SOLANO COUNTY PUBLIC SAFETY REALIGNMENT

SOLANO COUNTY CENTER FOR POSITIVE CHANGE (CPC)

Prepared for

Community Corrections Partnership

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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 Center For Positive Change (CPC) model program. The CCP has identified the following eight core elements for the CPC:

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 Center For Positive Change in Vallejo and 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 CPC. 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 CPC by the members of the Workgroups. This initial report and recommendations reflect many of their ideas.

The CPC 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.

CPC OPERATION AND PURPOSE

Programs similar to the CPC have been operating in the United States for more than twenty years. Historically these programs 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 the 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 Center would have as its primary goal the reduction of offender recidivism through positive sustained behavior change. Therefore, clients would come to the Center only to attend individual counseling and supervision sessions and receive services which would be in addition to the supervision and monitoring responsibility that would be carried out by the client's assigned probation supervision officer. It has been my own experience that trying to accomplish too much at a Center makes it difficult to manage, and does not lend itself to achieving reductions in criminal recidivism. Furthermore, not all client services can be conducted at the Center. Collaboration with community agencies and referral to both existing and perhaps new County programs and services will be important.

DATA REVIEW

The initial client group that will be targeted for services at the CPC are individuals placed on probation supervision through the 2011 Public Safety Realignment (AB109). As of November of 2012, there were approximately 273 males and 25 females who were in this group that had been assessed by the Probation Department. The first step in determining the primary services that should be available through the CPC 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 CLIENTS		
	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 client recidivism rates), it is important to focus you resources on changing the behavior of those clients who without intervention, are most likely to continue their criminal behavior. These "high risk" clients historically commit the majority of the crimes, although they may not make up the majority of the general criminal population. It is these clients who should be the target for intervention through the CPC. The research has demonstrated that providing extensive services and supervision to "low risk" clients may actually increase the likelihood of them continuing to commit crimes. (Lowenkamp, 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 or the severity of any future offenses, but rather their risk to reoffend. Below is a breakdown of the risk levels of the AB 109 clients 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 clients who are under probation supervision in the County being assessed as "Very High" or "High". Therefore, in comparison AB 109 clients are older and a higher risk group of individuals.

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 individual'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 CPC 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 CPC model:

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

ASSESSMENT AND RISK REDUCTION CENTER PROPOSED PROGRAM MODEL

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

1. Assessment / Case Planning
2. Client Engagement
3. Intervention
4. Relapse Prevention
5. Aftercare
6. Supportive Case Management
7. Positive Reinforcement and Sanctions

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. Often these mental health conditions when present need to first be addressed before the client is able to benefit from other interventions. 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).

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 a client's ability to adapt to stressful situations. Problem-solving therapies focus on clients' 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 clients 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 criminal behavior change programs are recommended:

- ✓ *Thinking For A Change (T4C)*
  This program begins by teaching clients 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 clients have learned into steps for problem-solving. Problem-solving becomes the central approach clients learn that enables them to work through difficult situations without engaging in criminal behavior. Clients 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, participants 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. Clients 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 clients 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&R2 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 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 participants 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 CPC'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.

The employment services program should include an initial assessment, employability skills, and job search and placement assistance based on the needs identified in each client's initial assessment. The program shall have built-in flexibility to accommodate individualized plans to address individual needs.

The program should include the following components:

1. ***Assessment***

The initial assessment should include an individual employment plan that outlines the steps necessary to achieve employment, a needs assessment that identifies the client's barriers (such as drug and/or alcohol addiction), education and literacy levels, charges/convictions, employment history, and personal goals.

2. ***Job Readiness Training***

A. **Employability Skills**: These skills are the foundational skills upon which occupational or technical skills rest. As such, employability skills are not job specific, but cut across all job levels and industry types. Employability skills include both thinking skills and personal qualities that are essential to successful job performance and are teachable, basic skills necessary to getting, keeping, and doing well on a job. Employability skills include:

(a) *Personal qualities* – Although these are not "skills", it is important for clients to learn and possess the following qualities to be successful in the workplace: responsibility, self-confidence, integrity, adaptability, punctuality, positive work attitude, personal grooming, self-motivated, and team work.

