

Treatment Alternatives and Diversion (TAD) Treatment Services Survey Report: July 2014



Wisconsin
Department of Health Services

Division of Mental Health and
Substance Abuse Services
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Madison, WI 53703

P-00881 (09/2014)

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SURVEY BACKGROUND

Treatment Alternatives and Diversion (TAD) is a program administered through the Department of Justice (DOJ) in collaboration with the Departments of Health Services (DHS), Corrections (DOC) and the Office of the State Courts that provides grants to counties and tribes to develop locally designed treatment and diversion alternatives to prosecution and incarceration for persons with substance use and co-occurring mental health disorders. This survey was provided through the DHS Division of Mental Health and Substance Abuse Services (DMHSAS).

DMHSAS administers two federal block grants that bring in some \$7 million in mental health and \$27 million in substance abuse services funds each year to Wisconsin. As part of the federal block grant application for Federal Fiscal Year 2014-2015, a data driven behavioral health needs assessment was completed to identify needs and gaps in the public funded service system. This behavioral health needs assessment was used to establish a work plan, which focused on addressing the high prevalence of substance use and mental health disorders in the population persons coming into contact with the criminal and juvenile justice systems. The goal established for this priority was to increase the use of effective, recovery-oriented evidence-based services for substance use and mental health disorders for this population.

DMHSAS decided to target technical assistance and training efforts toward TAD projects because of a planned expansion of TAD in Wisconsin. As part of this strategy, a survey was developed for the purpose of identifying needs within TAD projects that could be used to determine where and how technical assistance could be focused to assist sites in the following areas:

- Improve the quality, intensity and/or breadth of treatment services in addressing emerging trends or unmet needs;
- Increase the use evidence-based practices by treatment providers; and
- Strengthen the current partnerships between the criminal justice and treatment systems.

The results of this survey will be utilized by DMHSAS and the other TAD state agencies to determine where and how technical assistance and training could be focused to assist TAD sites with current and future initiatives.

PARTICIPATING TAD PROJECTS

The survey was sent to the twenty-two Treatment Alternatives and Diversion (TAD) projects that were funded at the time of the survey (April 2014). All twenty-two sites participated in the survey, and included:

- 2007 Original TAD sites (Burnett County in collaboration with the St. Croix Tribe, Dane County, Milwaukee County, Rock County, Washburn County, Washington County, and Wood County)
- 2011 Expansion TAD sites (Ashland and Bayfield counties), and
- 2014 Expansion TAD sites (Columbia County, Eau Claire County, Dodge County, Jefferson County, Kenosha County, Lac du Flambeau Tribe, Marinette County, Pierce County, St. Croix County, Trempealeau County, Walworth County, Waushara County and Waukesha County).

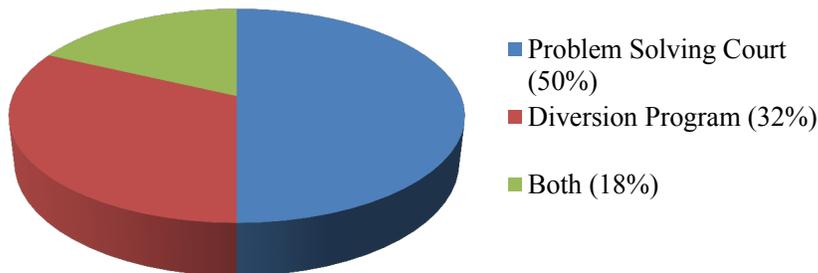
Given that some of the thirteen 2014 expansion sites were still in the process of developing their projects at the time of the survey, a response option of “still planning; don’t know” was provided with certain questions. New sites were encouraged to answer as many of the questions as possible. Out of the thirteen 2014 expansion sites, the response rate for “still planning; don’t know” ranged between three and nine sites per question.

Within the section on evidence-based practices, there were also some projects that simply skipped questions in this area; providing no response.

The “still planning; don’t know” responses along with the sites that did not provide an answer to the questions were combined as a No Response (NR) category in calculating the overall percentages for this report.

EMPHASIS OF TAD PROJECTS

Project sites were asked to identify what type of TAD project they were. Options provided were either a problem solving court, diversion program or both.

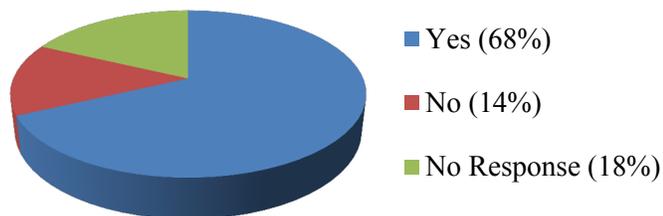


PARTNERSHIPS BETWEEN TREATMENT AND CRIMINAL JUSTICE

Participation on the Court/Diversion Teams

Project sites were asked if their program's treatment providers participate directly on court/diversion teams that conduct client reviews and/or court hearings of program participants. If they didn't participate they were asked how communication occurred between treatment providers and the courts.

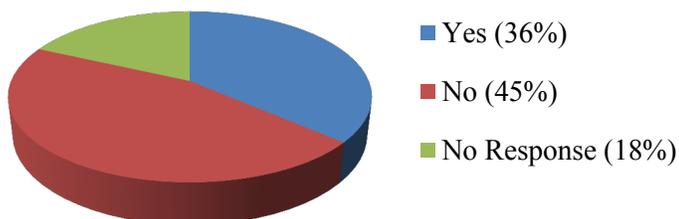
Most treatment providers participate directly on the team. In places where they don't participate directly, they do so through a formal liaison.



Participation in the Local Criminal Justice Coordinating Council (CJCC)

Project sites were asked if their program's treatment providers were represented on their local CJCC. If they did not participate directly they were asked how communication occurred between them.

Most treatment providers do not participate directly on the local CJCC. Instead, they have a formal liaison, participate in quarterly meetings, or participate in subcommittees of the Council. Two sites indicated that they have no standard practice for connecting the treatment providers to the work of the Council.

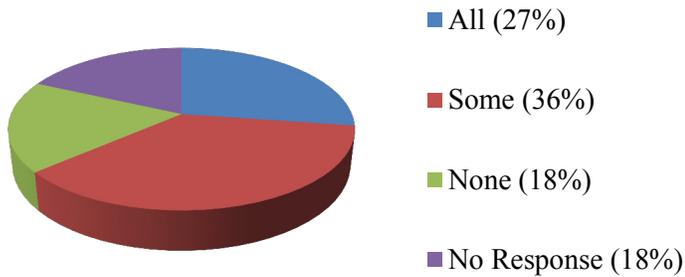


Cross Training Events with Criminal Justice System (CJS) Partners

Project sites were asked how many of their program's treatment providers have been involved in cross-training with their CJS partners.

Just over a quarter of TAD projects report that all of their treatment providers have been involved in cross training with the CJS partners.

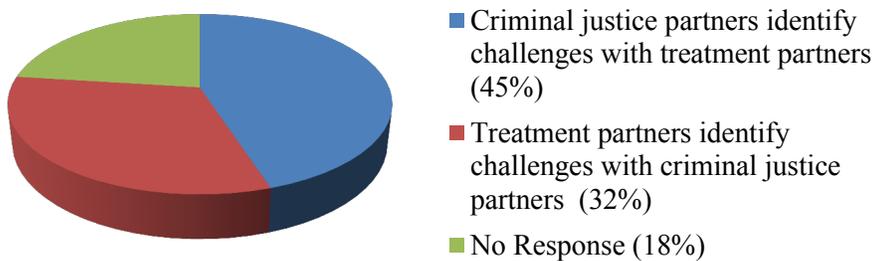
Eighteen percent of projects report that none of their treatment providers have been involved in cross-training.



Challenges in Cross System Collaboration

To help identify what types of cross system’s challenges are occurring for TAD projects, the same question was asked of treatment partners and criminal justice partners about their work with one another. Criminal justice partners were asked about the challenges working with their treatment partners and treatment partners were asked about their challenges working with their criminal justice partners.

In terms of challenges, programs report that the criminal justice system has more challenges working with treatment providers than vice versa.



