SOLANO COUNTY PUBLIC SAFETY REALIGNMENT

DAY REPORTING CENTER IMPLEMENTATION PLAN FRAMEWORK

Prepared for

Community Corrections Partnership

By:
Thomas White
Corrections Consultant

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INTRODUCTION

Decades of research on offender rehabilitation programs indicate clearly that effective supervision and treatment services can be developed and implemented resulting in a significant reduction in offender recidivism. Therefore we cannot continue to support offender supervision and treatment practices that are not supported by either the existing evidence of the causes of crime, or the existing knowledge of which correctional programs have been proven to positively change offender behavior. To improve community supervision effectiveness and enhance the safety of our communities, agencies should adopt evidence-based principles of offender supervision and treatment – principles that have been scientifically proven to reduce offender recidivism. Our budgets can no longer support programs and supervision practices that have not proven to be effective. (White, T., *Evidence-Based Practices In Probation And Parole: The Implementation Challenge,* Perspectives, Summer 2006)

With this in mind, the Solano County Community Corrections Partnership (CCP) has taken steps to develop an evidence-based Day Reporting Center (DRC) model program. The CCP has identified the following eight core elements for the DRC:

1. Cognitive Behavioral groups using Evidence-Based Practices such as Aggression Replacement Training, Moral Recognition, Crossroads, and/or Thinking For A Change.
2. Mental Health (MH) / Substance Abuse (SA) assessments tools using Evidence-Based Practices.
3. MH / SA treatment groups using Evidence-Based Practices and certified addiction counselors and peer mentors. Peer mentors are individuals who have had a successful experience in the justice system / substance abuse system and can be of assistance as a "safety net" of support to those currently navigating the reentry system.
4. GED / High School Diploma / Literacy Services.
5. Job readiness, vocational training and employability skills.
6. Drug testing.
7. Eligibility Benefits and other social services – both online self-service and in-person benefit assistance.
8. Transportation and Housing Assistance.

At the July 11, 2012 CCP meeting, direction was provided to explore the creation of a Day Reporting Center in Vallejo first, and then one in Fairfield. Four Operational Workgroups were established to refine the service delivery model:

1. Cognitive Behavioral Groups and Drug Testing: Probation
2. MH / Substance Abuse Assessments, Treatment and Benefit services: HS&S
3. GED / High School, Job Readiness and Vocational Training: WIB and Sheriff's Office
4. Housing: Reentry Council

In August the CCP secured the services of a consultant to assist in the development and implementation of the DRC. During the consultant's initial onsite visit he met individually and collectively with members of the CCP Executive committee, Workgroup Chairs, and identified stakeholders. It was evident that a significant amount of thought and work had gone into the development of the DRC by the members of the Workgroups. This initial report and recommendations reflect many of their ideas.

The DRC service model that is outlined in this report is based upon the following research supported offender behavior change principles: (See Dvoskin, J. etal, *Using Social Science to Reduce Violent Offending*, 2012).

1. **Tailor behavior change programs to the individual.** Given the heterogeneity of the offender population, there is a need to recognize that "one size does not fit all." Treatment services need to be tailored to the individual risk, needs, and responsivity factors that are unique to each offender.

2. **Use risk factors and protective factors to inform supervision and treatment.** Interventions should be strength based and built upon existing resilience and prosocial skills that the offender possesses, along with social and community resources.

3. **Clearly identify both wanted and unwanted behaviors and establish a positive reinforcement protocol that systematically reinforces the wanted behaviors.** The best way to influence offenders' behavior is to "catch them doing something right" and reward them for it. However, we must first understand what each offender finds rewarding, given his or her beliefs, expectations, and value system. In other words, people do what rewards them, but before we can change their ways of getting rewards, we have to understand what motivates them.

4. **Attend to issues of motivation and incorporate methods of facilitating treatment engagement and retention.** There is considerable merit in the perspective that many offenders are less "treatment resistant" than lacking in "readiness for change." To ameliorate this problem and to foster reinforcing offender-provider interactions, programs should incorporate motivational components, such as building the participatory involvement

of offenders in considering the pros and cons of behavioral change and in setting behavior change goals.

5. **Establish high-quality relationships with offenders**. A growing body of research has established that staff offender relationships that are viewed by the offender as firm, fair, caring and supportive are directly linked to positive behavior change on the part of the offender.

6. **Use and establish real evidence-based programs.** Evaluation measures and procedures should be built into programs so that progress can be monitored and ongoing feedback provided to both staff and offenders. For every program, the same questions should be asked: "How do you know it works?" "How strong is the evidence?"

7. **Implement a treatment approach that nurtures prosocial skills, encourages prosocial affiliations, and promotes a positive lifestyle.** What skills are likely to be used in a variety of life situations to prevent general antisocial behavior? Skills in solving problems, communicating and negotiating effectively with others, resolving conflicts, and planning for the future. Antisocial cognitions and behaviors must be replaced by prosocial values and actions.

8. **Incorporate procedures to increase the likelihood of generalization and maintenance of intervention effects.** This requires behavioral rehearsal and skills practice (e.g., role plays) that approximate real-life situations. This principle is vital. Intervention should not be limited to didactic instruction, because offenders' active participation is critical.

9. **Incorporate a relapse prevention component that actively involves the offender in considering possible obstacles to behavior change efforts and in formulating "game plans" and "backup plans" to confront each obstacle.** Relapse prevention strategies are relevant to preventing repetition of internally rewarding and exciting behavior, such as substance abuse and criminal offending. The goal is for offenders to foresee situations that might elicit criminal behavior and to develop self-management skills tailored to those situations, thereby reducing the risk of reoffending.