(b) *Higher-order skills* – Conducting Cognitive Behavioral classes that include: critical thinking, creative problem-solving, decision-making, appropriate social skills, and time management skills.

B. **Basic Computer Skills:** Hands-on practical computer training should be incorporated into the program to ensure that all clients possess at least the basic computer skills needed to increase their opportunities for employment. Instruction should include performing basic computer operations (using the keyboard and mouse, turning the computer on and off, opening software applications, opening, minimizing and closing windows, managing files and folders, etc.). Instruction should also include using email and using the internet for job search and instruction on resumé building.

3. ***Job Search Assistance***

The goal of this component would be to assist clients in determining a realistic and appropriate career path, and then equip clients with skills such as interviewing and resumé writing that are necessary to obtain employment. In addition, when appropriate clients should be linked to apprenticeship programs.

4. ***Job Placement***

Upon successful completion of the Job Readiness component, clients will need job placement assistance. The CPC should develop community contacts and knowledge of specific job openings to place job ready clients in paid employment.

5. ***Job Retention and Follow-Up***

Once employment is obtained, follow-up should be provided to encourage job retention. In addition, since many of the clients in this program will have substantial barriers to employment, a case management component should be included through which barriers are identified and addressed. Furthermore measures should be identified and program "success" and outcomes should be tracked and shared with the employer community.

Component Four: Relapse Prevention

As a subset of CBT, Relapse Prevention Therapy (RPT) includes concepts and skills for working with those clients 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, which 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 CPC 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 CPC clients who are assessed as having a significant 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 CPC 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:

- <u>During the Initial Contact</u>

  - ✓ 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.

- <u>Subsequent Contacts</u>

  - ✓ 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 CPC Case Manager, the Probation Supervision Officer and other CPC staff should assist the clients in meeting their needs by obtaining services that are not conducted at the CPC. These services may include:

- Educational Services
- Mental Health Services
- Basic Needs

Component Seven: Positive Reinforcement and Sanctions

An important role in shaping behavior is applying a combination of rewards and sanctions. Literature on effective correctional programming states that positive reinforcement should outnumber punishers at a ratio of not less than 4:1. Programs should look for ways of "catching" clients doing something good and have a systematic approach of rewarding desired behaviors that support behavior change. Positive reinforcement however, is not done at the expense of holding clients accountable and applying swift and certain sanctions for unacceptable behavior and failure to comply with program rules and regulations (See Attachment).

The application of reinforcements and sanctions is derived from the therapeutic research on Contingency Management. Contingency Management (CM) is an intervention wherein specific behaviors are targeted for rewards or punishments to exact behavioral change. CM is based on operant conditioning principles wherein behaviors that are reinforced, or rewarded, are more likely to increase, and behaviors that are punished are more likely to decrease over time (Higgins & Petry, 1999).

The purpose of reinforcement is to *increase* a specific target behavior and can be either positive or negative in nature. Positive means *adding* or administering a contingency after a target behavior is performed. Negative means *removing* a contingency after a behavior is performed (Higgins, etal, 2008). As such, positive reinforcement is *administering* a contingency in order to *increase* a target behavior. Negative reinforcement is the *removal* of a contingency but with the same goal of *increasing a target behavior*.

CM methods include but are not limited to token economies, shaping, behavior contracting, and voucher-based programs. Generally speaking, CM techniques are used in conjunction with other intervention methods including cognitive behavioral therapy.

Research has also demonstrated the efficacy of CM in reducing drinking and increasing compliance among alcoholics and problem drinking, as well as those involved with the criminal justice system (Higgins etal, 2008). To that end, the CPC should implement contingency management components into the everyday operations of the program.

CPC Case Managers should set up a contract with the client as part of the ISP, using the following four steps:

1. Staff arranges for targeted interventions/services based on risk and criminogenic needs.
2. Staff provides to client agreed upon tangible reinforcers when targets are reached (individualized incentives for each client).
3. Staff withholds designated incentives when targets are not completed.
4. Staff assists clients in establishing alternative, healthy options to replace the reinforcement derived from criminogenic areas.

CPC IMPLEMENTATION

Attached to this report is a flow chart of the CPC Services and Supervision Model. Based upon the recommended client services and within the annual budget, the CPC 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 CPC Program Team will be comprised of the following positions:

1. CPC 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 CPC will contract independently 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 CPC clients.

