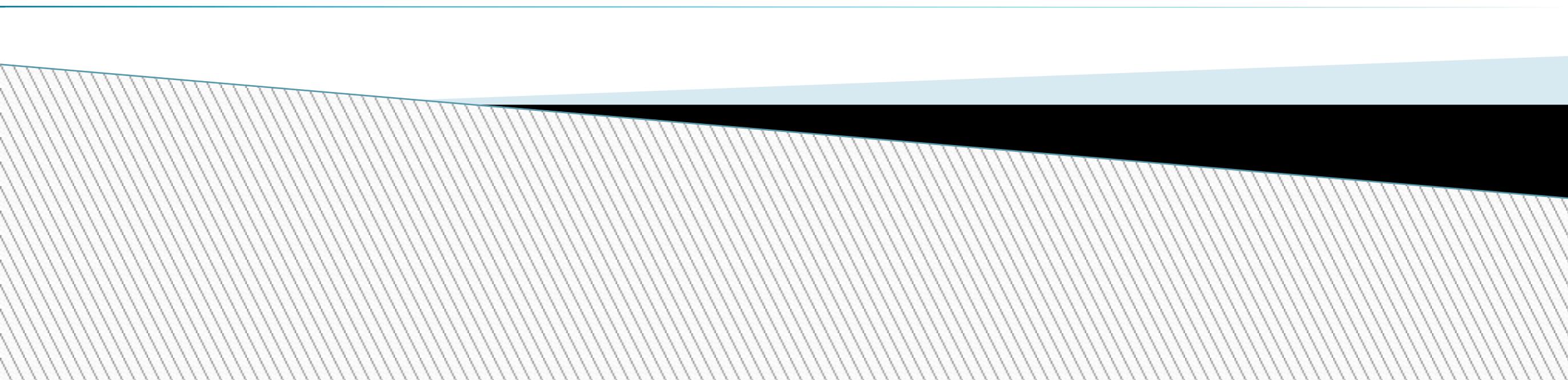
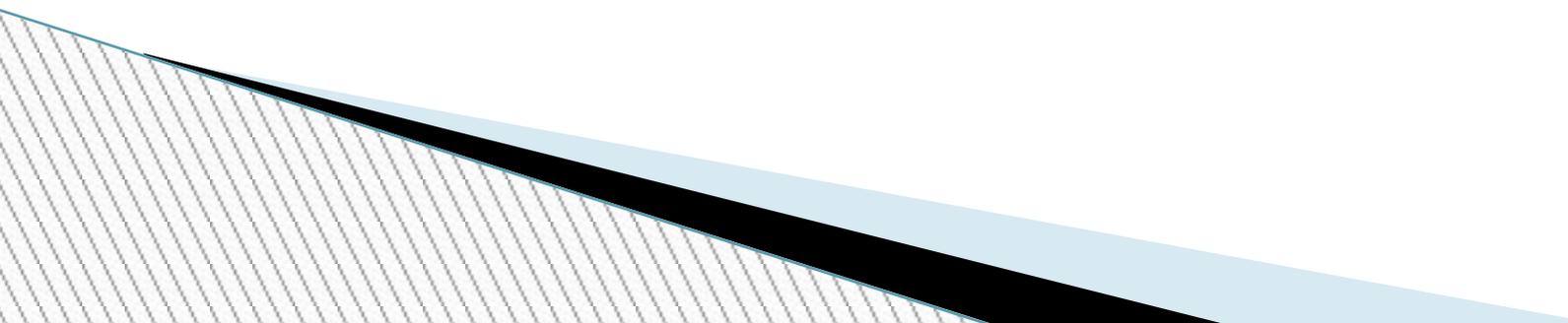


Implementation of Evidence-Based Practices: A Networking Opportunity



Today

- ▶ Director of the Conference – this workshop is an experiment based on feedback from you asking for more networking opportunities at the conference
 - ▶ A series of small group discussions assuming knowledge of the core correctional practice research and introducing how implementation science can be used to integrate the RNR model into mental health treatment
 - ▶ Tables by geography and one table for juveniles
- 

- Northern California
- Sacramento
- San Francisco & Bay Area
- Central Valley
- Central Coast
- Los Angeles & southern California
- Orange County
- San Diego
- Juveniles (“the kids’ table”)

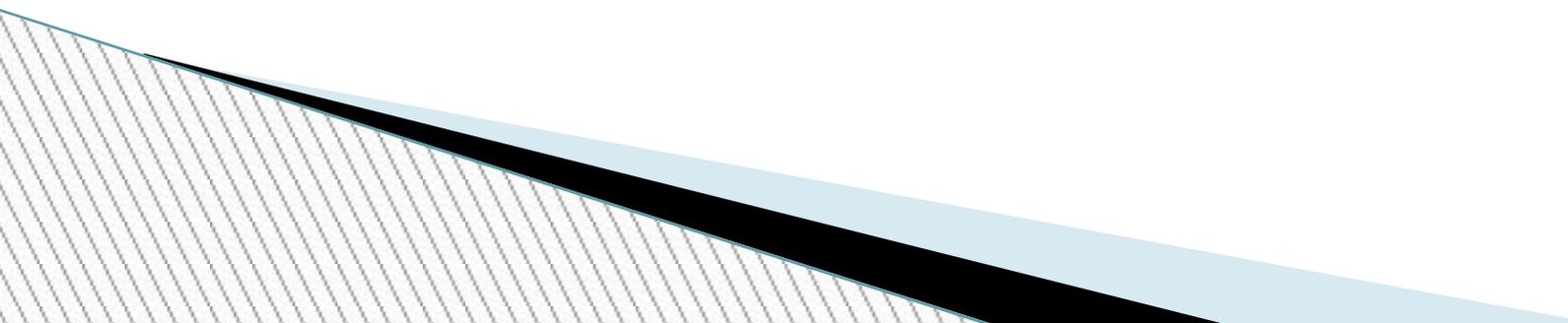
About Tom

- ▶ LCSW: Mental Health 1986–1999
- ▶ U. S. Probation 1999 to 4/30/19
 - ▶ Supervisor – EBP Coordinator
- ▶ Cal State L. A., School of Social Work, Lecturer, 2006 to now
- ▶ My interest right now: the integration of the recovery model with evidence-based practices
- ▶ “To teach is to learn”, Japanese proverb

