Strategies for Aftercare
Implementation: It’s Not Just Aftercare

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It’s Not Just Aftercare!!

• The rubber meets the road in the community.
• Community intervention is not simply repeating the same curricula done on the inside (always).
• Community Intervention involves other individuals in the community.
• Community Intervention involves meeting multiple needs, not just criminogenic needs.
• Requires strong coordination between supervision and various service providers.
EIGHT GUIDING PRINCIPLES FOR RISK/RECIDIVISM REDUCTION

RISK/NEED: ASSESS ACTUARIAL RISK

MEASURE RELEVANT PRACTICES

TARGET INTERVENTION

ENHANCE INTRINSIC MOTIVATION

RISK/NEED: ASSESS ACTUARIAL RISK

MEASUREMENT FEEDBACK

INCREMENT POSITIVE REINFORCEMENT

SKILL TRAIN WITH DIRECTED PRACTICE

ENGAGE ON-GOING SUPPORT IN COMM.

Source: NIC
EFFECTIVE COMMUNITY INTERVENTION FACTORS

• (CLINICAL) – A wide variety of interpersonal relations

• (PROGRAM ASSIGNMENT) – Continuous programmatic decisions that match offenders to varying levels and types of supervision conditions based on offender risk and need

• (PROGRAMMING) – Services (both treatment and monitoring interventions)

• (SANCTIONS) – Determinations of accountability for assigned obligations & accompanying consequences

• (COMMUNITY LINKAGES) – Formal and informal interfaces with various community organizations and groups

• (CASE MANAGEMENT) – A case management system that relegates individual case assignments with a prescribed set of procedural expectations, and;

• (ORGANIZATION) – Internal (operations) and external (policy environment) organizational structures, relations and cultures
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<th>Number of Tests</th>
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EIGHT GUIDING PRINCIPLES FOR RISK/RECIDIVISM REDUCTION

1. Measure relevant practices
2. Enhance intrinsic motivation
3. Skill train with directed practice
4. Increase positive reinforcement
5. Engage on-going support in comm.
6. Target intervention
7. Risk/need: assess actuarial risk
8. Measurement feedback

Source: NIC
ENHANCE INTRINSIC MOTIVATION: COMMUNICATE

Interpersonally in a Constructive and Sensitive Manner to Better Engage the Person

Dysfunctional Family Relations
Anti-Social Companions
Alcohol & Drug Problems
Low Self-Control
Anti-Social Attitudes
Callous Personality
MUST ASSESS ALL AREAS

- Family
- Leisure
- Education
- Employment
- Temperament
- Anti-Social Peers
- Anti-Social Attitudes
- Mental Health
- Substance Abuse
NO MATTER WHAT ELSE, IF THEY EXIST, YOU MUST FOCUS ON

• Anti-Social Attitudes
• Substance Abuse
• Education
• Employment
ALWAYS FOLLOW CORE CORRECTIONAL PRACTICES

Gendreau, Andrews and Theriault (2010)

Effective Reinforcement
Effective Disapproval
Effective Use of Authority
Cognitive Restructuring
Anti-Criminal Modeling/Structured Skill Building
Problem Solving
Relationship Skills/Motivational Interviewing
All staff members should view themselves as agents of change and support the goals of offender rehabilitation.

It is important to attend to issues that may block success including mental health, substance use, housing and employment issues.
TARGET INTERVENTIONS (& SERVICE ASSIGNMENT) TO CRIMINOGENIC NEEDS

- Anti-Social Companions
- Alcohol & Drug Problems
- Low Self-Control
- Anti-Social Attitudes
- Dysfunctional Family Relations
- Callous Personality
• Depending on the specific issues, the sequence of treatment responses might have to be different, sometimes done concomitantly, sometimes one after the other.
DECIDING INTERVENTION MODALITIES

• When should you provide:
  – Individual
  – Group
  – Family
TAILOR DOSAGE AND INTENSITY OF SERVICES TO THE TARGET POPULATION

• Higher-risk individuals benefit from significantly more structure and services than lower-risk offenders
  – High-risk: 300 hours
  – Moderate-risk: 200 hours
  – Low-risk: 100 hours

• During the initial three to nine months post-release, 40%-70% of high-risk individuals’ free time should be occupied with delineated routine and appropriate services
WHAT DO WE KNOW ABOUT “FORCED TREATMENT?”

• The literature show no statistical difference in outcomes. Issues that are relevant:
  – Enhancing Motivation
  – Engagement
  – Relationship w/ therapist
BUT, DOESN’T THAT MEAN INDIVIDUAL THERAPY?

• Engagement is not a function of modality
• Some models lend themselves better to group
• Individual tends to be related to the specific needs / deficit of an individual and in a few cases may need to be done prior to a group intervention.
• More often, it may be needed in addition to a group intervention.
OK, WHAT DO WE DO IN GROUP?

• Best to utilize an evidence-based curricula to impact the criminogenic factors
  – Thinking for a Change
  – Moral Reconciliation Therapy
  – Reasoning and Rehabilitation

• Open ended, conversational, client-directed, issue of the moment groups are ineffective.
USE COGNITIVE-BEHAVIORAL INTERVENTIONS

• These strategies are focused on changing individual thinking patterns in order to change behavior
• Social learning techniques can be incorporated into any reentry program
• Positive reinforcement is key
So, all we focus on are the cognitive interventions?