Challenges identified by criminal justice partners in working with treatment providers included (with the top three being the most commonly identified):

- Lack of providers
- Long waiting lists for some levels of service
- Lack of familiarity with the criminal justice system
- Lack of group therapy
- The use of different assessment tools
- Lack of Spanish speaking counselors

- Inability of treatment providers to bill for medical assistance/other insurance
- Communication (e.g. dosage hours of participants)

Specific challenges for treatment providers working with criminal justice partners included:

- Treatment providers lack understanding of the criminal justice system and the specialized needs of the offender population
- A clash of values between the two systems with regard to sanctions versus treatment
- Disagreement about participant motivation and what sanctions should be used for certain behaviors
- Lack of understanding on best practices for criminal justice clients (e.g. not mixing low risk with high risk participants)
- Inability to tailor new groups for the population due to insufficient numbers of referrals
- Low rates of reimbursement for medical assistance
- Ongoing funding to sustain programming once grant money ends

Benefits to Cross System Collaboration

Both the treatment and criminal justice systems unanimously saw benefit to working with one another. Benefits that were identified included:

- Improved outcomes for participants
- Higher quality of services
- Increased/improved communication across systems leading to better outcomes
- Team approach to helping participants
- Better identification of persons in the criminal justice system who need treatment
- More people involved in the treatment process
- Broader array of services available to participants
- More provider choices for participants (e.g. can choose treatment closest to their home, or where their insurance will cover)
- More appropriate responses for participants
- Improved insight and knowledge across systems
- Improved retention in treatment with accountability of criminal justice system
- Promotes use of EBP's and the fidelity to EBP's
- Reduction in incarceration and recidivism
- Improved access to court proceedings by treatment
- Appreciation that criminal justice system is not just punitive but interested in achieving the best outcomes for the individual and the community
- Improved data collection and monitoring of outcomes

PROGRAM QUALITY AND NEEDS ASSESSMENT

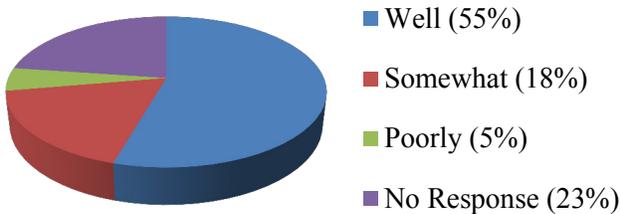
Program Responsiveness

Project sites were asked to respond to how well their programs performed in addressing and meeting the needs for substance abuse and mental health treatment; providing quick access to services; and reporting information to the court for program participants.

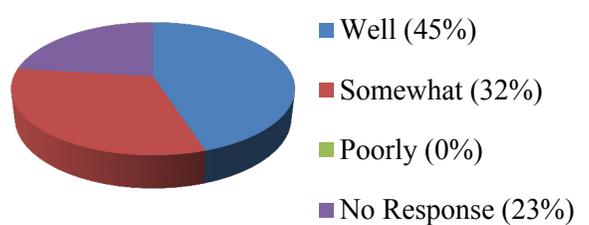
Programs that were operational at the time of the survey responded that their programs performed “well” to the following:

- Provide the courts with needed information (76%)
- Meet the substance abuse needs of participants (71%)
- Meet the mental health needs of participants (59%)
- Provide quick access to services (53%)

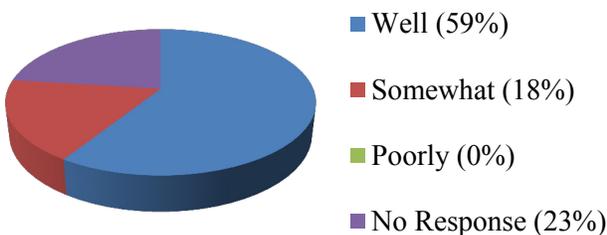
Address and meet the substance abuse needs



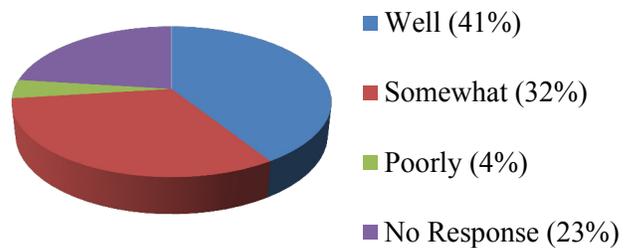
Address and meet the mental health needs



Provide the court with needed information



Provide Quick Access to Services



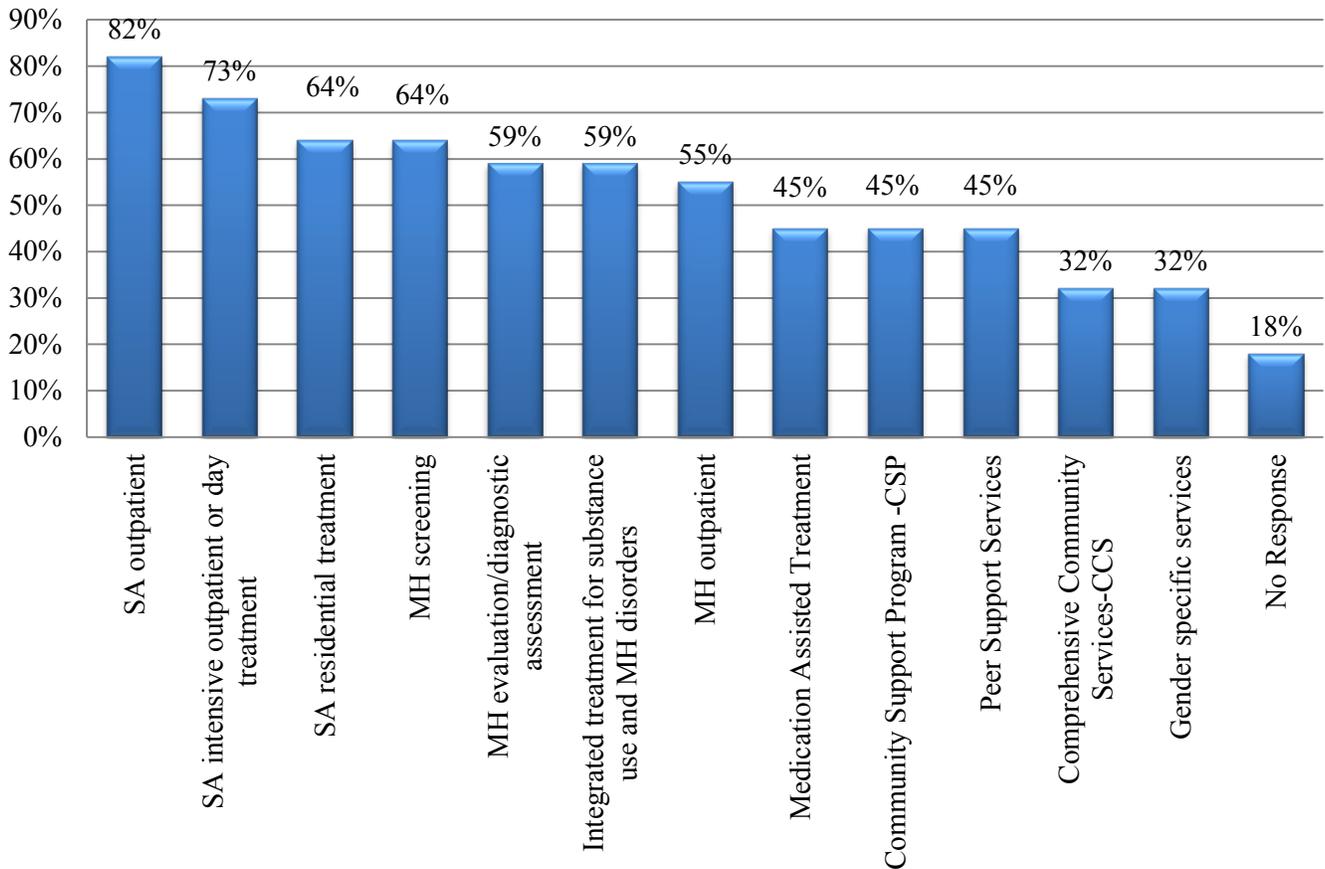
Treatment Services Provided

Project sites were given a list of substance abuse and mental health services that represented a continuum of treatment, and were asked to indicate which of those treatment services are being provided to their program participants. Programs were also able to identify any additional services that were not on the list.

All of the operational TAD projects are providing outpatient substance abuse treatment with the majority providing:

- Intensive substance abuse outpatient or day treatment,
- Residential substance abuse treatment,
- Mental health screening,
- Mental health evaluation and diagnostic assessment,
- Integrated treatment for substance use and mental health disorders,
- Mental health outpatient

Three projects identified the following as additional treatment services: Native American specific outpatient treatment; Wellbriety; Moral Reconciliation Therapy; Trauma; and Parenting and relationship classes.