Mental Health & Criminal Justice



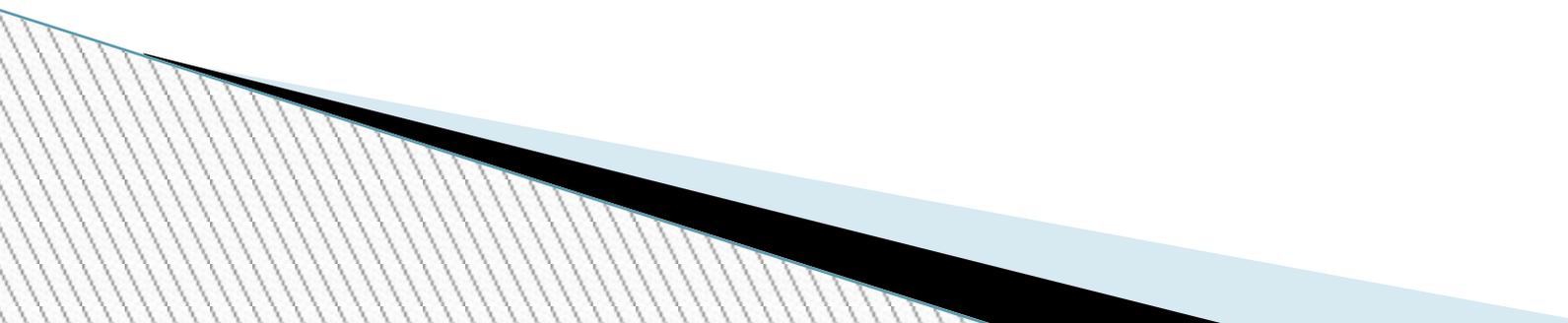
About Will

- ▶ Department of Public Safety, Implementation Specialist
 - ▶ City and County of Denver, 2010–'14
 - ▶ State of CO, Div of Criminal Justice 2014–'18
 - ▶ Founded Kmodity Corp in 2015
 - ▶ Designing *strength-based* reentry solutions for justice-involved populations
 - ▶ “The elephant never gets tired of carrying its tusks.” – Liberian proverb
- 

Discussion – introduce yourselves and ...

- ▶ About you – where are you from? what do you do?

Discussion – RNR?

- ▶ 1 = I thought this workshop was R *and* R – rest & relaxation
 - ▶ 2 = I've heard of it
 - ▶ 3 = I have had some training but need help knowing how to integrate it into my daily work with clients
 - ▶ 4 = I have had some training; I'm ready to integrate into my practice, but I don't have the agency support I need, i.e., ongoing training, coaching & supervision
 - ▶ 5 = I should be doing the training instead of these guys
- 

- ▶ Mental health clinicians? mental health administrators? probation/parole? attorneys? judges? police officers? missed anybody?
- ▶ RNR knowledge hopefully in the 3–5 range? We put in the workshop description we would assume knowledge – we will not be covering the model

Definitions of evidence-based practice (EBP) vary from:

- ▶ (Trotter, 2006) “...simply ... the use of research findings as a primary source of knowledge for practice”

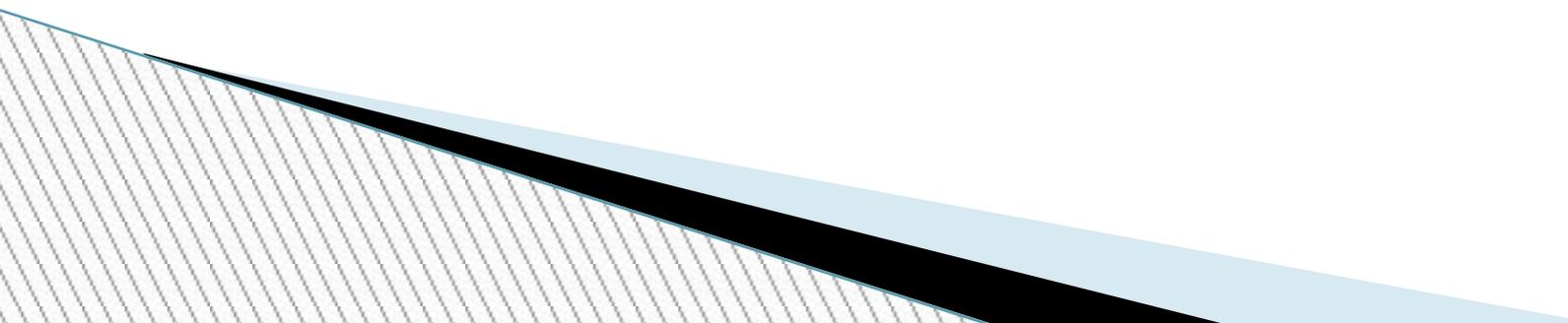
to: Washington State Institute for Public Policy (WSIPP)