DRC OPERATION AND PURPOSE

DRC's have been operating in the United States for more than twenty years. Historically DRC's served two primary purposes: 1) enhanced supervision and decreased liberty of offenders placed in the community; and 2) treatment of offenders' problems. Over the past decade a robust body of empirically sound research has led to the development of the Risk, Need, and Responsivity (RNR) model of offender behavior change (Andrews, D. and Bonta, J., *The Psychology of Criminal Conduct,* 2006). The RNR model has become predominate correctional practice for achieving

reductions in offender recidivism. The primary principles of the RNR model are that the level of service should be proportionate to the level of assessed risk (high risk individuals require the most intensive intervention); that treatment should be focused on changing criminogenic needs (these being dynamic factors which, when changed, are associated with reduced recidivism); and that the style and mode of the intervention should engage the offender and suit his or her learning style and cognitive abilities. These three principles require the development of comprehensive and validated assessment instruments to guide interventions. Treatment programs should be cognitive behavioral in orientation, highly structured, implemented by well trained, supported and supervised staff delivered with integrity (in the manner intended by program designers), based on manuals, and located in organizations committed to changing offender behavior.

Following a discussion with members of the Executive Committee of the CCP, it was decided that the DRC model would have as its primary goal the reduction of offender recidivism through positive sustained behavior change. Therefore, offenders would come to the DRC only to attend programs and receive services, and the supervision and monitoring responsibility would be carried out by the offender's assigned probation supervision officer. It has been my own experience that trying to accomplish too much at a DRC makes it difficult to manage, and does not lend itself to achieving reductions in offender recidivism. Furthermore, not all offender services can be conducted at the DRC. Collaboration with community agencies and referral to both existing and perhaps new County programs and services will be important.

DATA REVIEW

The initial offender group that will be targeted for services at the DRC are individuals placed on probation supervision through the 2011 Public Safety Realignment (AB109). At the present time, there are approximately 273 males and 25 females who are in this group and have been assessed by the Probation Department. The first step in determining the primary services that should be available through the DRC was to review the LS-CMI (Risk and Needs Assessment) available data on this targeted group. The racial composition and age breakdown of this group are reflected in the following tables:

LS / CMI DATA REVIEW AB 109 OFFENDERS		
	MALE	**FEMALE**
# OFFENDERS ASSESSED	273	25
RACIAL BREAKDOWN		
White	36%	36%
Black	45%	40%
Hispanic	14%	12%
Other	5%	12%

AGE BREAKDOWN	MALE	FEMALE
20 to 25 years of age	9%	4%
26 to 30 years of age	19%	16%
Over 30 years of age	72%	80%

Upon review, the majority of this group is over thirty years of age (male 72%, female 80%) with only 36% being white.

In order to realize the greatest reductions in crime (measured by offender recidivism rates), it is important to focus you resources on changing the behavior of those offenders who without intervention, are most likely to continue their criminal behavior. These "high risk" offenders historically commit the majority of the crimes although they may not make up the majority of the general criminal population. It is these high "base rate offenders" who should be the target for intervention through the DRC. The research has demonstrated that providing extensive services and supervision to "low risk" offenders may actually increase the likelihood of them continuing to commit crimes. (Lowencamp, C. and Latessa, E., *Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders,* 2004). It should be noted that general assessment tools that predict offender risk are not assessing the dangerousness of the offender nor the severity of any future offenses, but rather their risk to reoffend. Below is a breakdown of the risk levels of the AB 109 offenders who are under probation supervision as determined by a validated risk assessment tool:

ASSESSED RISK LEVEL		
RISK LEVELS	**MALE**	**FEMALE**
Very high	14%	12%
High	65%	66%
Medium	20%	22%
Low	1%	0%

Perhaps not surprising, 79% of the males and 78% of the females fall into the "Very High" or "High" risk categories. This compares to just under 50% of all the offenders who are under probation supervision in the County being assessed as "Very High" or "High". Therefore, in comparison AB 109 probationers are older and higher risk groups of offenders.

The most effective way to change criminal behavior is to modify the risk factors (criminogenic needs) that are the primary cause for an individual's antisocial (criminal) behavior (Andrews, D., Bonta, J., *The Psychology of Criminal Conduct,* 2006). Through years of research, eight risk factors have been identified that have the greatest effect on an individual's criminal behavior. These eight factors are summarized on the next page (Andrews, D., Bonta, J., *The Psychology of Criminal Conduct,* 2006).

MAJOR RISK AND/OR NEED FACTORS AND PROMISING INTERMEDIATE TARGETS FOR REDUCED RECIDIVISM		
Factor	**Risk**	**Dynamic Need**
History of Antisocial Behavior	Early and continued involvement in a number of antisocial acts	Build noncriminal alternative behaviors in risk situations
Antisocial Personality	Adventurous, pleasure seeking, weak self-control, restlessly aggressive	Build problem-solving, self-management, anger management and coping skills
Antisocial Cognition	Attitudes, values, beliefs and rationalizations supportive of crime, cognitive emotional states of anger, resentment, and defiance	Reduce antisocial cognition, recognize risky thinking and feelings, build up alternative less risky thinking and feelings. Adopt a reform and/or anticriminal identity
Antisocial Associates	Close association with criminals and relative isolation from prosocial people	Reduce association with criminals, enhance association with prosocial people
Family and/or Marital	Two key elements are nurturance and/or caring, better monitoring and/or supervision	Reduce conflict, build positive relationships, communication, enhance monitoring and supervision
Employment and/or Education	Low levels of performance and satisfaction	Enhance performance, rewards, and satisfaction
Leisure and/or Recreation	Low levels of involvement and satisfaction in anti-criminal leisure activities	Enhancement involvement and satisfaction in prosocial activities
Substance Abuse	Abuse of alcohol and/or drugs	Reduce SA, reduce the personal and interpersonal supports for SA behavior, enhance alternatives to SA

The first four of the above factors have been found to have the greatest influence (if present in someone's life) on an individual becoming a criminal. (Andrews, D., Bonta, J., *The Psychology of Criminal Conduct,* 2006). If we want to change an offender's criminal behavior and reduce crime, we need to identify and focus our efforts on changing those risk factors that are present in their lives.