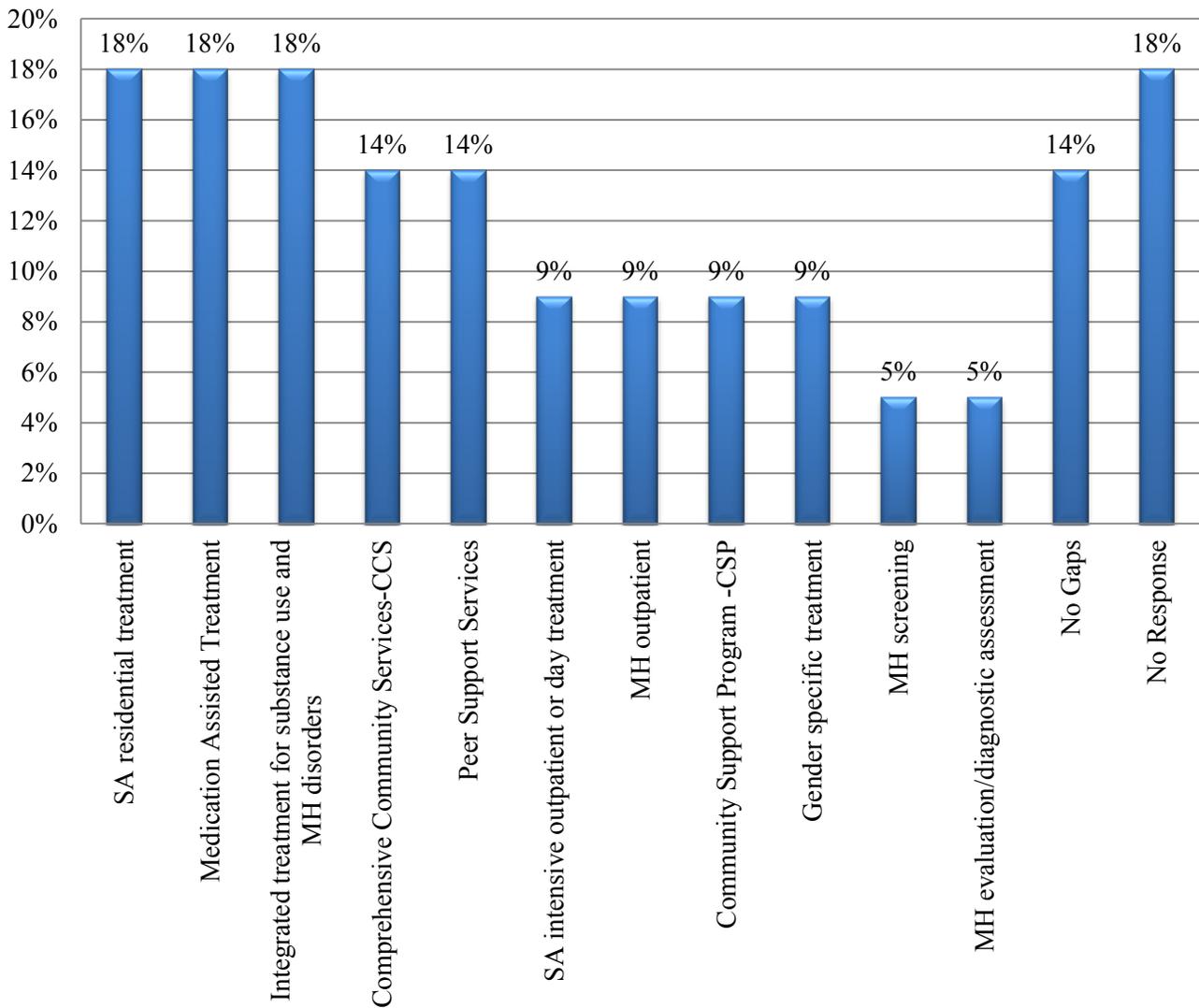


Treatment Service Gaps

In an effort to identify where gaps in services exist, projects were asked to identify which of the services they view as significant gaps for their program. This area of inquiry was based on the idea that not all of the unavailable services previously identified constitute a great need for each program given the populations that are being served by a program, while others may seem very relevant at the local level.

The areas of greatest need identified were residential substance abuse treatment, medication assisted treatment and integrated treatment for substance use and mental health disorders (18%). This was followed by Comprehensive Community Services (CCS) and peer support (14).

Fourteen percent of responding projects did not identify any serve gaps for their program.

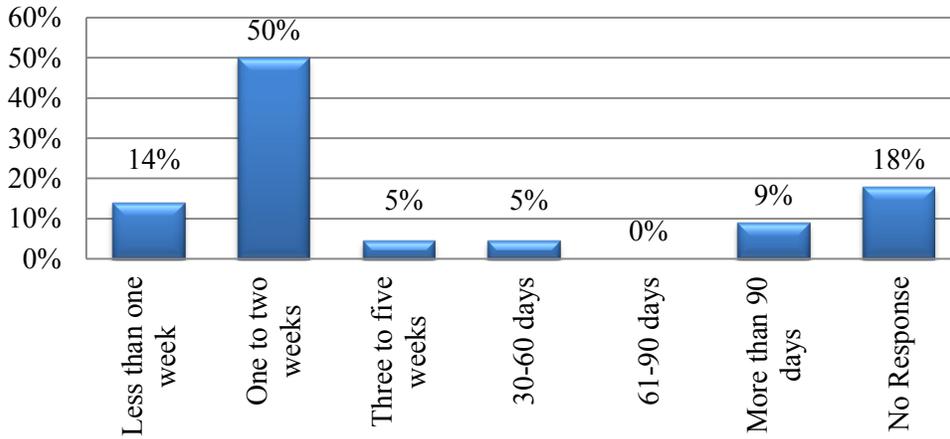


Wait Time to Access Treatment

Project sites were asked about the average length of time for their participants to begin treatment once they are admitted to TAD projects.

Wait times are modest. Most operational programs (78%) are able to see participants within two weeks of admission.

Two counties reported a wait period of more than 90 days for participants to begin treatment after admission to the program

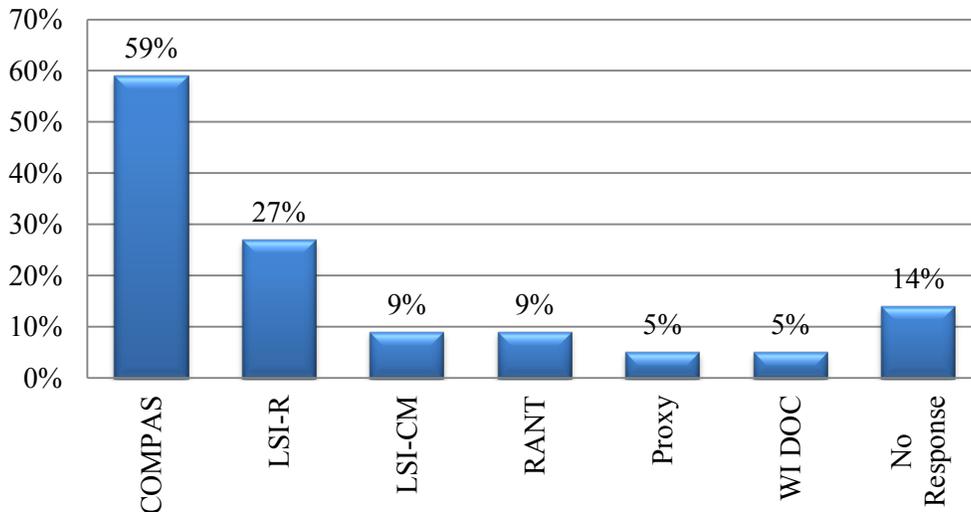


Screening and Assessment Instruments

Project sites were asked which screening/assessment instruments they use in the areas of: Risk and Needs, Substance Use Disorders, Mental Health Disorders, Treatment Placement Tools, and Participant Readiness for Change.