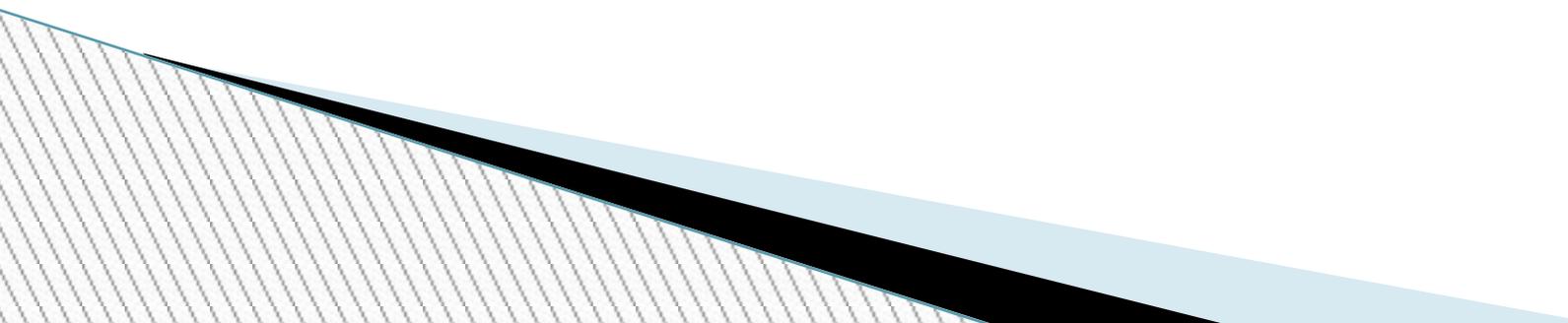
- ▶ Evidence-based: tested in heterogeneous or intended populations; multiple randomized and/or statistically-controlled evaluations or one large multiple-site randomized and/or statistically controlled evaluation; weight of systematic review demonstrates sustained improvements; can be implemented with a set of procedures for successful replication; cost-beneficial

In between:

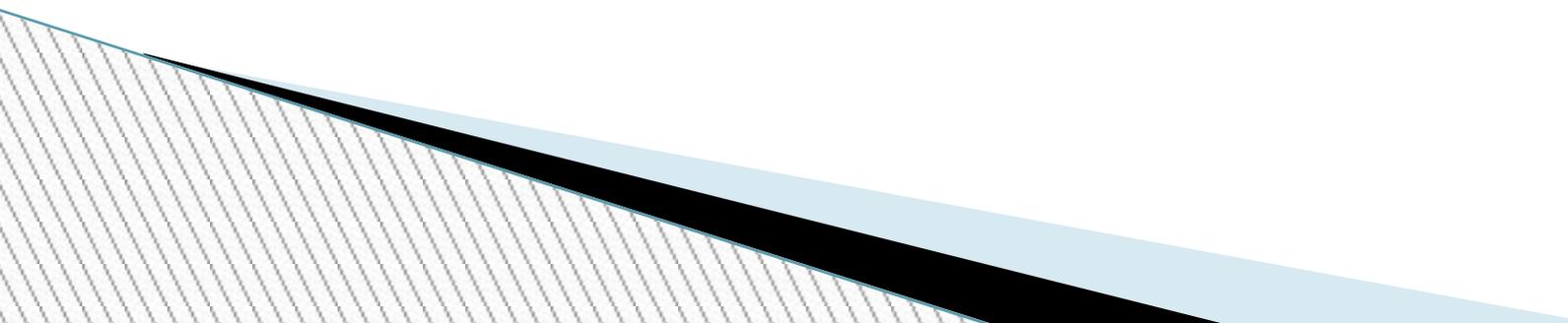
- ▶ National Institute of Corrections (NIC)
 - EBP = definable, measurable outcomes of practical realities, e.g., recidivism

- ▶ Substance Abuse and Mental Health Services Administration (SAMHSA)
National Registry of Evidence-based Programs and Practices (NREPP)
 - Evidence-based practice: “A practice that is based on rigorous research that has demonstrated effectiveness in achieving the outcomes that it is designed to achieve.”

- ▶ Office of Justice Programs (OJP),
National Institute of Justice (NIJ)
 - ▶ <http://www.crimesolutions.gov/>
 - ▶ Effective: “Programs have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity.”
- 

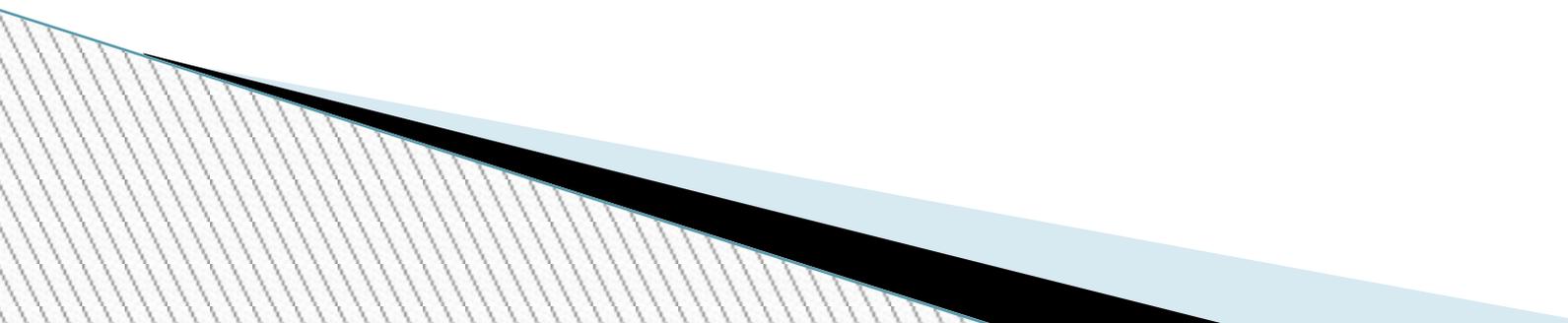
- Best practices = based on collective professional experience, not scientifically tested
 - “What works” = general outcomes
 - ▶ Promising: “Programs have some evidence to indicate their intended outcomes.”
 - ▶ No Effects
- 

How do we really know?

