symptoms of anxiety, agitation, insomnia, and panic attacks
  - Opiates produce agitation, anxiety, and physical symptoms such as abdominal pain, increased heart rate, and sweating.

## DOMAIN #5:

### *Tolerance and Withdrawal*

- 5. Have you had any of the following?
  - Blackouts or other periods of memory loss
  - Injury to your head after drinking or using drugs
  - Convulsions or delirium tremens ("DTs")
  - Hepatitis or other liver problems
  - Feeling sick, shaking or depressed when you stopped drinking or using drugs
  - Feeling "coke bugs" or a crawling feeling under the skin, after you stopped using drugs
  - Injury after drinking or using drugs
  - Using needles to shoot drugs

## Scoring the SSI

- Do NOT score questions 1 & 15 - too general
- Do NOT score questions 17 & 18 - gambling
- Do not score observational items
- Persons with AOD problems will usually score 4 or higher.
- Score of less than 4 does not rule out an AOD problem; use observations to assist with decision to refer to SA assessment / evaluation

## Where Does the SSI Information Go?

- BY WHOM: Justice Agency
  - If score of 4 or more, SSI given to SA provider along with Risk Assessment Standard Reporting Format
- TO WHOM: Sent to SA Assessment/ Evaluation provider; appropriate releases are in record
- HOW SENT: Determined between justice and provider - by fax, by snail mail
  
- QUESTIONS ABOUT SCREENING & THE SSP

## Overview of Risk Assessment in the Justice System

Presented by:  
Denise C. Herz, Ph.D.  
University of Nebraska—Omaha  
Department of Criminal Justice

## What are Risk/Need Assessments?

- Assessments are management tools that help justice and behavior health professionals determine appropriate types and levels of intervention.
- Utilized to produce a case plan that integrates appropriate levels of supervision, intervention, and treatment (if needed) in order to decrease risk and need factors and increase protective factors; thereby reducing his/her probability for future crime/delinquency.

## What are Risk Factors?

- Risk factors are characteristics that increase the probability that an individual will engage in crime/delinquency. Risk factors are broken into five domains:
  - Individual Factors
  - Peer Factors
  - Family Factors
  - School Factors
  - Community Factors

## Individual and Peer Factors

- Early onset antisocial behavior
- Low self-control, impulsivity
- Withdrawal from rebellious against conventional social norms
- Attitudes favorable toward problem behaviors
- Offense history
- Association with peers involved in delinquency or other problem behaviors

## Family Factors

- Multigenerational involvement in crime, substance abuse, and dropping out of school
- Poor parenting practices
- Inconsistent or overly punitive disciplinary practices
- High levels of family conflict
- Parental attitudes that condone substance use and/or delinquent behavior

### School Factors

- Early antisocial/aggressive behavior
- Continued disruptive behavior
- Truancy in early adolescent years
- Academic failure
- Lack of commitment to learning
- Lack of attachment to school setting

### Community Factors

- Extreme economic deprivation
- High rates of mobility
- Disorganized neighborhoods
- High levels of violence
- Availability of firearms, alcohol, and other drugs
- Norms favorable to drug use and/or crime,
- Low attachment and commitment to traditional neighborhood

### What are Need Factors?

- Need factors are characteristics that compound the effects of risk factors.
- Need factors fall in various domains. Examples include:
  - Substance use
  - Mental health problems
  - Financial need
  - Learning disabilities

### What are Protective Factors?

- Protective factors are conditions that counter risk factors or increase resistance to them; thus, inhibiting the development of problems.
- Protective factors fall into three areas:
  1. Individual Characteristics such as temperament, intelligence
  2. Attachment/commitment to prosocial persons, institutions, and values
  3. Healthy beliefs and clear standards for behavior

## Important Characteristics

- Risk, need, and protective factors vary in importance across life stages
- Risk, need, and protective factors are cumulative and synergistic rather than additive
- An effective justice system response depends on integrating interventions to address risk, need, and protective factors simultaneously
- Risk factors are both static and dynamic

## Static & Dynamic Risk Factors

- **Static:** Characteristics that cannot change
  - Age at first referral/adjudication
  - Number of prior referrals/arrests
  - Number of out-of-home placements
- **Dynamic:** Characteristics that can change with planned intervention or control of the situation
  - School performance and behavior
  - Substance Abuse & Mental Health Problems
  - Family stability and control
  - Peer Relationships

## Conclusions

- Risk/need assessments can play a critical role in planning interventions, monitoring progress, updating risk status judgments and making case management and termination decisions.
- Using assessments in this way increases juvenile justice system's ability to address both public safety and rehabilitation effectively and efficiently.