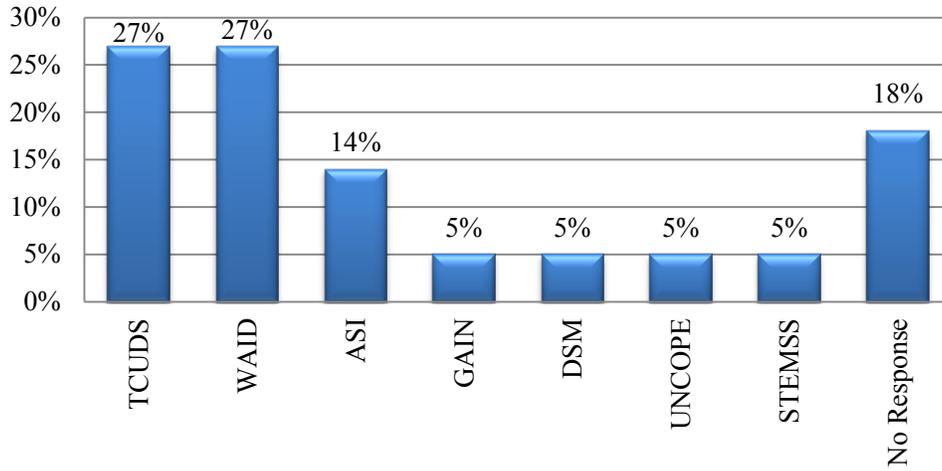
Risk and Needs

All of the operational TAD projects are using a risk and needs assessment; with the COMPASS being the most widely used (63%), followed by the LSI-R (32%).



Substance Use Disorders

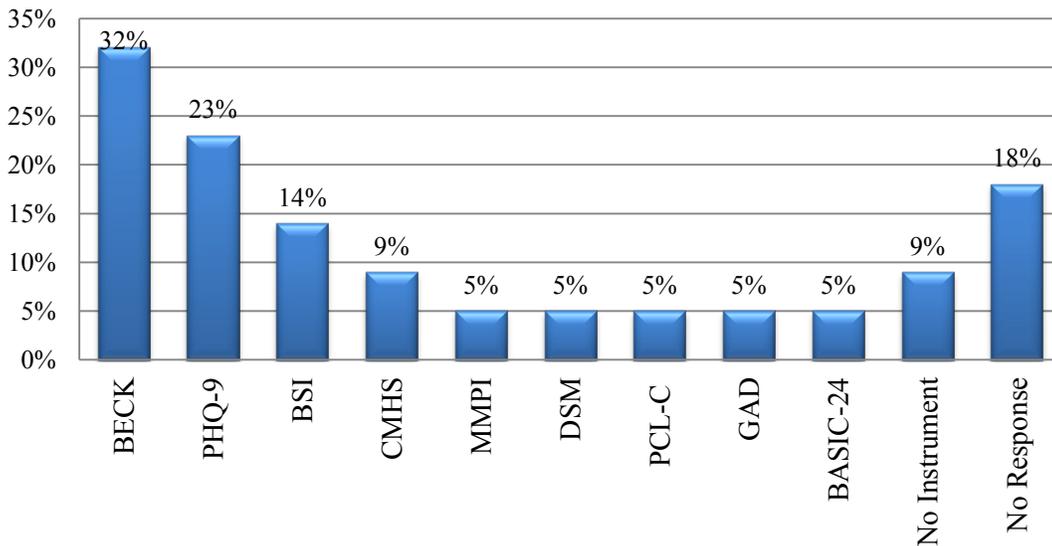
All of the operational TAD projects are using a substance use disorder screening instrument; with the TCUDS and WAID as the most common.



Mental Health Disorders

The BECK, PHQ-9, and the BSI were the most commonly used mental health disorder screening instruments.

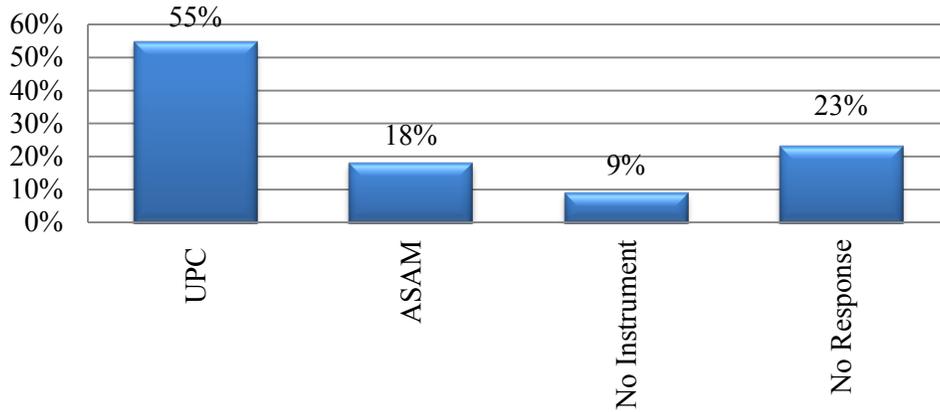
Two projects reported not using any mental health disorder screening instruments.



Treatment Placement Tools

The majority of operational projects who identified using a treatment placement instrument are using the WI Uniform Placement Criteria (UPC) tool (71%).

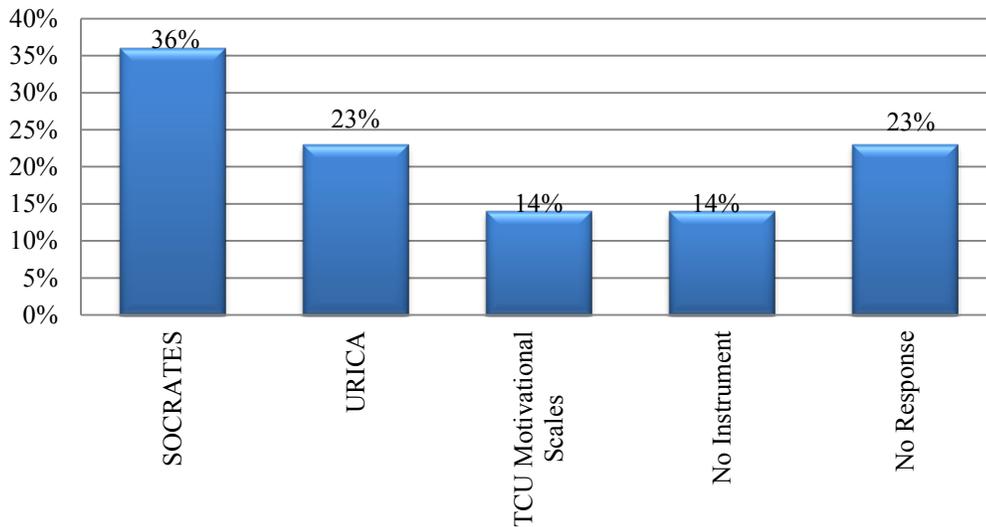
Two projects reported not using a treatment placement tool in their decision making process.



Participant Readiness for Change

The SOCRATES and URICA are the most commonly used readiness for change instruments.

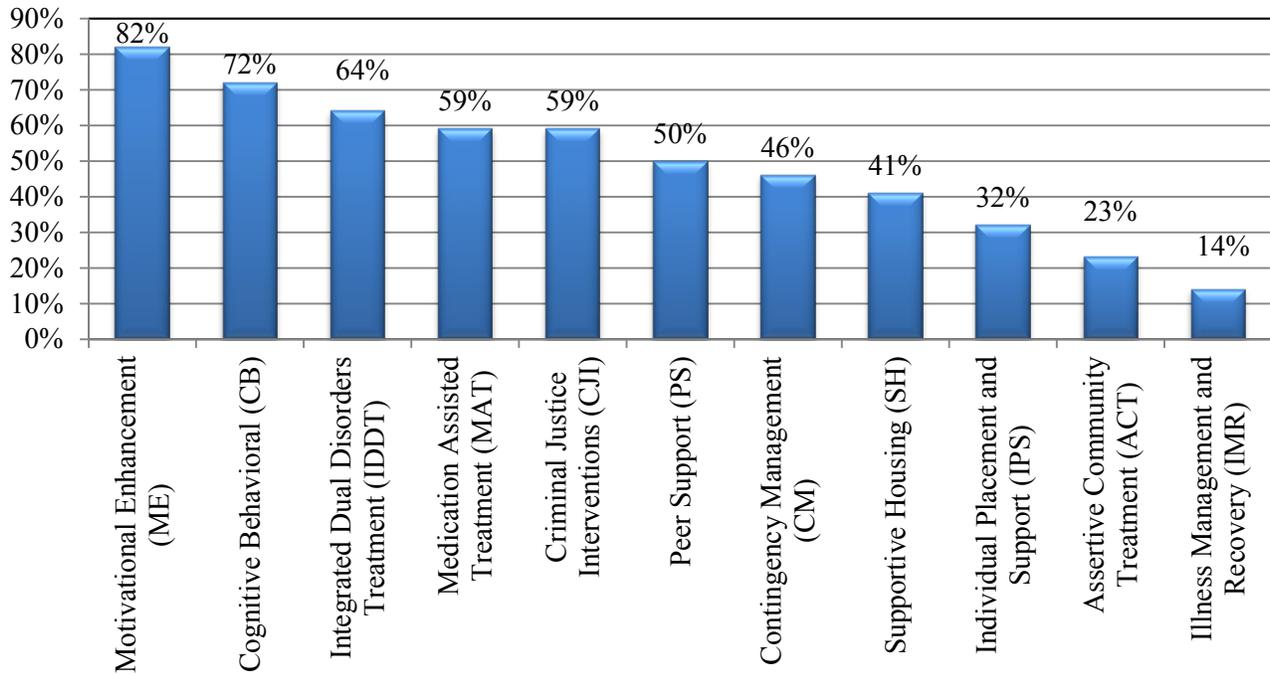
Three projects are not using a readiness for change instrument.