A review of the assessment data on the DRC target population indicates that the risk factors or criminogenic needs that were most often identified as being a very high or high need included the following:

RISK / NEED FACTOR	PERCENT ASSESSED AS VERY HIGH / HIGH
1. History of Antisocial Behavior	83%
2. Leisure / Recreation	79%
3. Employment / Education	75%
4. Antisocial Associates	63%
5. Substance Abuse	37%

Based upon the above data, it is recommended that the following services should be the primary program areas within the DRC model:

- Cognitive Behavioral Therapy
- Employment / Education Development
- Substance Abuse Treatment

DAY REPORTING CENTER PROPOSED PROGRAM MODEL

The following DRC model is based on a "stand alone" program location. In the future, if a DRC is co-located with the County jail, some changes in the program model would be both possible and necessary. The DRC recommended program model is comprised of the six following components:

1. Assessment / Case Planning
2. Client Engagement
3. Intervention
4. Relapse Prevention
5. Aftercare
6. Supportive Case Management

Component One: Assessment and Case Planning

Assessing clients using validated and reliable tools is a prerequisite for managing limited resources, and triaging cases essential to the effective management of clients. Assessment is a continuous and ongoing collection of information, observations and collateral information that goes beyond a one time event and used to inform case decisions, case planning, and targeting services.

Assessments are most reliable when staff are trained to administer the tools, and use effective interviewing and engagement techniques. Therefore, prior to any employee administering Assessments, staff must be trained in Administering and Interpreting the Assessments selected.

Assessment outputs should be used to develop frequency of reporting, targeting criminogenic needs, sequencing of services, identifying strengths, determining a client's level of motivation, and identification of basic needs.

The following Assessments are recommended:

- ***Level of Services Case Management Inventory (LS / CMI)***

  Risk / Need Assessments have undergone many transformations since their inception. Classifying offenders initially relied on unstructured clinical judgment. Then, with the first generation of Risk / Need Assessments, assessors began to consider mechanically gathered static predictors of an offender's risk to reoffend.

  Second generation Risk Assessments brought advances by considering dynamic (changeable) predictors in addition to the static risk factors. Dynamic factors can be changed through intervention, programming, and treatment, or as a result of environmental, social, or internal experiences.

  The third generation of Risk Assessments integrated risk and need components identifying criminogenic needs as well as producing a risk level estimate.

  Fourth generation Risk Assessment tools integrate general and specific risk / need components, addresses other client issues and responsivity concerns, and include a case management component.

  The LS / CMI is a valid fourth generation assessment, and is presently being used by the Solano County Probation Department.

- ***Correctional Mental Health Screen (CMHS)***

  The National Institute of Justice funded researchers to create and test a brief mental health screen for criminal offenders. (Ford, J. and Trestman, R., *Evidence-Based Enhancement of Detection, Prevention, and Treatment of Mental Illness in the Correction Systems,* 2005).

  The CMHS uses separate questionnaires for men and women. The version for women (CMHS-W) consists of 8 yes / no questions, and the version for men (CMHS-M) contains 12 yes / no questions about current and lifetime indications of serious mental disorder. Six questions regarding symptoms and history of mental illness are the same on both questionnaires; the remaining questions are unique to each gender screen. Each screen takes about 5 minutes to administer. It is recommended that male inmates who answer six or more questions "yes" and female inmates who answer five or more questions "yes" be referred for further mental health evaluation.

  Statistical analysis of the validation test results against the clinical assessments showed that these screens proved highly valid in identifying depression, anxiety, PTSD, some personality disorders, and the presence of any undetected mental illness. The CMHS-W was 75% accurate in correctly classifying female offenders, and the CMHS-M was 75.5% accurate in correctly classifying male offenders as having a previously undetected mental illness.

- ***Adult Substance Use Survey – Revised (ASUS-R)***

  The ASUS-R is a 96 item psychometric-based, adult self report survey comprised of 15 basic scales and three supplemental scales. It is appropriate for clients 18 years or older, and may be self or interview administered. The ASUS-R meets the needs of a self report instrument that is an essential component of a convergent validation approach to the assessment of patterns and problems associated with the use of alcohol and other drugs (AOD).

  The ASUS-R is designed to differentially screen and assess an individual's alcohol and other drug use involvement in ten commonly defined drug categories and to measure the degree of disruptive symptoms that result from the use of these drugs. The ASUS-R provides a mental health screen, a scale that measures social non-conformity and a scale that measures legal non-resistance to self-disclosure, and a measure of self-perceived strengths. Three supplemental scales provided a differential assessment of disruptive AOD use outcomes which are subscales of the general disruption scale. The ASUS-R provides measures of AOD involvement and legal conforming for the most recent six month period the client has been in the community. The ASUS-R rater scale allows a comparison of the evaluator's perception of the client's drug use and abuse with the client's perception of that use.

The ASUS-R can be used to provide guidelines for assessing levels of AOD problems, abuse and dependence. It can also be used to provide referral guidelines for various levels of services for clients with a history of AOD and co-occurring problems.

- ***Basic Needs Screening***

For many clients, unmet basic needs can often serve as a barrier to the treatment that is critical for positive behavior change to occur. Therefore, an important component of Assessment and Case Planning is to identify and address a client's basic needs. Below are some of the basic needs that clients should be screened for:

SSI / SSD	Application for Supplemental Security Income or Social Security Disability
CAL FRESH/WORKS	Application for Temporary Assistance for Needy Families
WIC	Application for Women, Infants and Children benefits
Food	Connection with food pantry, soup kitchens, application for food stamps, etc.
Housing	Connection with shelters, temporary housing, applications for housing assistance, and other affordable housing options
Clothing	Directly meeting clothing needs or connecting the client with a program such as Dress for Success that can provide clothing
Medical Insurance	Help with obtaining either employer sponsored, private, or government sponsored medical and/or dental insurance for self and/or family
Medical Services	Includes connection with general practitioners, dental, OB/GYN, family planning counseling, HIV/STD educations as well as health related needs such as obtaining prescriptions, glasses, hearing aids, wheel chairs, etc.
Identification	Assistance with obtaining birth certificates and social security cards.
Drivers License / Transportation	Assistance with obtaining a drivers license, enrollment in drivers education, assistance with accessing public transportation
Child Care	Connection with day care, pre-schools, etc.
Personal Hygiene	Provide or make connection to obtain personal hygiene items (toothbrush, toothpaste, etc.)