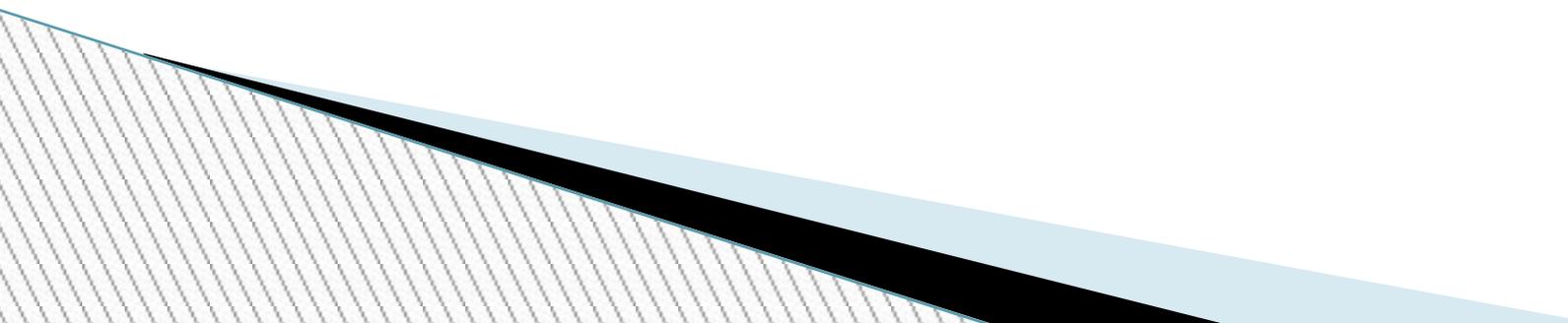
- ▶ Excited over data?
 - ▶ “There are 3 kinds of lies: lies, damned lies, and statistics” (Benjamin Disraeli)
 - ▶ Best we have.
- 

- ▶ RNR is evidence based – it works
- ▶ RNR reduces recidivism 25–50% = win–win–win: truly “ex”–offenders, their families, and prevention of real victims!

The personal & organizational why

- ▶ Take a minute to remember why we chose this work: sounds cliché? to help people, to make a difference
 - ▶ High caseloads, paperwork, agency rules, agency politics takes the humanity out of us and our clients?
 - ▶ Are you still passionate about your work?
- 

Evidence Based Practices in Mental Health

- ▶ The Relationship
 - ▶ Illness Management & Recovery
 - May include medication
 - ▶ Assertive Community Treatment
 - ▶ Integrated Co-Occurring Disorders Treatment
 - May include Medication Assisted Treatment (MAT) for addiction recovery
 - ▶ Trauma Interventions
 - ▶ Supported housing and supported employment
- 

Promising and Best Practices in Forensic Mental Health Treatment

- ▶ Individualized and Comprehensive
 - Forensic Assertive Community Treatment (FACT)
 - RNR
 - Basic necessity care and goal-planning
 - Community based support including medical/dental
 - Family and vocational support
 - Court/Criminal Justice advocacy and liaison
 - Transition and step down planning
 - Adherence monitoring
 - Partnership between Criminal Justice and Clinical Service Providers
 - Problem solving approaches to behavior challenges

How to integrate RNR into mental health services? Organizational Change



Implementation Science

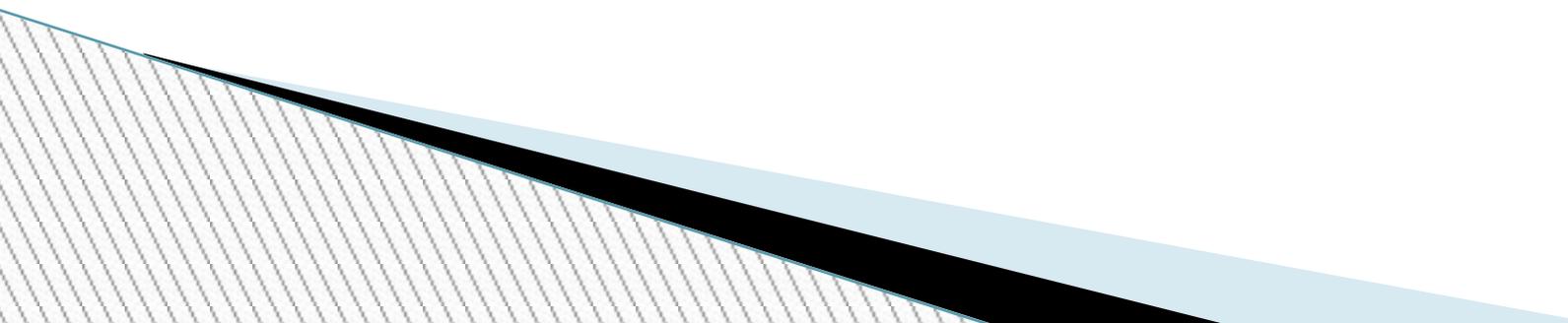
- ▶ Implementation: "A specified set of activities designed to put into practice an activity or program of known dimensions"
- ▶ "Implementation Science is the study of factors that influence the full and effective use of innovations in practice. The goal is not to answer factual questions about what is, but rather to determine what is required."
- ▶ National Implementation Research Network (NIRN)
<http://nirn.fpg.unc.edu>
- ▶ Fixsen et al. 2015 & 2005

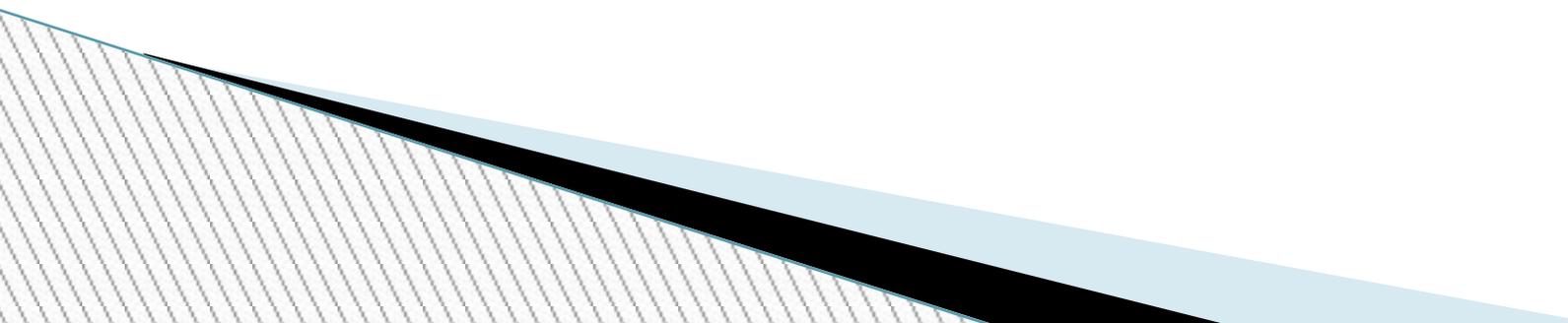
Clinical staff – don't check out here; why this is important to talk about