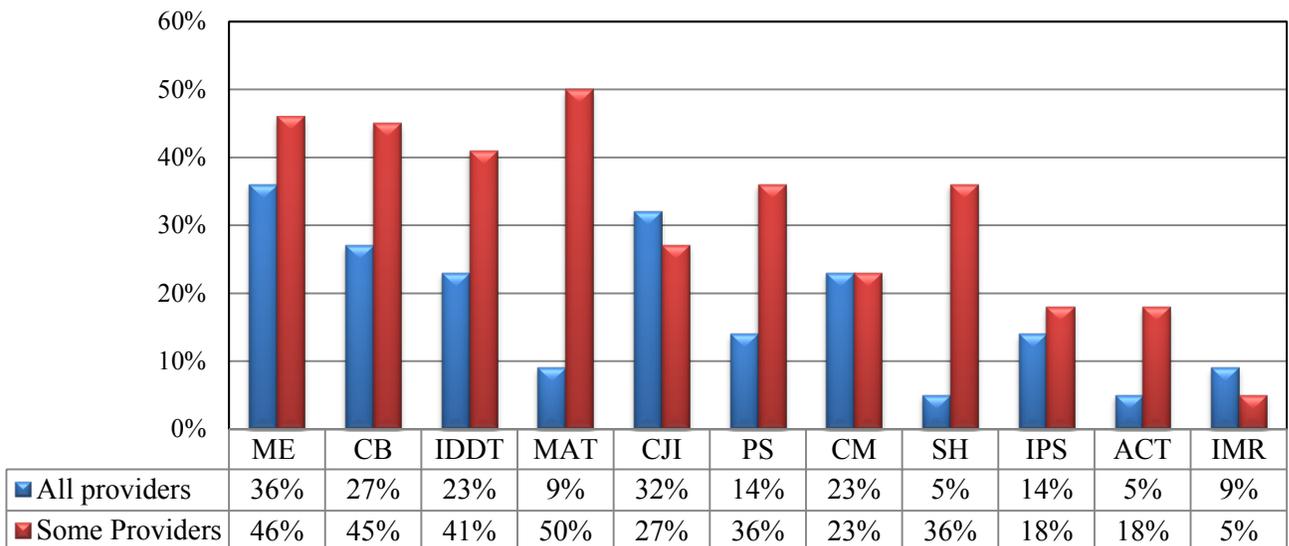
EVIDENCE-BASED PRACTICES (EBP)

Types of EBPs

The most common EBPs offered in TAD projects are: Motivational Enhancement (ME), Cognitive Behavioral (CB), Integrated Dual Disorders Treatment (IDDT), Medication Assisted Treatment (MAT) and National Institute of Correction (NIC) Principles of Effective Criminal Justice Based Interventions. Given that the current focus of TAD is for persons with substance use disorders, it is not surprising to find that the more specific EBP's for persons with mental illness are used to a much lesser degree.

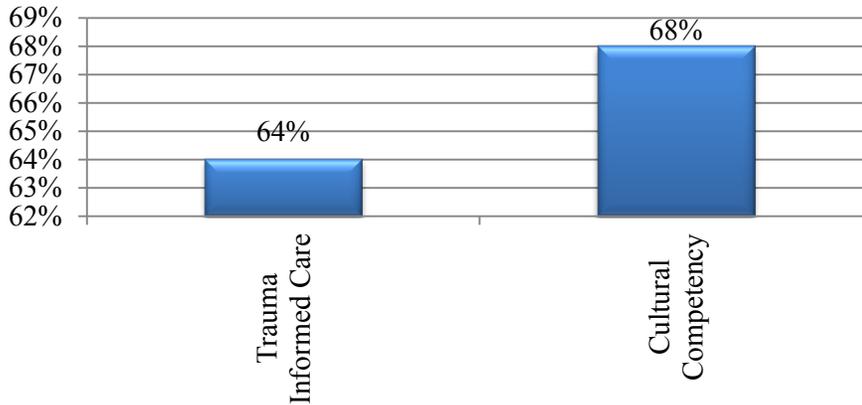


Degree to which EBPs is used by providers



Trauma Informed Care and Cultural Competency

In addition to specific EBPs, projects were also asked if their staff have been trained in Trauma Informed Care and cultural competency. The majority of projects indicated that more than 60% of staff were trained in these areas.



Barriers to Use of EBPs

TAD projects were asked how many of their treatment providers deliver the specific EBPs listed and were asked to indicate the reasons why the EBP may not be used in their program.

The biggest barriers identified for providing an EBP was:

- A lack of training resources,
- A lack of familiarity with the practice,
- Unsure how to get started,
- A perception that it is too expensive.

To a lesser degree there were some EBPs that were perceived as involving too much staff time or being irrelevant to the individuals being served in their program.

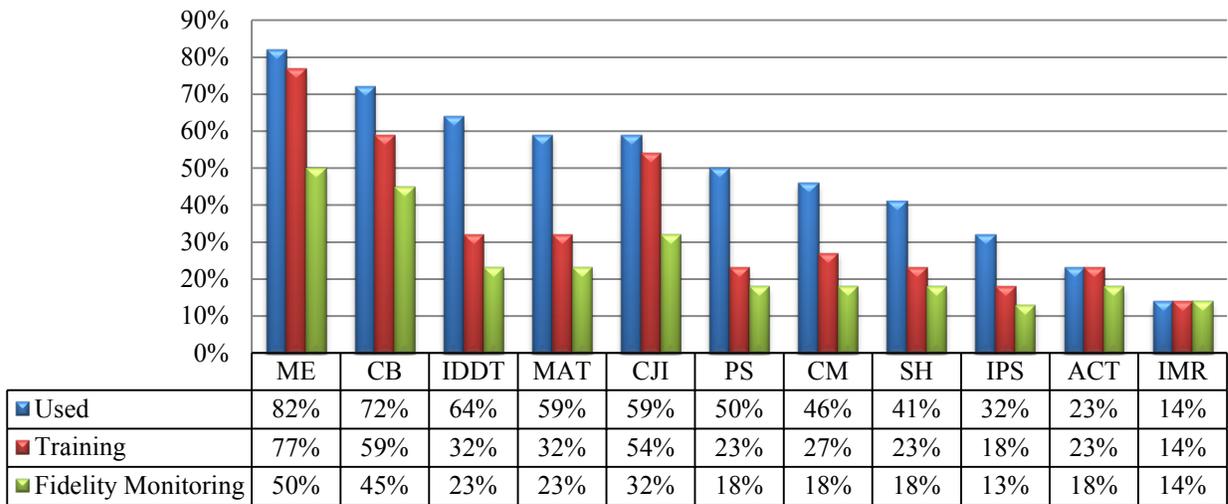
Training and Fidelity Monitoring of EBPs

TAD projects were asked if their staff have been specifically trained to implement the EBPs listed in the survey and whether they monitored fidelity for the EBP within their program.