- ***Individual Service Plan (ISP)***

The results of the Assessment process should be the development of an ISP which identifies the client's needs and other risk factors and formulating a written plan of action that is specific to each client in order to address their needs.

The following principles should be followed when developing the ISP:

✓ The development of the ISP should be a collaborative process that the case worker and client complete together.

- ✓ Addressing the client's highest criminogenic needs at the appropriate time is essential to changing their criminal behavior.
- ✓ Beginning with the issues that the client has identified can build trust and increase chances that they will follow the ISP.
- ✓ Trying to address too many needs, goals, activities and obligations at the same time can lead to frustration and failure.
- ✓ ISP goals must be clearly understood by the client, realistic and achievable.
- ✓ Short-term steps that the client should take to achieve the agreed upon goal should be incrementally identified.
- ✓ A timeframe for the client to finalize the identified steps they need to complete should be established.
- ✓ The ISP should be frequently reviewed and discussed with the client and modified when needed.
- ✓ The client should be encouraged and positively reinforced for their efforts toward achieving the ISP steps and goals.
- ✓ Client setbacks and barriers to completing the ISP should be identified, discussed, and problem-solved.

Component Two: Client Engagement

There is abundant evidence that motivational factors (broadly defined) are central in understanding, preventing and reversing criminal behavior. (Miller, William, etal, *Rethinking Substance Abuse: What the Science Shows and What We Should Do About It,* 2005).

It appears that actively doing *something* toward change may be more important than the particular actions that are taken. The traditional wisdom that "It works if you work it" appears to be true of many different routes to change. Placing a client in the right treatment program that they do not complete has no value in changing their behavior, even when the program is evidence-based. Client motivation needs to be assessed and strengthened early on and throughout the treatment process. It is clear from the research that brief motivational interventions often trigger change. Therefore, the following individual interventions (as opposed to group counseling) are being recommended:

- ***Motivational Interviewing (MI)***

  Motivational Interviewing is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. Although many variations in technique exist, the MI counseling style generally includes the following elements:

  - ✓ Establishing rapport with the client and listening reflectively.
  - ✓ Asking open-ended questions to explore the client's own motivations for change.
  - ✓ Affirming the client's change-related statements and efforts.
  - ✓ Eliciting recognition of the gap between current behavior and desired life goals.
  - ✓ Asking permission before providing information or advice.
  - ✓ Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the counselor to adjust the approach).
  - ✓ Encouraging the client's self-efficacy for change.
  - ✓ Developing an action plan to which the client is willing to commit.

- ***Motivational Enhancement Therapy (MET)***

  Motivational Enhancement Therapy is an adaptation of motivational interviewing that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner. This intervention has been extensively tested in treatment evaluations of alcohol and other drug use/misuse. MET uses an empathic but directive approach in which the counselor provides feedback that is intended to strengthen and consolidate the client's commitment to change and promote a sense of self-efficacy. MET aims to elicit intrinsic motivation to change problem behaviors by resolving client ambivalence, evoking self-motivational statements and commitment to change, and "rolling with resistance" (responding in a neutral way to the client's resistance to change rather than contradicting or correcting the client).

- ***Brief Strengths-Based Case Management for Substance Abuse (SBCM)***

  Brief Strengths-Based Case Management for Substance Abuse is a one-on-one social service intervention for adults with substance use disorders that is designed to reduce the barriers and time to treatment entry and improve overall client functioning. The intervention is a time-limited version of SBCM that focuses on substance abuse. SBCM differs from conventional case management in its use of a strengths perspective. This perspective

defines how to carry out the five functions of SBCM's case management component: assessment, planning, linkage, monitoring, and advocacy. The case manager helps the client identify personal skills, abilities, and assets through discussion; supports client decision making so that the client sets treatment goals and determines how the goals will be met; encourages client participation in seeking informal sources of assistance; and works to resolve any client-identified barriers to treatment, such as lack of transportation, child care, and social support. Although broad system change is not the intent, the counselor also advocates with treatment providers and seeks system accommodation on behalf of the client. The counselor strives to develop a strong working alliance with the client, which is considered central to the process of linking with and using substance abuse treatment services effectively. Unlike SBCM, which is usually structured over many months and sometimes years, Brief SBCM for Substance Abuse delivered in a maximum of 5 sessions over a limited, predetermined period. Sessions typically average 90 minutes, with some requiring more than 2 hours. Each session is flexible, providing an opportunity to develop and implement a personal, client-driven plan that improves the individual's overall functioning and/or addresses specific barriers to linking with treatment.

Each of the above interventions has been identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice. Although primarily researched in the field of addiction programming, each of the above interventions has broad application to other need areas.

Component Three: Primary Interventions

- ***Criminal Thinking and Life Skills***

  The most extensively researched and effective programs for changing criminal behavior are Cognitive-Behavioral Therapies (CBT). (Hansen, C., *Cognitive-Behavioral Interventions: Where They Come From and What They Do,* 2008).

  CBT programs, in general, are directed toward changing distorted or dysfunctional cognitions or teaching new cognitive skills and involve structured learning experiences designed to affect such cognitive processes. These processes include interpreting social cues, identifying and compensating for distortions and errors in thinking, generating alternative solutions, and making decisions about appropriate behavior.

  Traditional cognitive-behavioral approaches used with correctional populations have been designed as either cognitive-restructuring, coping skills, or problem-solving therapies. The cognitive-restructuring approach views problem behaviors as a consequence of maladaptive or dysfunctional thought processes, including cognitive distortions, social misperceptions, and faulty logic. The coping skills approaches focus on improving deficits in an offender's ability to adapt to stressful situations. Problem-solving therapies focus on offenders'

behaviors and skills (rather than their thought processes) as the element that is ineffective and maladaptive.