## References/Resources

### Resources:

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## INTRODUCTION TO SUBSTANCE ABUSE ASSESSMENT/EVALUATION

Presented by:

Linda Wittmuss, P.A., Clinical / MC Program  
Manager

Office of Mental Health, Substance Abuse and  
Addiction Services

Nebraska Department of Health and Human  
Services

July, 2002

## THE PROBLEM

- **Inconsistent Recommendations from SA Evaluation**
  - Assessment of Need Not Matching Recommendations or Client Service Placement
  - No Consideration of Criminogenic Risk Factors
  - No Consistency in Reporting to Justice System
- **Quality of Evaluations Vary Across Providers**
- **SA Evaluation Shopping**
- **Inability to Identify Service Gaps in System**
- **No Outcomes Measurement**
  - How do you determine if treatment works
  - How do you determine what works best for offenders

## SA ASSESSMENT / EVALUATION INSTRUMENT SELECTION

- **General Elements Considered by Task Force to Select Substance Abuse Evaluation Instrument**
  - Psychometrically Reliable and Valid
  - Most Used Nationally
  - Public Domain/Fee for Use
  - Administration
    - Assessing/Interview Time Frame
    - Administration Time Frame
    - Training Time Frame
  - Single vs. Multi-Dimensional
  - User Friendly

## SA ASSESSMENT / EVALUATION INSTRUMENT SELECTION

- **Benefits of Assessment Considered by Task Force to Select Substance Abuse Evaluation Instrument**
  - **Clinical Utility - Useful to the Clinician**
    - Assessment of Need
    - Diagnosis
    - Patient Placement
    - Treatment Planning
    - Recommendations to Justice System
  - **Program Evaluation - Useful to the System**
    - Measuring Outcomes
    - Managing Resources
    - Reports to Funding Sources
  - **Research - Useful to the System**
    - Treatment Effectiveness

## EVALUATION TOOLS SELECTED FOR JUSTICE SYSTEM REFERRALS

- **Addiction Severity Index (ASI)**
- **Comprehensive Adolescent Severity Inventory (CASI)**
- **Major Reasons for Selecting These Two Tools**
  - Public Domain
  - Widely Accepted Nationally/Required By Majority of States
  - Comprehensive in Scope / Multi-dimensional
  - Reliability and Validity
  - Eliminates Bias
  - Flexible to Accommodate Various Interview Styles
  - Ease of Administration & Time Frame with Training/Practice

## ASI & CASI

- **Clinical Applicability**
  - Serve as a primary intake tool and guides substance abuse treatment intake
  - Design intake summaries
  - Develop treatment plans
  - Make recommendations for appropriate client service placement
  - Do not replace clinical decision making
  - Standardize content
  - Enhance interviewer objectivity
  - Alert the interviewer to inconsistencies
  - Provide a common unified language

## ASI & CASI

- **Clinical and Program Evaluation**

Both instruments facilitate critical clinical and administrative decisions:

  - Eligibility Determinations
  - Service Placement and Level of Care
  - Interventions
  - Intensity of Service

## ASI & CASI

- **Program Evaluation**
  - Identify types of clients & problems presenting for treatment
  - Identify agencies/providers' strengths & areas for improvement with particular populations and problems
  - Enable management by outcome
    - Program Design
    - Resource Allocation
    - Funding Decisions

## ADDICTION SEVERITY INDEX (ASI)

### ■ What is the ASI?

- A standardized, semi-structured, multi-focused, interactive clinical assessment
- Primarily for use with Substance Abusing clients
- Used to collect information regarding nature and severity of problems substance abusers have
- Has clinical, program evaluation and research applicability

## ADDICTION SEVERITY INDEX (ASI)

### ■ Benefits of Using the ASI

- Reliable assessment/evaluation instrument
- Assists in identifying dually disordered clients
- Can be re-administered reliably at different points in treatment
- Helps identify inconsistencies in client responses
- Widely used, can compare one program results with others

## ADDICTION SEVERITY INDEX (ASI)

### ■ Limitations

- Does not provide quantity estimates of alcohol and drug use
- Does not directly assess HIV risk
- Does not cover issues that are specific to treating female clients

### ■ Common Concerns

- Seems too complicated
- Does not include all areas currently assessed
- Seems too rigid
- Seems like more work

## ADDICTION SEVERITY INDEX (ASI)

### 7 Problem Areas Reviewed

- Medical
- Legal
- Employment/Support
- Psychiatric
- Alcohol
- Family/Social
- Drug