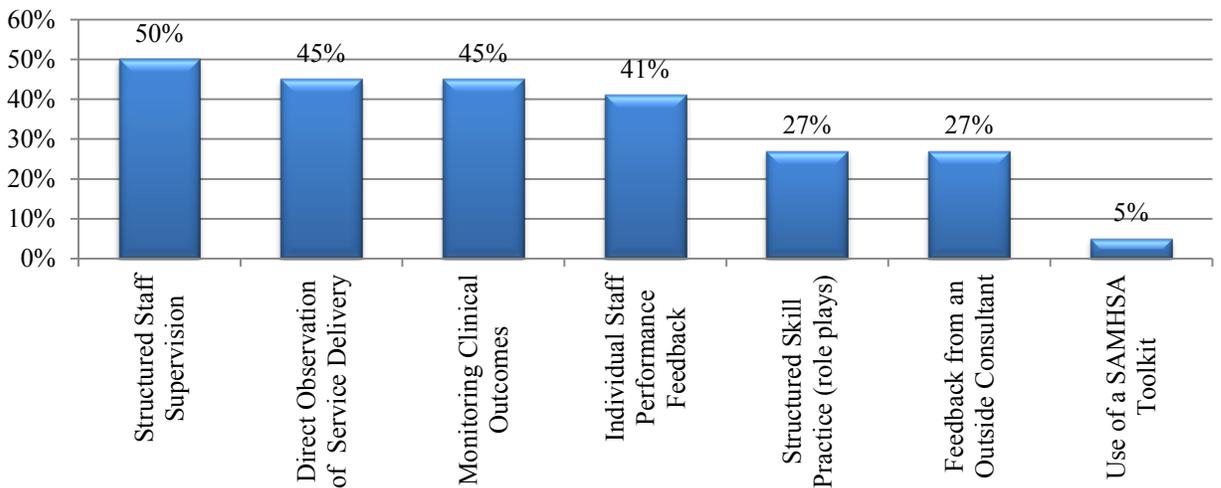
Across all TAD projects, there is a progressive reduction from their use of an EBP to the percent of staff that have received training for a specific EBP and to the percent of programs that monitor fidelity of the EBP. Programs using ACT and IMR were most likely to have staff that are trained and involved in fidelity monitoring; though these are the two least used EBPs within TAD projects.

More than three quarters of TAD projects received EBP training for Motivational Enhancement Approaches. This was followed most closely by training for Cognitive Behavioral Approaches and NIC’s Principles of Effective Criminal Justice Based Interventions. Though IDDT and MAT are also used by more than fifty percent of the TAD projects, training of staff for these EBP’s occurred on a much less frequent basis.

For projects that conduct fidelity monitoring there are a variety of approaches utilized. The most common include: structured staff supervision for the use of EBP’s, direct observation of service delivery and monitoring of clinical outcomes.



Fidelity Monitoring Activities



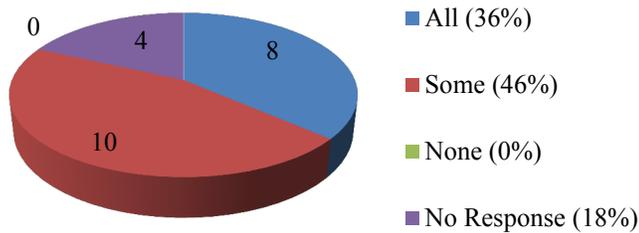
Motivational Enhancement Approaches

The specific programs used by projects are:

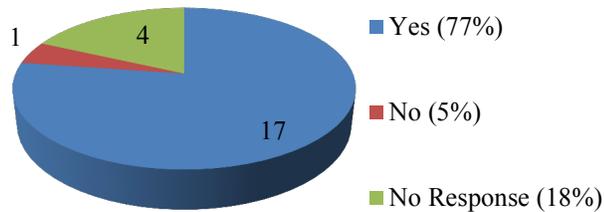
- Motivational Enhancement Therapy (MET)
- Motivational Interviewing (MI)
- Brief Intervention (BI)

One hundred percent of operational projects reported to provide this EBP with either all or some of their providers.

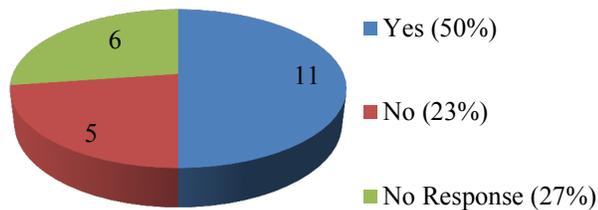
How many of your treatment providers offer this EBP?



Have staff been specifically trained to implement the EBP?



Does the program monitor fidelity to this EBP?

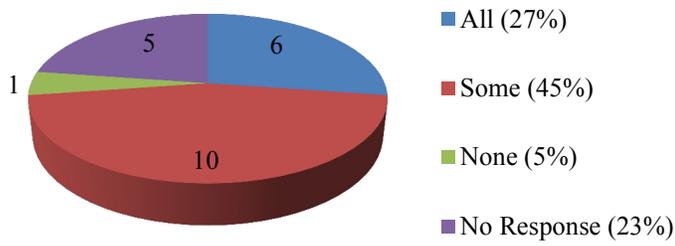


Cognitive Behavioral Approaches

The specific programs used by projects are:

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Moral Reconciliation Therapy (MRT)
- Trauma based Cognitive Behavioral Therapy (CBT)

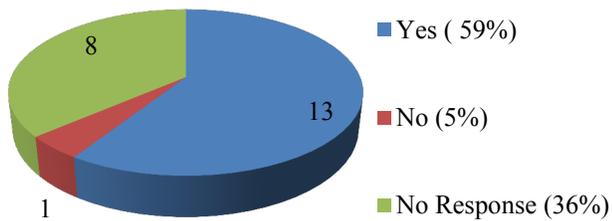
How many of your treatment providers offer this EBP?



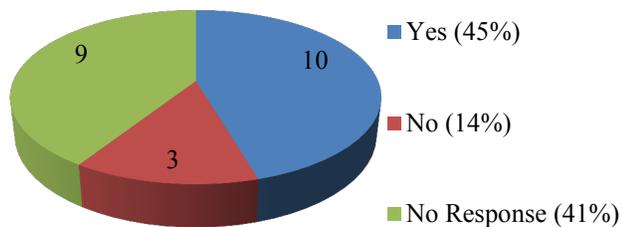
Reasons for not providing this EBP:

- Lack of familiarity with the EBP

Have staff been specifically trained to implement the EBP?

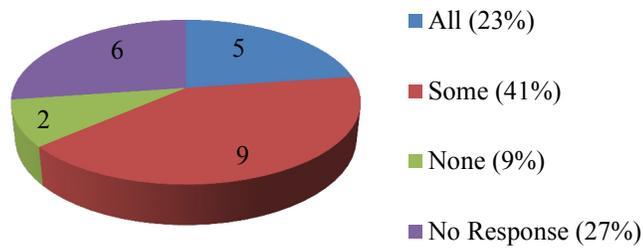


Does the program monitor fidelity to this EBP?



Integrated Mental Health and Substance Abuse Services

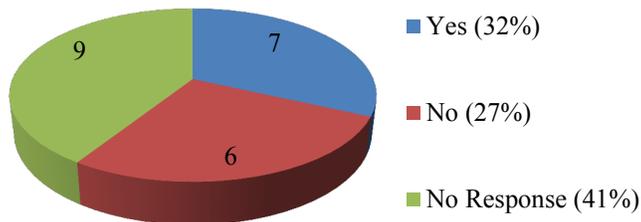
How many of your treatment providers offer this EBP?



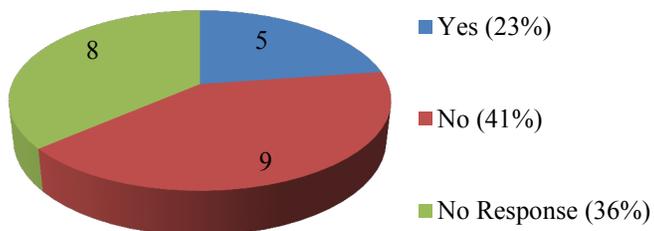
Reasons for not providing this EBP:

- Irrelevant to participants
- Lack of training resources

Have staff been specifically trained to implement the EBP?



Does the program monitor fidelity to this EBP?



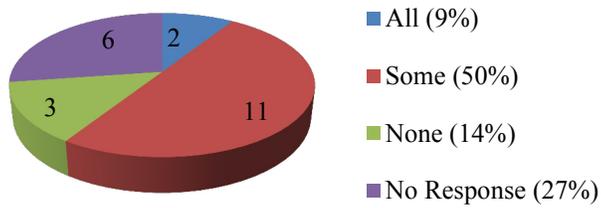
Pharmacotherapy (MAT)

The most common MAT's being used are:

- Buprenorphine (Suboxone, Subutex),
- Naltrexone (Vivitrol)
- Disulfiram (Anatabuse).

Some sites also identified using Methadone and Acamprasate (Campral).

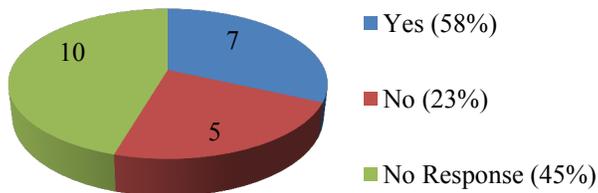
How many of your treatment providers offer this EBP?