- ▶ Will you go and actually change your practice after this training? The research says you won't

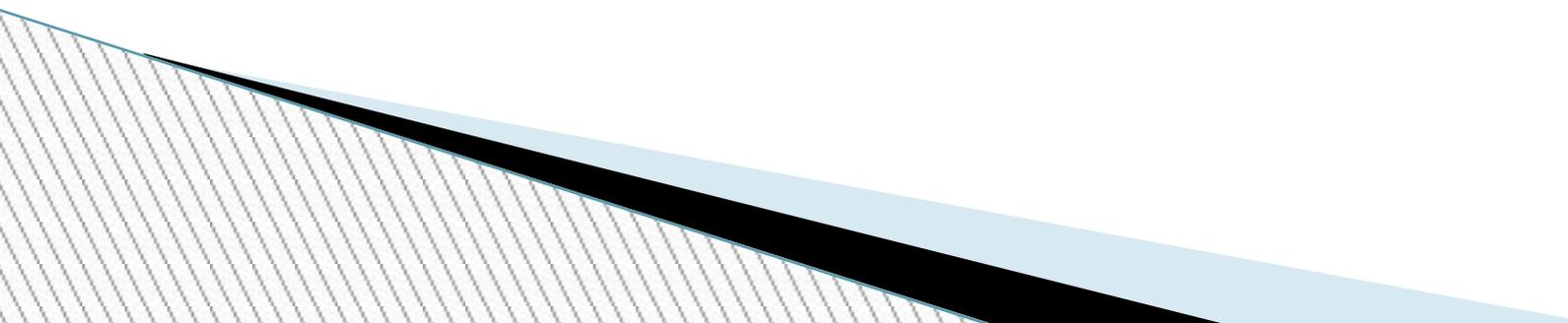
- ▶ A study with teachers in education:
 - Theory & discussion in training – 0 use in the classroom
 - Demonstration in training – 0 use in the classroom
 - Practice & feedback in training – 5% use in the classroom
 - Coaching in the classroom – 95% use

◦ Joyce & Showers, 2002

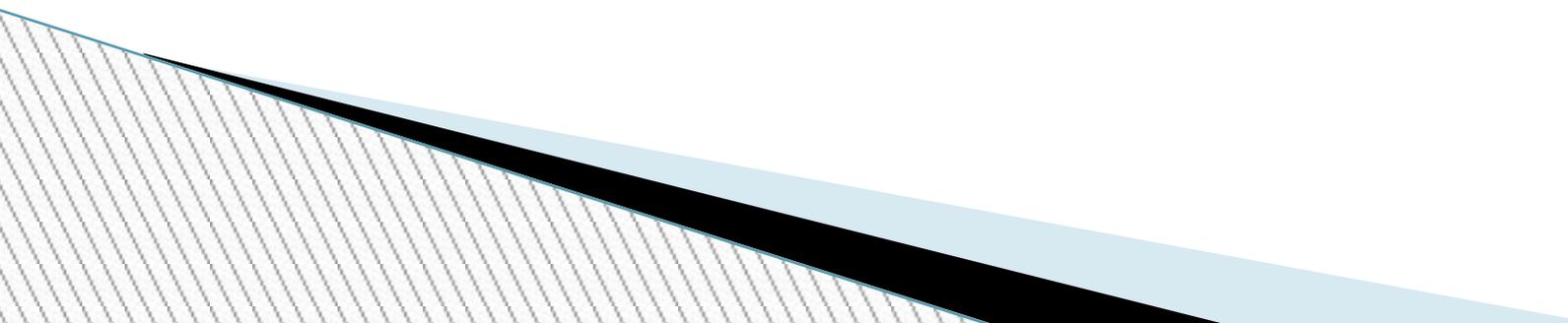


- ▶ We are asking our clients to change their behavior
 - ▶ EBP implementation requires behavioral change by practitioner, supervisor, & administrators. Training & coaching are the #1 way behavior change brought about.
- 