## ADDICTION SEVERITY INDEX (ASI)

### ■ General Information Section

- Provides identifying & demographic information about the client
- Determines if client has been in a living situation which restricted freedom of movement & access to alcohol & other drugs

### ■ Medical Information Section

- Gathers basic physical health information including
  - Client's medical history
  - Lifetime hospitalizations
  - Long term medical problems
  - Recent physical ailments

## ADDICTION SEVERITY INDEX (ASI)

### ■ Employment Section

- Gathers basic information about
  - Resources the client can record on a job application

### ■ Drug & Alcohol Section

- Gathers basic information including
  - Client's substance abuse history
  - Lifetime substance abuse
  - Consequences of abuse
  - Periods of abstinence
  - Treatment episodes
  - Financial burden of abuse

## ADDICTION SEVERITY INDEX (ASI)

### ■ Legal Status Section

- Gathers basic information about
  - Client's legal history
  - Information about probation or parole
  - Charges, convictions, incarcerations, detainment & illegal activities

### ■ Psychiatric Status Section

- Determines the client's long term & recent psychological & emotional functioning
- Explores the potential for dual disorder

## ADDICTION SEVERITY INDEX (ASI)

### ■ Family/Social History Section

- Summarizes the psychiatric, alcohol and drug abuse problems of the biological relatives of the client
- Determines the nature of the client's personal relationships
- Determines if the client has relationship problems NOT DUE to alcohol or other drug use

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

- What is the CASI?
  - A standardized, semi-structured, interactive clinical assessment & outcomes interview.
  - Used to collect information regarding nature and severity of problems ADOLESCENTS have
  - Has clinical, program evaluation and research applicability

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

- Benefits of the CASI
  - Adolescent Focused
  - Strength based
    - What assets does the adolescent bring that can be built upon
    - Youth have ability to recover and bounce back from adversity
    - Paradigm shift to solution based approach rather than flaw fixing
    - View youth as capable and able
    - Recognize youth as having the resources for successful outcomes
  - Follow-Up: Have strengths and deficits been improved
  - Allows identification of where improvement has occurred within modules

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

- Strengths Approach Counters the Natural Youth View of Assessment/Evaluation Situation
  - Adult authority is instinctively perceived as a threat
  - Youth will predictably become aggressive or defensive in response to the perceived threat
  - Predictable that many youth have had a history of abuse from adults
  - Youth believe drug/alcohol use helps to win the "game"
  - Stuck a "unfairness" – not their fault for taking alcohol/ drugs
  - Resistant to intrusive behaviors by adults to elicit information or exact control

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

### 10 Life Modules

(\*5 Selected by Nebraska)

- |                                    |   |
|------------------------------------|---|
| 1. * <i>Health</i>                 | 7. Sexual Behavior                                |
| 2. Stressful Life Events           | 8. Legal Issues                                   |
| 3. Education                       | 9. * <i>Family Household Member Relationships</i> |
| 4. * <i>Peer Relationships</i>     | 10. * <i>Mental Health</i>                        |
| 5. * <i>Drug &amp; Alcohol Use</i> |   |
| 6. Use of Free Time                |   |

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

### ■ General Information Section

- Provides identifying & demographic information about the client
- Determines whether or not a youth has been in a controlled environment in the past 30 days
- Spiritual beliefs

### ■ Medical Information Section

- Gathers basic physical health information including
  - Youth's current ongoing medical problems
  - Hospitalizations
  - Medications
  - Allergies
  - Date of Last Physical Exam

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

### ■ Stressful Life Events Section

- Assesses quality of life as it relates to family, community, and individual stressors
- Violence, loss and rejection
- Violence aspects that a child has been or is exposed to

### ■ Education Section

- Is the youth enrolled & attending vs. enrolled and not attending for at least 30 days and/or not enrolled at all
- Schools attended
- Grades repeated
- Problems and/or educational interventions
- Quality of school life experiences

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

### ■ Drugs and Alcohol Use Section

- History, pattern, circumstances & routine route of use
- Behavior while using
- Consequences of use
- Methods for obtaining substances used
- Treatment history

### ■ Peer Relationships Section

- Obtain a description of the peer group during specific time periods
- Assess the youth's relationships with friends and/or peer groups
- Assess support systems
- Identify serious problems, intensity and duration that jeopardizes the youth's relationship with others

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

### ■ Sexual Behavior Section

- Obtain information about various sexual activity, risk for HIV & other STD's as well as pregnancy