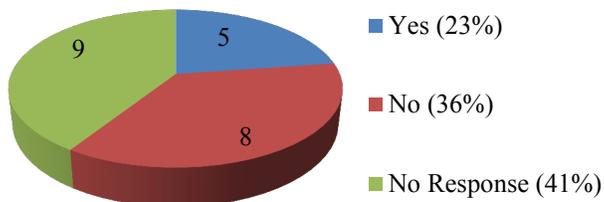
Reasons for not providing this EBP:

- Too expensive
- Too complicated
- Lack of training resources
- No doctors to prescribe

Have staff been specifically trained to implement the EBP?

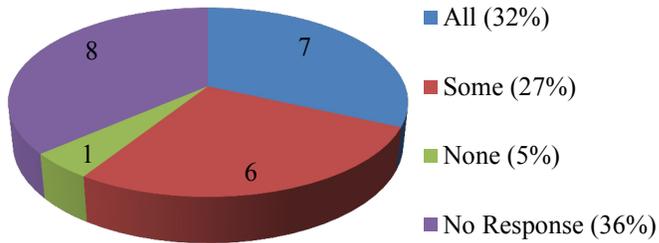


Does the program monitor fidelity to this EBP?



Criminal Justice Based Interventions (National Institute of Corrections' Eight Principles)

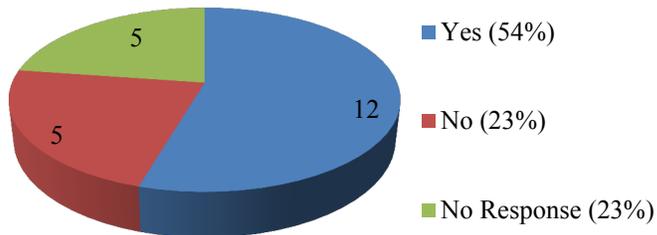
How many of your treatment providers offer this EBP?



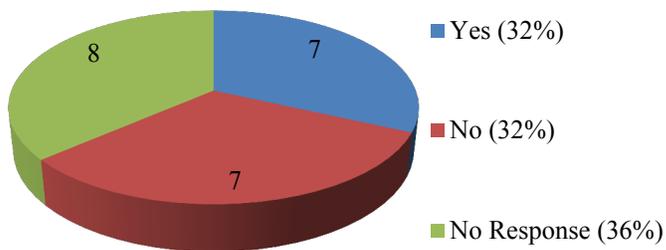
Reasons for not providing this EBP:

- Too expensive

Have staff been specifically trained to implement the EBP?

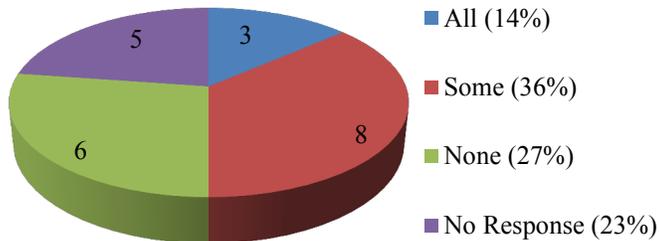


Does the program monitor fidelity to this EBP?



Peer Support Services/Peer Recovery Support Services

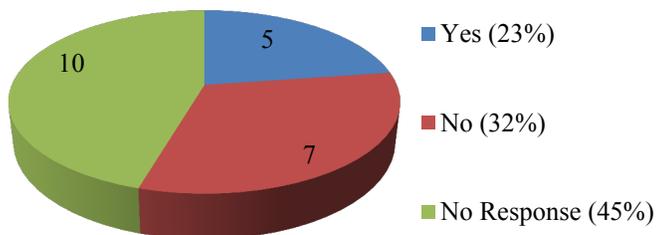
How many of your treatment providers offer this EBP?



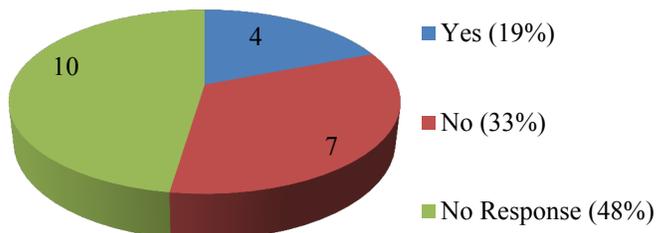
Reasons for not providing this EBP:

- Lack of training resources
- Too much staff time required
- Too expensive
- Unsure how to get started

Have staff been specifically trained to implement the EBP?

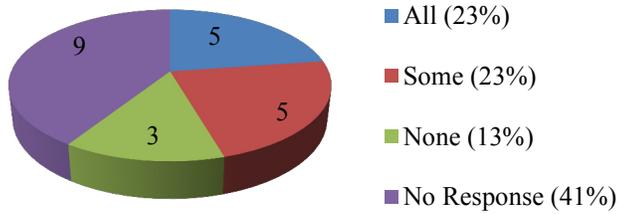


Does the program monitor fidelity to this EBP?



Contingency Management

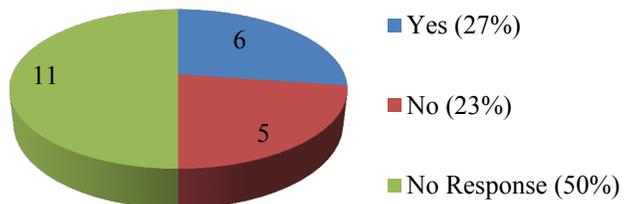
How many of your treatment providers offer this EBP?



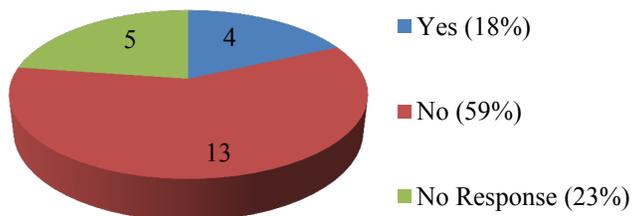
Reasons for not providing this EBP:

- Lack of familiarity with the EBP
- Unsure how to get started
- Too expensive

Have staff been specifically trained to implement the EBP?

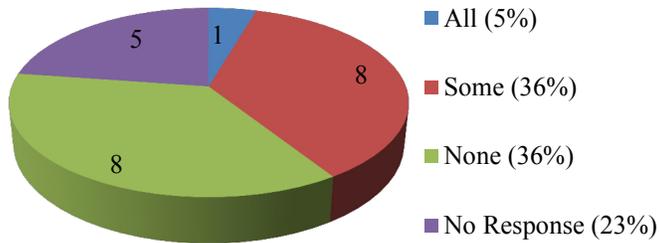


Does the program monitor fidelity to this EBP?



Supported Housing

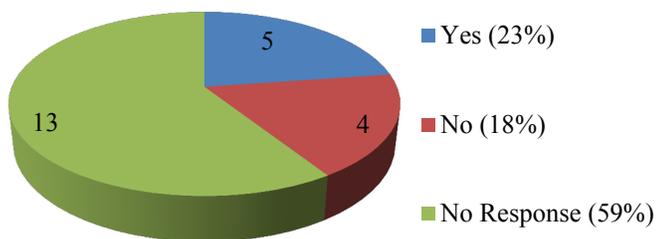
How many of your treatment providers offer this EBP?



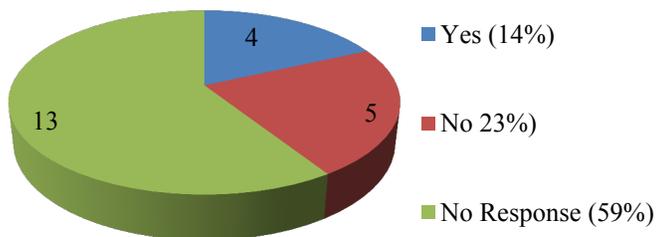
Reasons for not providing this EBP:

- Too expensive
- Unsure how to get started
- Lack of training resources
- Too complicated
- Too much staff time required
- Unfamiliarity with the EBP

Have staff been specifically trained to implement the EBP?

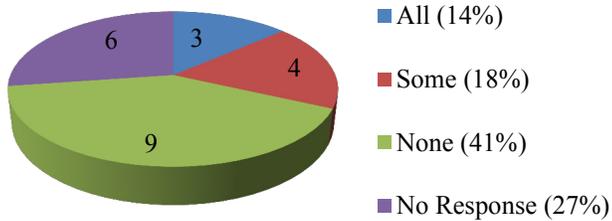


Does the program monitor fidelity to this EBP?