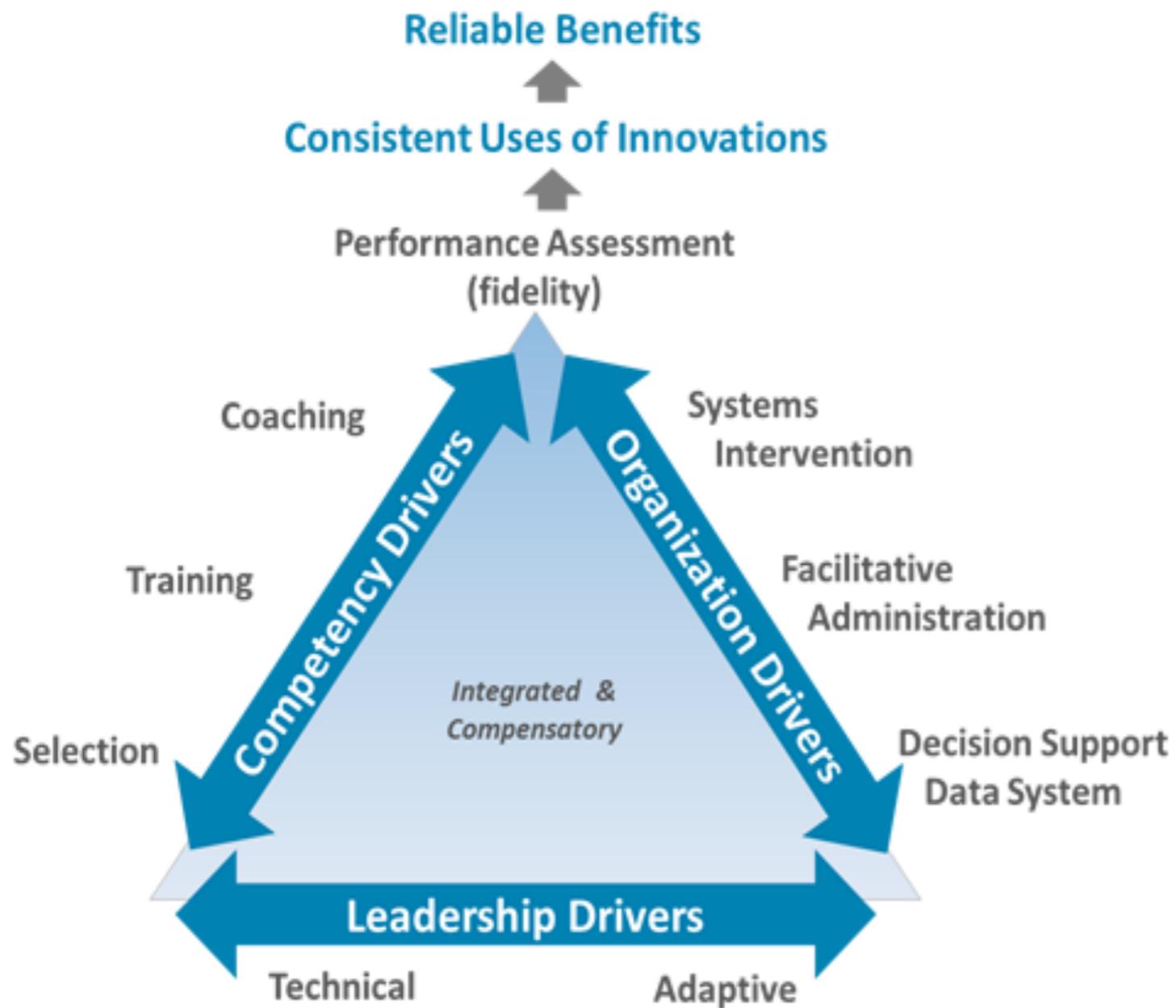
Implementation Stages

1. Exploration & Adoption
 2. Program Installation
 3. Initial Implementation
 4. Full Operation
 - 50% of positions are filled with practitioners that meet the fidelity criteria
 5. Innovation
 - Typically occurs after 1–2 years of full implementation
 6. Sustainability
- 

Discussion: What stage are you in?

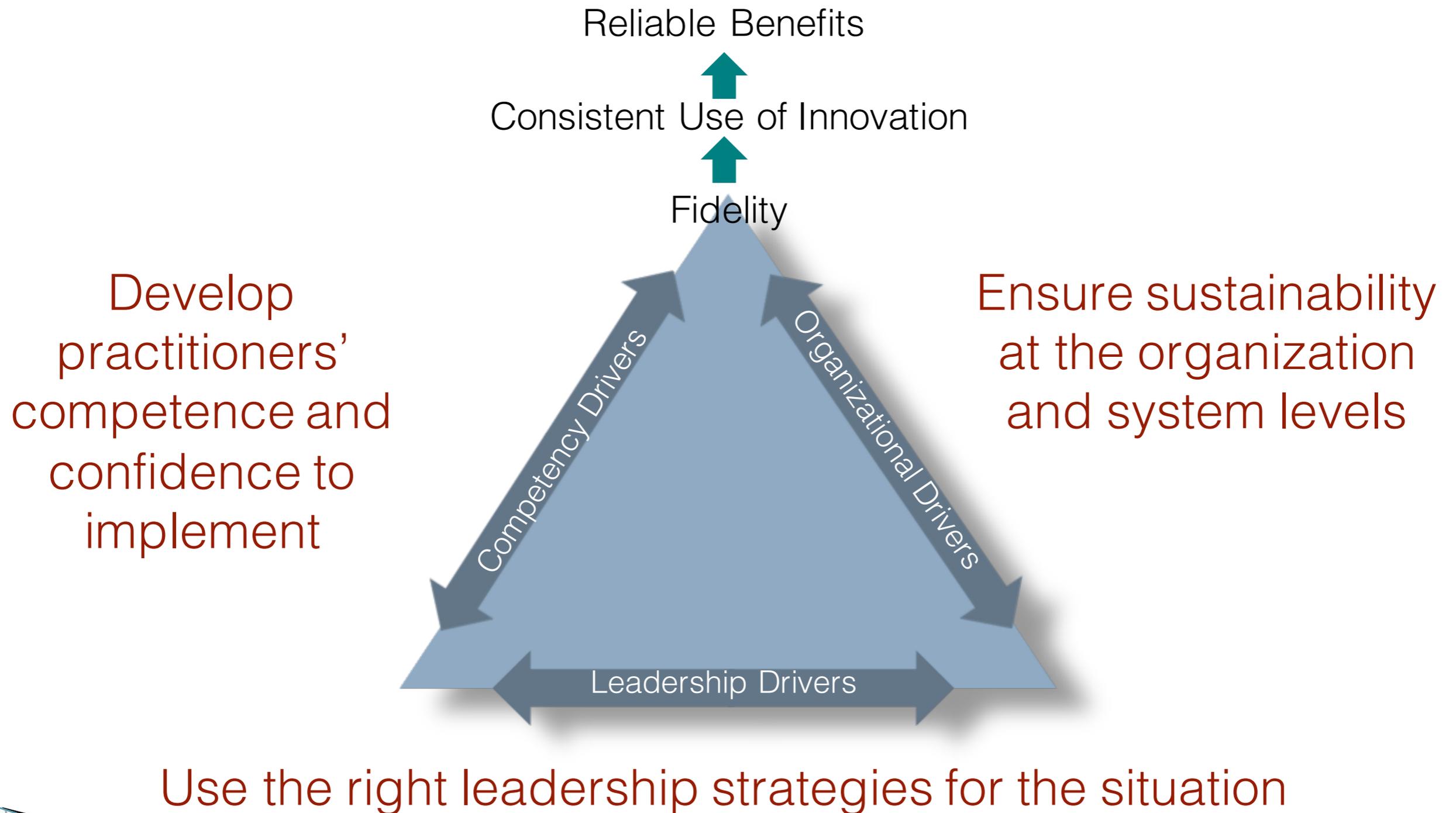
- ▶ Exploration & Adoption
 - ▶ Program Installation
 - ▶ Initial Implementation
 - ▶ Full Operation
 - ▶ Innovation
 - ▶ Sustainability
- 