Effective cognitive-behavioral programs of all types attempt to assist offenders in four primary tasks: (1) define the problems that led them into conflict with authorities, (2) select goals, (3) generate new alternative prosocial solutions, and (4) implement these solutions.

Generally, cognitive-behavioral therapies in correctional settings consist of highly structured treatments that are detailed in standardized manuals, and typically delivered to groups of 8 to 12 clients in a classroom-like setting. The following CBT offender change programs are recommended:

- ✓ *Thinking For A Change (T4C)*
  This program begins by teaching offenders an introspective process for examining their ways of thinking and their feelings, beliefs, and attitudes. This process is reinforced throughout the program. Social-skills training is provided as an alternative to antisocial behaviors. The program culminates by integrating the skills offenders have learned into steps for problem-solving. Problem-solving becomes the central approach offenders learn that enables them to work through difficult situations without engaging in criminal behavior. Offenders learn how to report on situations that could lead to criminal behavior and to identify the cognitive processes that might lead them to offending. They learn how to write and use a "thinking report" as a means of determining their awareness of the risky thinking that leads them into trouble. Within the social skills component of the program, offenders try using their newly developed social skills in role-playing situations. After each role-play, the group discusses and assesses how well the participant did in following the steps of the social skill being learned. Offenders also apply problem-solving steps to problems in their own lives. Written homework assignments, a social skills checklist, and input form a person who knows the client well are all used by the class to create a profile of necessary social skills, which becomes the basis for additional lessons. Through a variety of approaches, including cognitive restructuring, social-skills training, and problem-solving, T4C seeks to provide offenders with the skills as well as the internal motivation necessary to avoid criminal behavior.

The curriculum is divided into 22 lessons, each lasting 1 to 2 hours. No more than one lesson should be offered per day; two per week is optimal. It is recommended that at least 10 additional sessions be held using the social skills profile developed by the class (as noted above). Lessons are sequential, and program flow and integrity are important.

- ✓ *Reasoning and Rehabilitation II (R&R2)*
  This program focuses on enhancing self-control, interpersonal problem-solving, social perspectives, and prosocial attitudes. Participants are taught to think before

acting, to consider consequences of actions, and to conceptualize alternate patterns of behavior. The authors of R&R2 believe that long-term intervention can both tax the motivation of many offenders and can be associated with high attrition rates; it can also tax the motivation of trainers and overburden agency budgets.

This program is designed to increase the prosocial competence of the participants. R & R II objectives include:

- Provider assessment. This program can be used as an assessment device, with the client's performance providing a more complete measure of cognitive functioning than testing alone. It can also direct the provider toward needs for other programs.
- Participant assessment. R&R2 allows participants to experience CBT and assess whether they may be open to further program treatments.
- Motivation. Participants may become engaged in the process and more motivated to get involved in longer treatment programs when needed.
- Preparation. Often programs require a higher level of cognitive skills than many clients possess. R&R2 allows them to learn the skills required to continue with cognitive behavioral programs.

The program provides just over seventeen hours of actual training. Lessons require the transfer of cognitive skills to real-life events, and every one of the 17 sessions has homework assignments. Each session includes time for feedback from offenders on their observations and experiences that occurred between sessions. R&R2 manuals include the "Handbook," which is a detailed instruction manual for trainers that has all materials required for each session, and the "Participant's Workbook," which contains handouts, exercises, and worksheets that should be available for each participant. The ideal group size is 8 clients or, depending on the characteristics of the group, no less than 4 and no more than 10. Sessions are flexible, but two to three 90-minute sessions per week are suggested.

- ***Substance Abuse Treatment***

A significant amount of research has been conducted in the field of substance abuse treatment. A large number of these studies have investigated potential differences in outcome between various forms of inpatient and outpatient treatment in the treatment of both alcohol and drug dependence.

As stated in a recent publication (See Miller, William etal, *Rethinking Substance Abuse: What the Science Shows and What We Should Do About It*, 2005):

"There have been more than 30 studies in which alcohol- or drug-dependent patients have been randomly assigned to an equal length (usually 30-60 days) of some form of residential or inpatient treatment, or to some form of outpatient or day hospital treatment. While virtually all of these studies have shown significant improvements in substance use from admission to posttreatment outcome (usually 6-12 months postdischarge), it has been surprising to many that the great majority of these studies have shown essentially no significant differences in effectiveness between different settings of care, in either alcohol- or drug-dependent patient groups.

This body of research suggests that across a range of study designs and patient populations, there appears to be no significant advantage provided by inpatient or residential care over traditional outpatient care in the rehabilitation of alcohol or drug dependence – despite the substantial different in costs. It should be noted, however, that in virtually every study of treatment setting, premature dropout was significantly higher in the outpatient condition than in the inpatient condition. While this is pertinent to the relative attractiveness of these two settings of care, it is not relevant to the relative effectiveness comparisons because most studies examined both intent-to-treat and fully treated groups, finding no evidence of differential effectiveness....."

"....Drug problem severity occurs along a smooth continuum, and diagnostic criteria (such as the current distinction between drug *abuse* and drug *dependence*) represent somewhat arbitrary cut points in symptom counts. Drug involvement typically develops through gradually increasing levels of use, consequences, dependence, and variety of drugs. In this sense, prevention and treatment are not distinct interventions, so societal response to drug problems should involve an integrated continuum of care that addresses the full range of problem development. The concept of stepped care is a sensible albeit still largely untested approach suggesting that when one level of care is insufficient, a more intensive level of intervention is warranted and likely to succeed.

A further argument for a menu and spectrum of services is to permit people to find levels and types of services that they find appropriate and attractive. Poor outcomes are likely to ensue when people's goals are mismatched to program goals. A reasonable and under-utilized approach would be to offer brief motivational counseling as a first-line intervention, and then to offer more expensive and intensive services to those who do not respond to this brief intervention....."