• No, it is important to focus on all of the relevant areas that may not directly cause, but so impact recidivism.
Focusing on all the relevant areas

Low Criminogenic Risk
(low)

Medium to High Criminogenic Risk
(med/high)

Low Severity of Substance Abuse
(low)

Substance Dependence
(med/high)

Low Severity of Substance Abuse
(low)

Substance Dependence
(med/high)

Low Severity of Mental Illness
(low)

Serious Mental Illness
(med/high)

Low Severity of Mental Illness
(low)

Serious Mental Illness
(med/high)

Low Severity of Mental Illness
(low)

Serious Mental Illness
(med/high)

Low Severity of Mental Illness
(low)

Serious Mental Illness
(med/high)

Group 1
I – L
CR: low
SA: low
MI: low

Group 2
II – L
CR: low
SA: low
MI: med/high

Group 3
III – L
CR: low
SA: low
MI: med/high

Group 4
IV – L
CR: low
SA: med/high
MI: med/high

Group 5
I – H
CR: med/high
SA: low
MI: low

Group 6
II – H
CR: med/high
SA: low
MI: med/high

Group 7
III – H
CR: med/high
SA: med/high
MI: low

Group 8
IV – H
CR: med/high
SA: med/high
MI: med/high
Interventions

• Substance Abuse
  – Integrated Treatment
  – People, places and things
• Family support
  – Multi-family therapy
• School/Work
  – Supported Employment
• Homelessness
  – Housing first
• Antisocial Cognitions/Associates/Character
  – Monitoring
  – Cognitive behavioral interventions
Cognitive-Behavioral Interventions
CJ-Involved Populations

• Introspection skills
• Cognitive Restructuring
  – Problem Solving
    • Identification of cognitions
    • Cost-benefit analysis
• Social Skills
  – Conflict Resolution
• Moral Reasoning/Community Responsibility
SERVICE ASSIGNMENT: BE RESPONSIVE TO TEMPERAMENT, LEARNING STYLE, AND CULTURE WHEN ASSIGNING PROGRAMS

- Dysfunctional Family Relations
- Anti-Social Companions
- Alcohol & Drug Problems
- Low Self-Control
- Anti-Social Attitudes
- Callous Personality

TOOLS
• Responsivity has three components: the individual, the provider, and the culture/system involved.

• There are important interactions between the learning and personality style of the offender and their setting or situation.

• Therapist’s skills should be matched with appropriate program type.

• Offender’s strength and limitations should be considered in program plans- for example, an offender with limited literacy may not be appropriate for a program requiring extensive reading or journaling.
SKILL TRAIN WITH DIRECTED PRACTICE: PROMOTE EVIDENCE-BASED PROGRAMMING (MST, COG. SKILLS, RP, MI) THAT EMPHASIZES COGNITIVE/BEHAVIORAL STRATEGIES
IN OTHER WORDS: PRACTICE, PRACTICE, PRACTICE!!

• The most effective interventions provide opportunities for participants to practice new behavior patterns and skills with feedback from program staff
• Pro-Social Behavioral Modeling is required for effective cognitive-interventions
INCREASE POSITIVE REINFORCEMENT: REWARD PRO-SOCIAL BEHAVIORAL SKILLS TO IMPROVE COMPLIANCE
Remember, 4:1 positive reinforcement is required to create behavior change in individuals.

ENGAGE ON-GOING SUPPORT FOR OFFENDERS IN THEIR NATURAL COMMUNITIES
ENGAGE ON-GOING SUPPORT IN NATURAL COMMUNITIES

• Collaborative relationships between community and faith-based organizations and government agencies improves reentry

• Community supports (family members, spouses, and other supportive community members) should be engaged as a regular part of case planning
SOCIAL NETWORK MAPPING

PRO SOCIAL ORIENTATION:
- Acquaintance
- Friend

Friends & acquaintances the subject sees almost every MONTH

Friends & acquaintances the subject sees almost every WEEK

PRO CRIMINAL ORIENTATION:
- Acquaintance
- Friend

SUBJECT
• Research shows that individuals who returning to the community from incarceration have significantly higher survival curves (success rates) if they have at least one significant, non-criminal support. The more supports they have, the better the outcome.
DIFFERENTIAL LEVELS OF INVOLVEMENT

• Family and Close friends to help monitor:
  – Substance use
  – How individual interacts with others (pro- vs. anti-social)
  – View of authority
  – Where they spend leisure time
  – Participate in pro-social leisure events
  – Participate in religious services
  – Work or school involvement
  – Pro-social hobbies
  – Manage their emotions
  – Quality of decision-making
• Employers, Educators, Faith Community
  – Monitor attendance
  – Provide appropriate peers
  – Extend social supports for holidays and giving back to the community (especially the faith community)
Client's T1 Rank Order of Needs:  No.1_Emotion, [.10] ~ No.2_Alcohol/Drug, [.89] ~ No.3_Family, [.75]
MUST BE ASSESS PROGRESS

- Pre- and post-testing is imperative
- All clients should be evaluated for progress at least every quarter.
- Assessment of Treatment and Supervision progress should be integrated.
Thank You

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