### ■ Family/Household Member Relationships Section

- Household composition
- Living accommodations
- Family household interaction
- Abuse / neglect issues
- Parenting practices
- Parental monitoring
- Family history
- Support systems
- Problems in household ever & during past 30 days

## COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

### ■ Legal Section

- Has youth ever committed, been charged with or convicted of a crime
- Has youth ever been in a juvenile detention facility or jail
- Has youth ever been on probation or parole
- Has youth ever obtained a restraining order or had one place on them

### ■ Mental Health Section

- Treatment for emotional, mental health and/or psychiatric problems
- Psychiatric symptoms and problems with social adjustments
- Indications of well being

## ASI AND CASI SUMMARY

### ■ Key to Scoring the Instruments

- Understanding the intent of the questions
- Critical importance of “**COMMENTS**” section where all other pertinent information is recorded
- Evaluation recommendations are based on information gathered in the CASI interview

## ASI AND CASI SUMMARY

- ASI and CASI do **NOT** take the place of “Good Clinical Judgement” or “Clinical Decision Making”

- “Client Information”, “ASI or CASI Clinical Interview Information”, and “Service Treatment/Placement” recommendations reported in the *Standardized Reporting Format*

## NEBRASKA STANDARDIZED REPORTING FORMAT

### ■ Purpose:

- Standardized Organization of Evaluation Information
- Consistency in Reporting Format When Received by Justice
- Provide a Common Unified Language for Consistent Information Exchange Between Treatment Providers and Justice

## WHERE DOES THE STANDARDIZED REPORTING FORMAT GO?

- **BY WHOM:** SA Provider
  - ASI & CASI scoring, comments, other clinical interview info kept in clinical client record - not sent with SRF
- **TO WHOM:** *Standardized Reporting Format (SRF)* sent to justice entity referring client for evaluation; appropriate releases are in the record
- **HOW USED:** Justice makes determination of service treatment/placement based on SA Provider recommendation

## SYSTEM CHANGE

- **PARTNERSHIPS WORK!!!**



## SUBSTANCE ABUSE LEVELS OF CARE AND SERVICES AND APPROVED PROVIDER CRITERIA

Presented by  
Barbara W. Thomas, Assistant Director  
Office of Mental Health, Substance Abuse and  
Addiction Services  
Nebraska Department of Health and Human  
Services  
July, 2002

## NEED FOR STANDARDIZED LEVELS OF CARE / SERVICES

- Varying SA service definitions used in different systems and by different private providers
- Perception that one SA treatment can help everyone (e.g., Inpatient)
- No consistency in treatment recommendations with multiple service terms/definitions (one person's outpatient could be another's intensive outpatient)

## CROSSWALK DEVELOPED

- Crosswalk of Services and Systems
  - all services and levels of care
  - all justice systems
  - all HHS service systems; Medicaid
  - American Society of Addiction Medicine (ASAM) criteria
- Agreement to adopt Levels of Care and Service terms used by State Substance Abuse Authority

## ASAM CRITERIA

- Role of ASAM Criteria in standardizing levels of care and service definitions
  - National clinical criteria for the Addictions Field; currently required in 20 states
  - Sets the minimum standard for best practices in substance abuse treatment
  - Criteria describe levels of care and provide specific treatment guidelines for client placement decisions
  - Goal: To place a client in least intensive level of care to achieve treatment objectives without sacrificing safety or security

## ASAM CRITERIA

- ASAM Criteria: Treatment is individualized
  - One size doesn't fit all
  - Treatment must match the severity or level of functioning with the intensity of service
- ASAM Criteria: Treatment follows a good assessment
  - Determines level of functioning (client's assets and obstacles to improvement)
  - Determines intensity of service need (what modalities/ strategies of treatment and location of service match the client's needs)
- Helps the Addiction Field guide proper placement, improve practice guidelines and develop outcomes data to continually improve

## STANDARDIZED LEVELS OF CARE / SA SERVICES

- Correlates all definitions used by the different systems under similar levels of care
- Provides one definition that overlays all terminologies used
- Standardized definitions completed for BOTH adult and juvenile services
- ENABLES JUSTICE AND PROVIDERS TO SPEAK ONE LANGUAGE
- ONE uniform set of services and levels of care

## LEVELS OF CARE / SERVICES

- Glossary of Terms
  - Substance Use vs. Substance Abuse vs. Chemically Dependent
  - Dual Disorder vs. Dual Disorder Treatment vs. Dual Enhanced Treatment
- Substance Abuse Services for Justice Clients
  - **Level of Care:** general overall category that includes several similar types of services
  - **Substance Abuse Services:** a specific service that more specifically identifies the type of actual SA service activities a client will receive