All CPC clients will be under Probation supervision, and the supervising probation officer will work closely with the CPC staff.

A substantial amount of staff training and coaching will need to be provided to the CPC staff as well as the probation officers supervising the cases. Once all of the CPC staff have been hired, it will take a number of weeks before they will be ready to conduct the CPC 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 CPC Director should report directly to the Chief or Deputy Chief of the Probation Department. After the CPC has stabilized and the desired outcomes are being achieved, the CPC Director could report to a Probation Manager. There will be many challenges that will need to be overcome to effectively implement the CPC. 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. The CPC will help to mitigate any potential adverse impact resulting from Realignment within the communities where the CPC is located. 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.

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ATTACHMENTS

ADMINISTRATIVE SANCTIONS FOR VIOLATIONS OF TERMS OF POSTRELEASE COMMUNITY SUPERVISION

It is the intent of the Solano County District Attorney, Chief of Probation, Public Defender and Sheriff to facilitate successful completion of postrelease community supervision for offenders under their supervision by imposing graduated sanctions in response to technical violations in lieu of filing a petition for revocation with the court.

Below are guidelines for response to technical violations of postrelease community supervision relating to the imposition of graduated sanctions. The Level 1, 2, and 3 violations listed are not all-inclusive and may include other behaviors regarding noncompliance with terms and conditions of post release community supervision. Violations will be considered on a case-by-case basis consistent with risk level. **Level 3 sanctions will be approved by the Supervising Probation Officer.** The following list of sanctions consists of actions available to be utilized proportionately by your Probation Officer in response to your action(s). The sanctions are community-based interventions and are considered swift and certain consequences to your behavior as delayed response encourages violations. Sanctions do not always occur in a linear fashion.

Level 1 Violations	**Level 1 Sanctions Available**
Failure to Report – Arrest/Citation Failure to Report – As Instructed Failure to Report – Address/Telephone Number Change Failure to Register – 11590 HS Failure to Pay Fines/Fees Failure to Complete Community Service 1st positive Drug/Alcohol Test Refusal to Drug/Alcohol Test Missed Treatment/Program Group Possession of Prohibited Items (non-weapons)	Verbal Warning Written Letter of Apology Referral to Education/Employment/Life Skills Program Develop Relapse Prevention Plan Educational / Home Study Activity Increased Drug Testing Increased Alcohol Testing Referral to Drug/Alcohol Treatment Community Service with Probation (Complete up to 24 hours within 30 days)
Level 2 Violations	**Level 2 Sanctions Available**
Multiple Level 1 Violations Failure to Comply with Level 1 Sanction 2nd Positive Drug/Alcohol Test Offense Related Violation Continued Missed Treatment/Program Group Contact with Restricted Person/Place Possession of Prohibited Items (weapons) Failure to attend Offense-Specific Treatment Failure to follow Electronic Monitoring program rules Failure to follow Work Release program rules	Any Level 1 Sanction Multiple Level Sanctions in combination Referral for Treatment Assessment Increased Drug/Alcohol Testing Increased Reporting as Directed Modification of Treatment Plan Work Release with Sheriff's Office (Complete up to 48 hours within 30 days) Alcohol Monitoring with Sheriff's Office Curfew with Restriction using Voice ID System
Level 3 Violations	**Level 3 Sanctions Available**
Multiple Level 2 Violations Failure to comply with Level 2 Sanction Non-Threatening contact with victim Misd. Behavior (non–offense related) Leave State of CA without permission Termination from treatment program (non-residential) Failure to report from CDCR as instructed District Attorney Deferral	Any Level 1 or 2 Sanction Multiple Level Sanctions in Combination Modification of supervision terms and conditions Electronic Monitoring for up to 30 days Flash Incarceration up to 10 days

Multiple or severe violations such as but not limited to the following will result in immediate incarceration and will be reported to the court through the filing of a petition for revocation of community supervision: Abscond/termination from residential treatment program, Escape from Electronic Monitoring Program, new law violation, threatening contact with victim, and any continued Level 3 sanction violation.

Amended by CCP on June 13, 2012

CPC SERVICES AND SUPERVISION MODEL