Drivers of Successful Implementation



- Competent workforce
- Hospitable environment
- Engaging leaders

Implementation Drivers



Focus on Implementation Includes...

Changing organizational cultures and climates, which require multiple layers of change, determination, and time.

Developing leadership's ongoing and unwavering commitment to tackling challenges.

Staff integration of new programs and practices.

Technical v. Adaptive

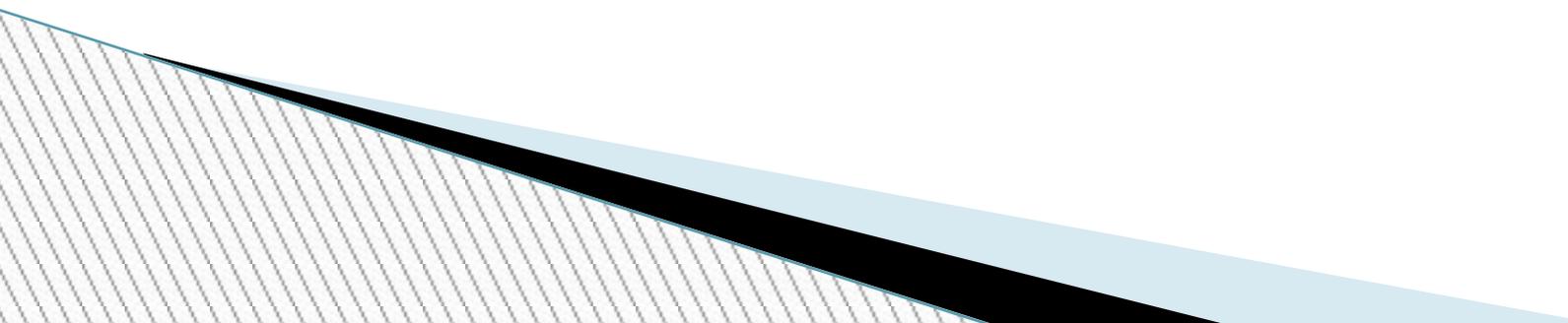
Technical example	Defining the Problem	Who Solves the Problem	Type of Work
	Simple	Authority	Apparent
Broken arm	Broken arm	Doctor	Set and cast

Technical v. Adaptive

	Defining the Problem	Locus of Work	Type of Work
Technical	Simple	Authority	Apparent
Adaptive	Complex and Difficult	The Individual // Stakeholders	Unclear and Evolving / May require new learning / Experiments

Kind of Work	Problem & Solution Definition	Locus of Work	Type of Work
<p>TECHNICAL</p> <p>e.g. Broken Arm</p>	<p>CLEAR</p> <p>Set & Cast</p>	<p>AUTHORITY</p> <p>Doctor</p>	<p>OPTIMIZE EXECUTION</p> <p>Set and cast arm as efficiently and comfortably as possible</p>

Adaptive Flags

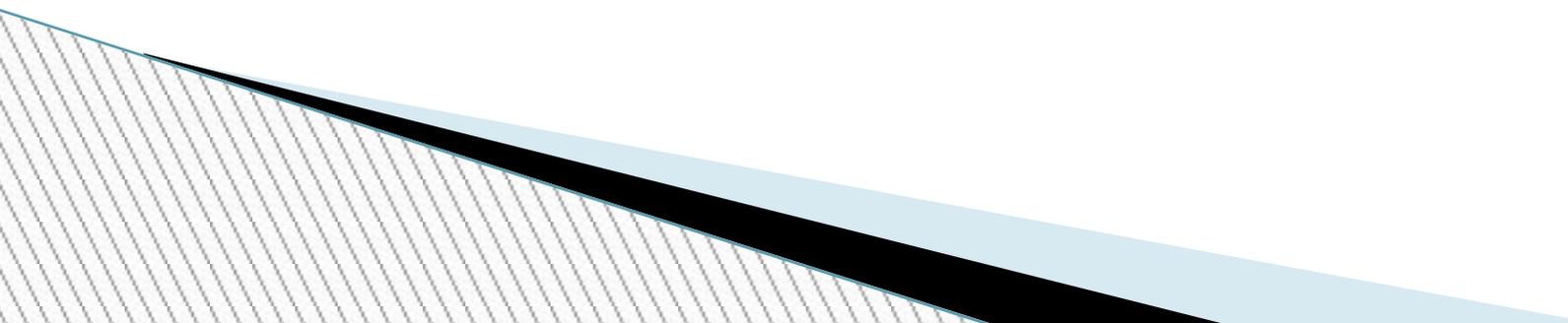
1. No Known Solution
 2. People Would Rather Avoid the Issue
 3. Reason and Logic Alone Won't Get You There
 4. Recurring Problem
 5. Emotional Response
 6. Failure to Resolve Competing Priorities
 7. Moving Forward Feels Risky
 8. Casualties
 9. People Must Work Across Boundaries
 10. Progress Is Not Linear
- 

Activity

Identify a challenge with implementing an evidence-based practice or intervention in your organization

- ▶ Describe the challenge
- ▶ List 3 technical aspects of the challenge
- ▶ Choose at least 1 adaptive flag or indicator that might apply to challenge.