Considering the above, and based upon my own experience in operating DRC's, I am recommending two levels of substance abuse treatment, an intermediate and intensive outpatient model. There are some existing evidence-based intermediate interventions (e.g., Cognitive Behavioral Coping Skills Therapy) and intensive outpatient interventions. For the intensive outpatient treatment I am recommending the following:

✓ *Matrix Model*

The Matrix Model is an intensive outpatient treatment approach for substance abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse prevention groups, education groups, social support groups, individual counseling, and urine and breath testing delivered over a 16-week period. Clients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction. The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the client and using that relationship to reinforce positive behavior change. The interaction between the therapist and the client is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the client's dignity and self-worth.

- ***Employment Services***

One of the major hurdles for clients is obtaining and maintaining employment. Research has shown that employment is associated with lower rates of re-offending, and higher wages are associated with lower rates of criminal activity. To achieve these outcomes working with clients on techniques to identify an appropriate occupation, employer, and retain employment with advancement opportunities is essential.

A number of offender pre-employment training programs have been developed that should be reviewed for possible use at the DRC. These programs provide skill training including administering interest inventories, completing applications, mock interviewing, addressing

proper interview / job attire and interview etiquette in addition to teaching employment "soft skills". Soft skills are the skills that assist clients in getting jobs as well as being successful in the workplace. Soft skills include: reporting to work on time, getting along with other workers, problem-solving and managing conflict resolution. Job development and placement services are also a critical part of effective employment services, and DRC staff should work with local employment and workforce development agencies to assist in placing DRC clients in jobs.

Component Four: Relapse Prevention

As a subset of CBT, Relapse Prevention Therapy (RPT) includes concepts and skills for working with those who are at risk of relapsing from their commitments to abstain from addictive or compulsive behaviors.

RPT proposes that relapse is less likely to occur when an individual possesses effective coping mechanisms to deal with such high-risk situations. With this, the individual experiences increased self-efficacy and, as the length of abstinence from inappropriate behavior increases and effective coping with risk situations multiplies, the likelihood of relapse diminishes.

RPT involves five change strategies:

1. Coping-skills training, which teaches ways to handle urges and cravings that occur in early stages of the habit change journey.

2. "Relapse Road Maps," which are used to identify tempting and dangerous situations, with "detours" presented for avoiding these situations and successfully coping without having a lapse or relapse.

3. Strategies to identify and cope with cognitive distortions, such as denial and rationalization, that can increase the possibility of relapse with little conscious awareness.

4. Lifestyle modification techniques, so that harmful compulsive behavior with constructive and health-promoting activities and habits.

5. Learning to anticipate possible relapses, with unrealistic expectations of perfection replaced with encouragement to be prepared for mistakes or breakdowns and skills taught on how to learn from those mistakes and continue on.

RPT should be conducted at the DRC as a stand-alone intervention following completion of the primary interventions, or included as a component within the primary intervention.

In addition to RPT, each of the CBT and intermediate substance abuse interventions should conduct booster sessions for those clients who complete their treatment. The goals of booster sessions are to anticipate and prepare clients to face problem situations that will lead to crime; train clients to rehearse alternatives to antisocial behavior, encourage clients to practice new prosocial behaviors in increasingly difficult situations, and reward clients for demonstrating improved competencies. Booster sessions allow clients to practice real world application and struggles with the newly learned skills through behavioral methods such as role playing, feedback and praise. It is anticipated that most clients would benefit from booster sessions following the completion of a primary intervention.

Component Five: Aftercare

All DRC clients who are assessed as having a substance abuse problem and complete treatment should participate in Peer Recovery Support Services.

Peer recovery support services help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.

Peer recovery support service projects have developed a variety of peer services. Not all programs provide all services, and some peer leaders may provide more than one service. Four major types of recovery support are (1) peer mentoring or coaching, (2) recovery resource connecting, (3) facilitating and leading recovery groups, and (4) building community:

Peer recovery support services can fill a need long recognized by treatment providers for services to support recovery after an individual leaves a treatment program. In addition, peer recovery support services hold promise as a vital link between systems that treat substance use disorders in a clinical setting and the larger communities in which people seeking to achieve and sustain recovery live. Using a nonmedical model in which social support services are provided by peer leaders who have experienced a substance use disorder and recovery, these services extend the continuum of care by facilitating entry into treatment, providing social support services during treatment, and providing a posttreatment safety net to those who are seeking to sustain treatment gains.

Component Six: Supportive Case Management

Case management is an active and purposeful intervention that can best be described as a coordinated approach of assessment, engagement, planning, setting goals, connecting clients to

community-based agencies, as well as holding clients accountable for their behaviors. The DRC Case Manager and the Probation Supervision Officer are responsible for the overall management of the client.

Following are some key activities that should be incorporated into their initial and subsequent contacts with the client:

- During the Initial Contact

  - ✓ Explain the goals of the program and how the program will work with him/her to successfully complete the program.
  - ✓ Using Motivational Interviewing techniques, discuss the circumstances that lead to the client being placed in the program.
  - ✓ Explain that the role of the case manager and program staff is to both help him/her remain crime-free, address basic needs and if necessary, respond to any non-compliance with conditions set by the referral source and program rules.
  - ✓ Review program rules and conditions of the referral source and how the program will communicate all information with the referral source.
  - ✓ Explain the range of responses for non-compliance with conditions and program rules.
  - ✓ Complete initial program intake and program paperwork gathering contact information and alternate addresses or phone numbers.
  - ✓ Schedule the client for his/her assessment. Be sure to review any barriers the client may have in attending their session and how long the session will be.
  - ✓ Answer all questions the client may ask.