## LEVELS OF CARE / SERVICES

- Levels of Care
  - Emergency Services
    - Short term, unscheduled service available in time of crisis in a variety of settings to stabilize symptoms
  - Assessment/Evaluation Services
    - **Screening:** brief set of questions to determine the level of the SA problem and refer for full assessment
    - **Evaluation:** process using psychometric assessment instruments to determine the severity of a Substance Abuse problem and the intensity level of care/service a client would need to change behavior; generally completed in a non-residential setting

## LEVELS OF CARE / SERVICES

- Levels of Care (continued)
  - Non-Residential Services
    - Least intensive array of services based on clinical need identified in a good assessment; offered in a variety of community settings; client lives independently
  - Residential Services
    - More intensive array of treatment services that are provided in a 24 hour community based residential setting
    - For clients with chemically dependency or substance abuse diagnoses

## SERVICES FOR ADULTS & YOUTH

- Adult Services
  - developed to meet need of client at a certain level of maturation
  - for ages 19 and over
- Youth Services
  - activities specific to address juvenile's stage of development (e.g., higher staffing ratio, not good at self study; more active participation)
  - for ages 18 and under (exception: Medicaid)
- Age waiver in NBHS

## APPROVED PROVIDER CRITERIA

- 1 Evaluations for justice client MUST be completed by a Certified Alcohol and Drug Abuse Counselor (CADAC), or by a Provisional CADAC (CPADAC) who is supervised by a CADAC, by a licensed psychologist, or by a licensed physician with an addictions specialty.
- 2 Attend training and achieve competency on the Standardized Model.

## APPROVED PROVIDER CRITERIA

- 3 Attend training and achieve competency on the ASI and/or the CASI.
- 4 Formal agreement with justice agencies with regard to collateral contacts and the exchange of information within the rules of confidentiality.

## APPROVED PROVIDER CRITERIA

- 5 Compliance with the Standardized Model evaluation and reporting format process.
- 6 Successful completion of 12 hours of Continuing Education credits in criminal behaviors, criminal thinking, and the criminal and juvenile justice systems.

## IMPLEMENTATION SCHEDULE

*January 1, 2003*

- ASI and CASI Trainers Trained
- Standardized Model Training held
  - Training of Justice System on (1) Simple Screening Instrument & (2) Risk Assessment Reporting Format
- Cross Training Curricula developed
  - SA Treatment Module for Justice Agencies/Staff
  - Justice Module for SA Treatment Provider
- Justice and Service Systems and Providers begin using the Standardized Model (including Standardized Levels of Care / Services)

## IMPLEMENTATION SCHEDULE

*January 1, 2004*

- ASI and CASI trainings held across the state for CADACs and CPADACs
- CEU courses made available on criminal behaviors / criminal thinking
- Agreements formalized between individual providers and justice system referral sources for smooth exchange of information
- Approved Provider List developed, maintained and distributed to providers and justice system
  - CADACs and CPADACs who have met all approved provider criteria and competency requirements will have their names on the list

## PLAN FOR FUTURE TRAINING

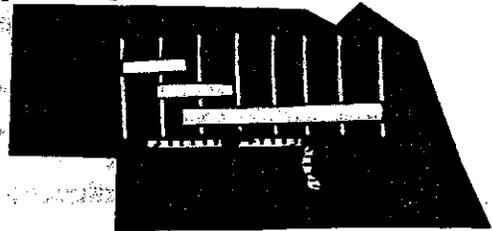
- ASI and CASI trainings to begin in September 2002
  - Class size limited to 25 in each
  - Offered across the state
  - Two 2-day sessions of training; the first session to learn the tool; the second session to determine competency in the tool; sessions held a few weeks apart to allow practice in tool
  - 24 CEUs available for ASI and CASI trainings

## PLAN FOR FUTURE TRAINING

- Standardized Model Training
  - Offered 1-2 more times from January through June 2003
- Criminal Behaviors / Criminal Thinking CEUs
  - Offered by the State's SA Counselor Certification training contractor (Lincoln Medical Education Foundation/LMEF) between July 2002 & June 2003
  - If course not a State sponsored training, submit appropriate information to the Office for approval

## OUTCOME OF IMPLEMENTING THE STANDARDIZED MODEL

- Improved quality of SA assessments and reports
- Improved referral to APPROPRIATE SA treatment
- Improved cooperation between service and justice system



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