Share and report out ideas



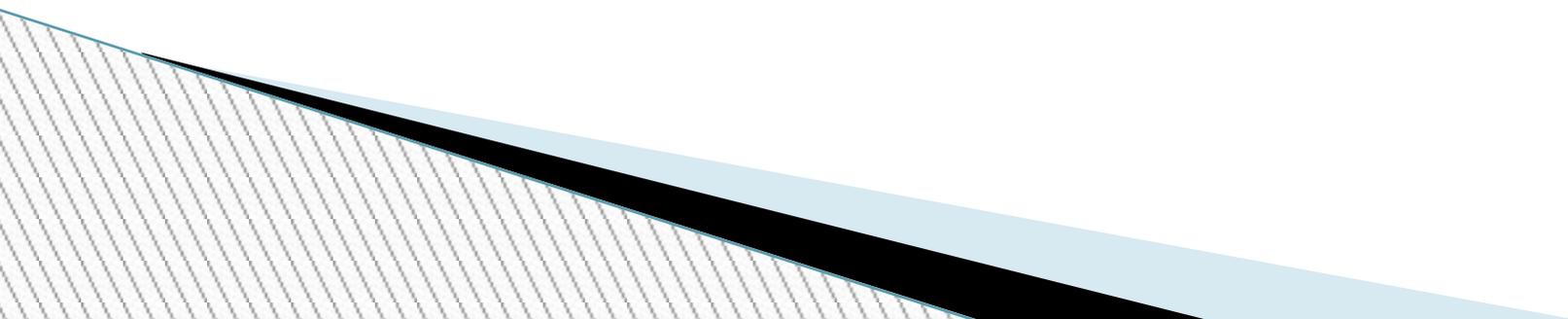
Discussion – who pays?

- ▶ Is this a big question for you?
 - Who does the correctional treatment and who pays for it? Mental health or probation/parole or both?
 - Reimbursement issues – treating antisocial and other personality disorders (or traits)?

Q&A – Common Questions

1. Why does implementation seem so complicated?
2. How can we find time and resources to do *effective* implementation?

Implementation at the clinical level ...

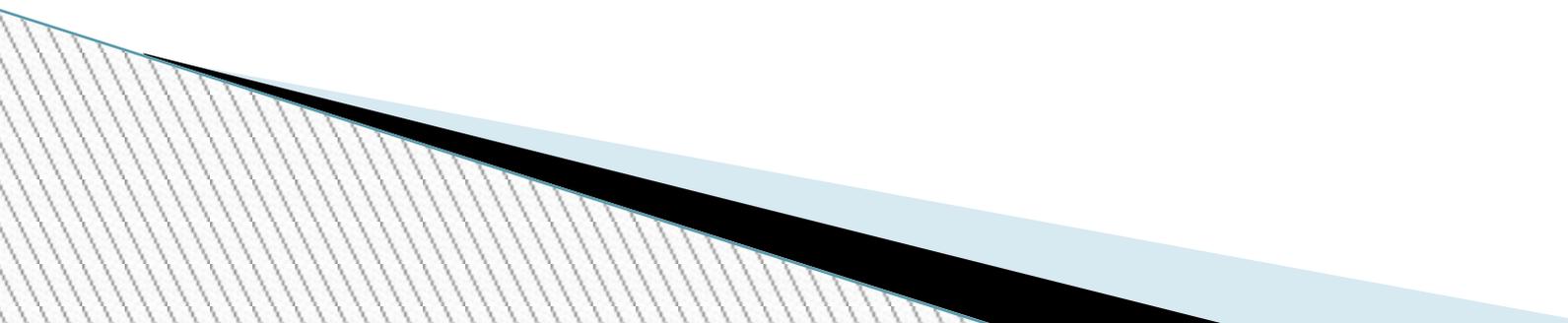


“I have this guy ...”

- Don is a 50 year old male court-ordered to psychotherapy. He says that although he does not think he has any problems that he needs counseling for, he will come to therapy because he does not want to go back to prison. Don has a lengthy criminal history starting with multiple car thefts and burglaries as an adolescent. As an adult, he has been convicted of crimes ranging in seriousness from driving with a suspended license to attempted rape. He has been convicted of multiple forgeries, credit card fraud violations and drug possession. He also has multiple arrests for forgery that he was not convicted of.

- At age 25, he was less than honorably discharged from the Army. He has an 11th grade education and has been unable to keep jobs between his incarcerations. He has a history of methamphetamine addiction. He has no medical problems. He says he is through with his criminal lifestyle because he is too old to go to prison again, but he shows no remorse for his actions. He was recently released after 5 years in prison. He is currently living with his elderly father and he has a girlfriend, but he has no other friends. He is currently unemployed. He denies any symptoms of depression, anxiety, or psychosis.

What more information do you need?

- ▶ From RNR perspective:
 - ▶ Risk level is High
 - ▶ Top 3 dynamic risk factors are Cognitions, Social Networks, Substance Abuse
 - ▶ Responsivity factor – motivation?
- 

What's his treatment plan?

The treatment plan ...

- ▶ In addition to traditional mental health treatment – cognitive behavioral, social learning, and motivational interviewing approaches to address dynamic risk factors

In conclusion: Implementation

- ▶ Not rocket science, but you have to implement training in the intervention(s), ongoing coaching, fidelity, and process and outcomes measurement

Effective *implementation strategies are essential* to successful outcomes

- 2-4 year process with implementation support versus 17 years without!

In conclusion: “Correctional Quackery”

- ▶ Quackery = common sense or tradition over scientific evidence
- ▶ Unscientific services -- no change or can increase antisocial behavior (Flores et al. 2005)

Our encouragement and challenge for you...

- ▶ Don't practice correctional quackery
- ▶ A personal action plan... tell the person next to you one change you are going to make when you return to your office as a result of attending this workshop?

Our contact info

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 - ▶ will@kmodity.com
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