- Subsequent Contacts

  - ✓ Help the client explore and weigh the pro's and con's of changing his/her criminal behavior.
  - ✓ Review goals and objective that have been developed by the client, reinforce strengths and explore any problems or concerns the client is having.
  - ✓ Focus on criminogenic needs and help the client identify possible options to address them, including referrals to community programs.
  - ✓ Use role plays to practice skills learned in groups.

- ✓ Help develop and encourage prosocial supports to assist the client now, and after he/she leaves the program.

- ✓ Point out, explore and challenge any distorted and/or criminal thinking exhibited by the client.

- ✓ Conclude each session by summarizing and reinforcing any positive progress and behavior. Summarize client's responsibilities that need to be completed by the next visit.

In addition to the above, the DRC Case Manager, the Probation Supervision Officer and other DRC staff should assist the clients in meeting their needs by obtaining services that are not conducted at the DRC. These services may include:

- Educational Services
- Mental Health Services
- Basic Needs

DRC IMPLEMENTATION

Attached to this report is a flow chart of the DRC Services and Supervision Model, along with a projected annual operating budget. Based upon the recommended client services and within the annual budget, the DRC is projected to be approximately a 75 client/slot program. The program duration will be based upon the individual client's needs, and normally will be six to ten months. The DRC Program Team will be comprised of the following positions:

1. DRC Administrator (Probation Supervisor)
2. Three Case Managers (2 Journey Probation officers and Clinical Services Associate)
3. One Social Worker (.6 position)
4. One Patient Benefit Specialist (H&SS)
5. One Assessment Specialist (Dual Diagnosis (H&SS)
6. One Legal Procedures Clerk

The Probation Supervisor will serve as the Team leader and provide supervision to all other team members. The Case Managers will each carry a caseload of approximately 25 clients and provide weekly individual counseling. The Case Managers will also facilitate the client treatment groups for, Thinking For A Change; Reasoning and Rehabilitation; Intermediate Substance Abuse; and

Program Booster Sessions. In addition the DRC will contract independently, or through Solano County Health and Social Services (H&SS), for the following services/positions.

1. Intensive Out Patient Substance Abuse Treatment
2. Residential Substance Abuse Treatment
3. Employment Specialist
4. Peer Recovery Support Services
5. Educational Services (GED/Literacy)
6. Transportation
7. Transitional Housing

H&SS will also provide Mental Health Services to DRC clients.

All DRC clients at the Vallejo location will be under Probation supervision, and the supervising probation officer will work closely with the DRC staff.

Although only minor physical plant modifications will be required at the Vallejo location, a substantial amount of staff training and coaching will need to be provided to the DRC staff as well as the probation officers supervising the cases. Once all of the DRC staff have been hired, it will take a number of weeks before they will be ready to conduct the DRC services that have been identified in this Report.

One of the reasons that evidence-based programs fail to achieve the expected results is the failure to implement and sustain the program as designed. As a new program, the DRC Director should report directly to the Chief or Deputy Chief of the Probation Department. After the DRC has stabilized and the desired outcomes are being achieved, the DRC Director could report to a Probation Manager. There will be many challenges that will need to be overcome to effectively implement the DRC. After approval of the program model, components and services, the focus will need to shift to implementation. Following are some brief general recommendations:

1. The program components should be derived from an examination of the risk and needs of the targeted participants, and be manageable.
2. The program model and interventions should be based on credible scientific evidence.
3. The program should not overstate the gains to be realized..
4. The fiscal requirements of the program should be cost-effective, sustainable, and should not jeopardize existing effective programs.

5. Program implementation should proceed incrementally and initially focus on achieving intermediate process goals.

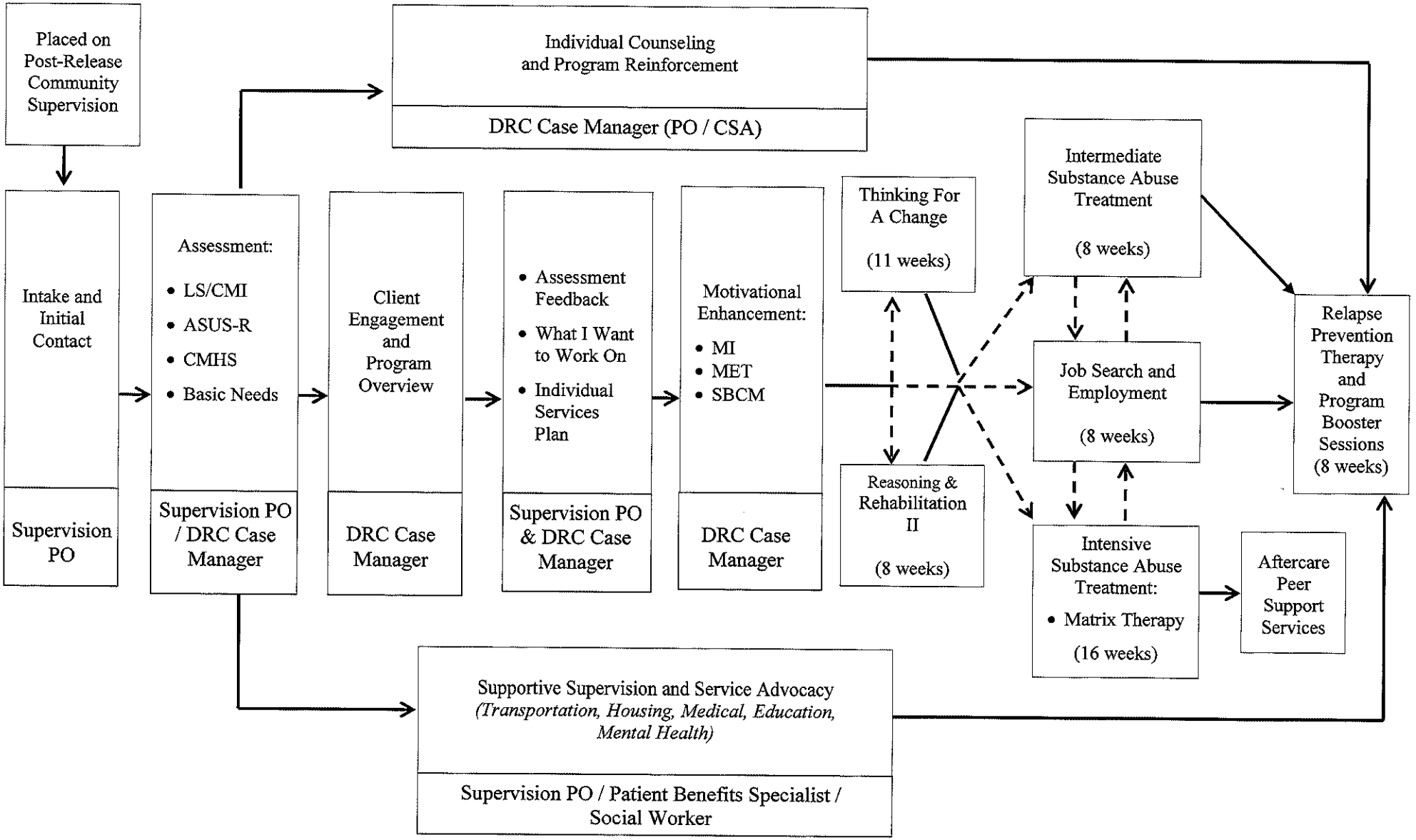
6. A system for clinical supervision, continuous quality improvement, and program evaluation should be established.