Individual Placement and Support (IPS) Employment

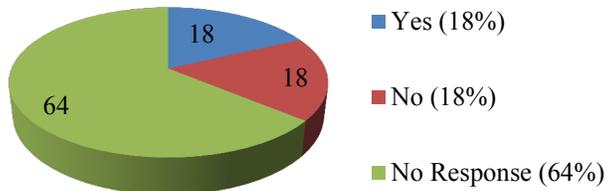
How many of your treatment providers offer this EBP?



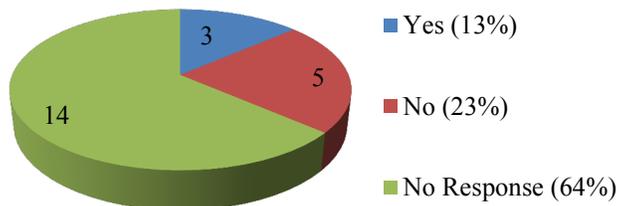
Reasons for not providing this EBP:

- Lack of familiarity with the EBP
- Too expensive
- Lack of training resources
- Unsure how to get started
- Just started ISP in CSP and haven't looked beyond the MH population
- IPS used in county for the non-criminal justice population

Have staff been specifically trained to implement the EBP?

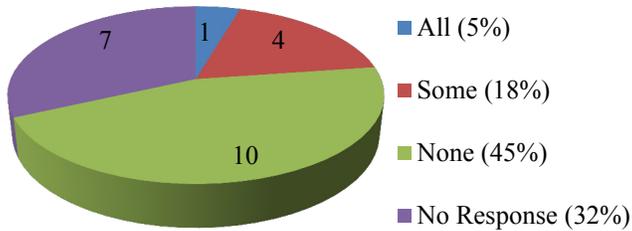


Does the program monitor fidelity to this EBP?



Assertive Community Treatment

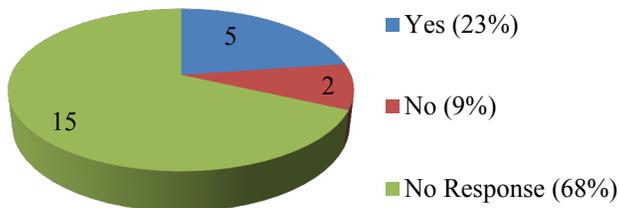
How many of your treatment providers offer this EBP?



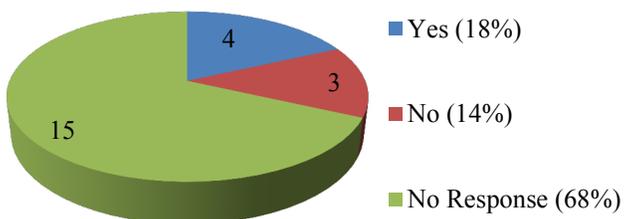
Reasons for not providing this EBP:

- Irrelevant to participants
- Lack of familiarity with the EBP
- Unsure how to get started
- Lack of training resources
- Not available within the county

Have staff been specifically trained to implement the EBP?

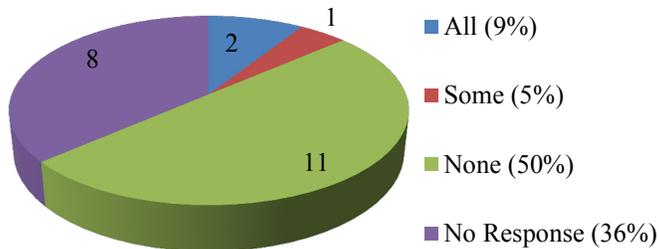


Does the program monitor fidelity to this EBP?



Illness Management and Recovery (IMR)

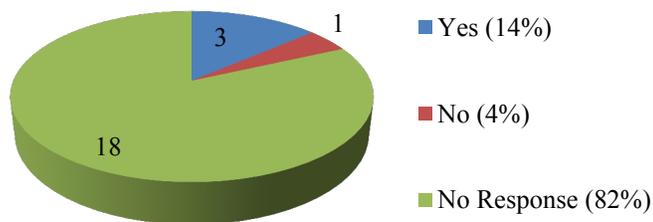
How many of your treatment providers offer this EBP?



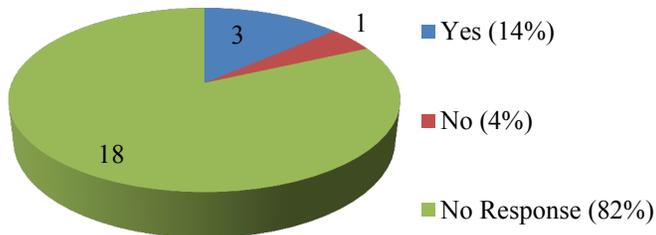
Reasons for not providing this EBP:

- Irrelevant to participants
- Lack of familiarity with the EBP
- Lack of training resources
- Too much staff time required

Have staff been specifically trained to implement the EBP?



Does the program monitor fidelity to this EBP?

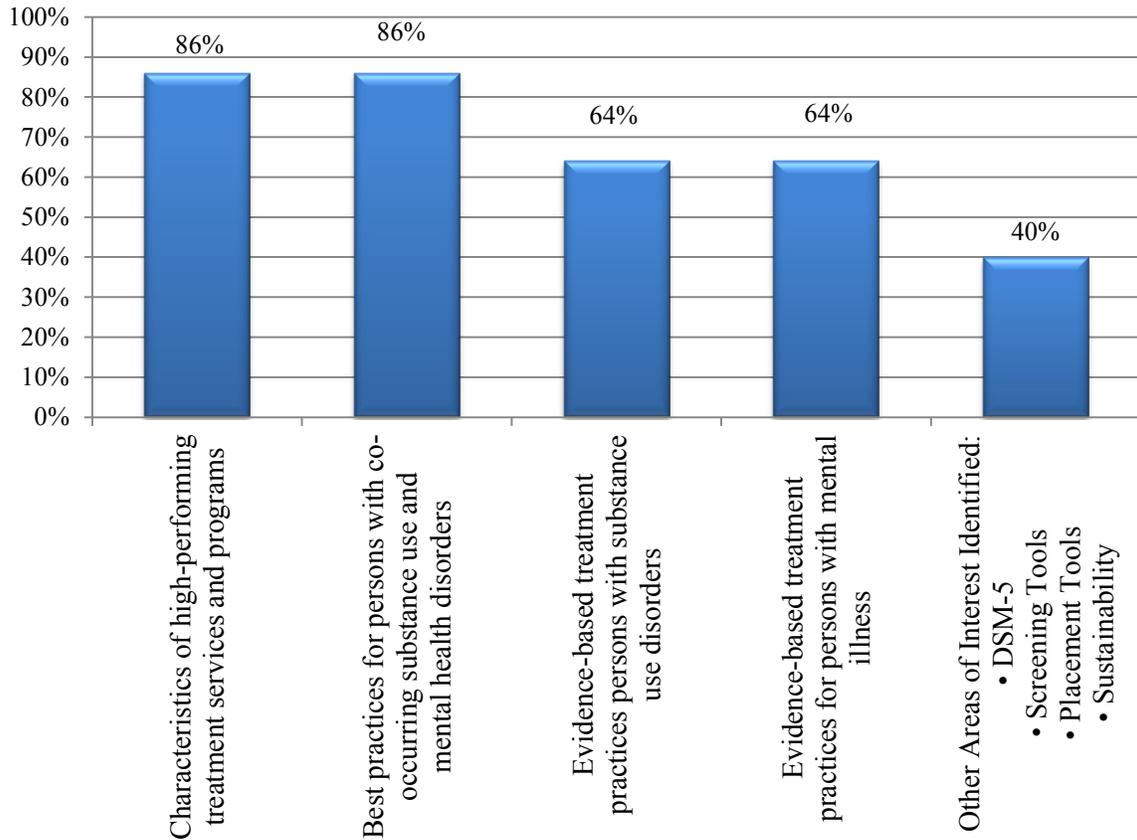


FUTURE TRAINING NEEDS

General Topics of Interest

With regard to basic approaches, close to 90% of projects are interested in training on:

- Characteristics of high-performing treatment services/programs
- Working with people with co-occurring needs



EBP Training of Interest

With regard to specific EBP's, Integrated Mental Health and Substance Abuse Services (IDDT) is ranked the highest (73%). Pharmacotherapy, Criminal Justice Based Interventions and Peer Support Services were also identified by the majority of the projects.