CONCLUSION

Realignment will change how Solano County responds to many of its residents who are charged with, or convicted of a criminal offense. With this increased responsibility there is an opportunity to reduce recidivism and crime within the County. We are now confronted with the adage that if we continue to do what we have been doing, we will likely get the same results. With the recidivism rates of those offenders who are leaving the State's prison system at unacceptable levels, the County is in a position to do better. "Doing better" will undoubtedly not occur overnight, and will require persistence, patience, and leadership. In this regard, Solano County is fortunate to have a group of talented and dedicated individuals who are more than capable of leading this effort.

ATTACHMENTS

DRC SERVICES AND SUPERVISION MODEL



DRC Annual Operating Budget

Day Reporting Center (DRC)

Personnel			
1.0	Deputy Probation Officer Supervisor		132,000
2.0	Deputy Probation Officer (Journey Level)		212,000
1.0	Legal Procedures Clerk		77,504
0.6	Social Worker III		72,000
1.0	Substance Abuse CSA		112,059
1.0	Patient Benefit Specialist		H&SS
1.0	Licensed Mental Health Clinician (Dual Diagnosis)		H&SS
	Workers Compensation, Unemployment Insurance and Administration Overhead		13,242
	5.6 FTE are requested as part of DRC Budget &		
Sub Total	2.0 FTE are included in H&SS Budget*	$	*618,805*
Contracted Services			
	Outpatient Substance Abuse		85,000
	Residential Substance Abuse		H&SS
	Outpatient Mental Health		H&SS
	Employment / Education		
	Job Development Services		114,000
	GED		31,000
	After Care (Peer to Peer)		80,000
	Continuous Quality Assurance / Training		20,000
	Transportation		7,000
	Housing		25,000
Sub Total		$	*362,000*
Facility and Miscellaneous			
	DRC space		27,000
	Telephone		2,200
	Cell Phone		600
	Food/Snacks		6,500
	Office Supplies		10,000
	Computers		25,000
	Security		50,000
Sub Total		$	*121,300*
Total		**$**	**1,102,105**

*H&SS - Cost are included in the Health and Social Services FY2012/13 Adopted Budget

DRC Initial Start Up Cost

Equipment	No of Items	Estimated Cost per Unit	Estimated Total Cost
Computers (18 Computers + 6 workstations)	24	1,000	24,000
Smart Boards	4	1,000	4,000
Projectors (one in each conference room	2	1,000	2,000
TV's DVD - AV equipment for 3 conference room - Signal Solutions and Facilities	3	2,833	8,500
Workstations (1 is an add on in front)	6	3,000	18,000
Quality Assurance Cameras / Security - 3 groups running at the same time need to export file (6 to 8) no sound in front	8	2,684	21,475
Cameras installation cost	1	5,475	5,475
Copy Machine Lease	230	12	2,760
Network Printers	2	1,700	3,400
Printers	2	300	600
Copy/Fax Printer for Front Desk	1	2,300	2,300
Doit switches	3	1,000	3,000
Motivational Decore	1	5,000	5,000
Lobby Seating	3	5,000	15,000
Other			
Task Chairs	6	618	3,708
Phones - VOIP	5	350	1,750
Supplies		2,000	2,000
Art Work (est $250 each plus tax)	13	268	3,490
Keller Group (cable management equipment)	1	5,000	5,000
Blinds	5	1,200	6,000
Computer Electrical Work (estimates)			1,000
Signage	1	5,435	5,435
Painting (Fox painting)	1	2,000	2,000
Facilities Processing (inspection, project coordination) est	1	5,000	5,000
Custodial/Vendor (carpet, dush, resurface the VCT flooring)	1	1,000	1,000
Software			
ASUS/R		10,000	10,000
Sub Total DRC Start up Cost			*$ 161,893*
Training and Quality Assurance			
Assessment Training and Quality Assuarnace			
LS - CMI with Quality Assurance	10 Trainees	5 QA	16,000
Adult Substance Use Survey Training			
ASUS/R	10 Trainees		3,000
Thinking for a Change and Coaching	6 Trainees	10 QA	19,000
R&R II Training and Coaching	6 Trainees	10 QA	25,000
Assessment Interpretation/Client Feedback and Case Planning			6,000
Effective Practices in Correctional Settings			20,000
Motivational Enhancement Therapy (MET) or Strength Base Case Management (SBCM)			12,000
Matrix Therapy			12,000
Pre-Employment Skills Training			6,000
Sub Total Training Cost			*$ 119,000*
Total DRC Start up Cost			**$ 280,893**