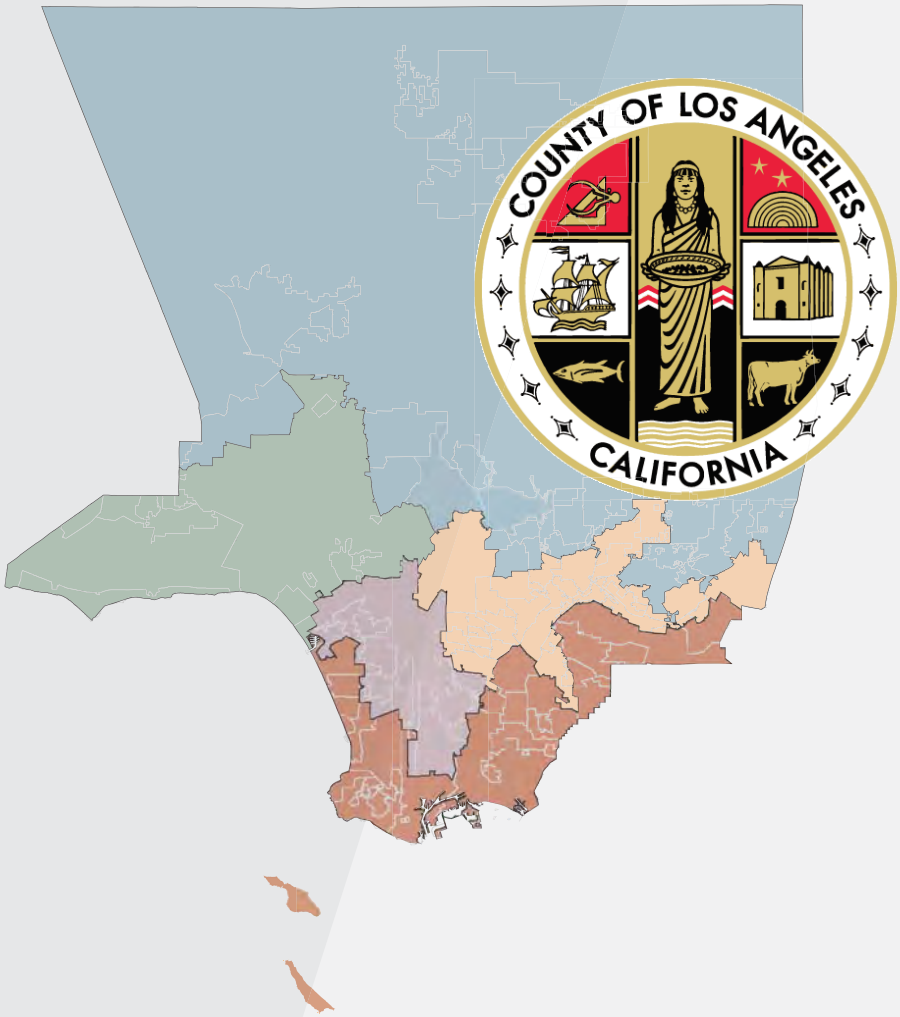

ARCHITECTURAL PROGRAM FOR THE CONSOLIDATED CORRECTIONAL TREATMENT FACILITY AND MIRA LOMA DETENTION CENTER

LOS ANGELES COUNTY JAIL PLAN

Independent Review and Comprehensive Report

Final Report – April 21, 2014

APPENDIX VOLUME 2

VANIR

APPENDIX INDEX

VOLUME 2

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Prepared by the Los Angeles County Department of Mental Health

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Prepared by RJS Justice Services, LLC

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

JAIL MENTAL HEALTH SERVICES

Consolidated Correctional Treatment Facility
Mental Health Treatment Program

The Consolidated Correctional Treatment Facility (CCTF) provides an integrated medical/mental health/substance abuse treatment center as a component of the Jail Plan being developed at the direction of the Los Angeles County Board of Supervisors. The CCTF Mental Health Treatment Program (MHTP) will incorporate best practices in jail mental health care, including optimal facility and integrated program design, curricula and staffing within a safe and secure correctional environment.

A. Overview

Approach

The MHTP will utilize a multidisciplinary team approach to create a therapeutic environment that provides the most effective mental health programming with a focus on group interventions, integration of mental health, substance abuse and medical care, and inclusion of community providers through in-reach activities that foster development of a healthy community to support clients while incarcerated and in their neighborhoods upon release to the community. Emphasis in the MHTP will be on expanded daily programming, with the primary strategies being evidence-based group therapies, integrated care planning and case management beginning at the point of admission to the MHTP to develop and implement realistic plans for housing, benefits/income, mental health care and other necessary services and supports upon release. Best practices in psychopharmacology and medical stabilization in partnership with Los Angeles Sheriff's Department (LASD) pharmacy and Medical Services Bureau (MSB) in addition to the Department of Public Health (DPH) will also be features of the MHTP. In addition, the Department of Mental Health (DMH) will continue to collaborate with LASD and other stakeholders to develop pre- and post-booking jail diversion programs for individuals whose low level offenses appear to be the result of or associated with their mental illness.

Goals

The goals of the MHTP are to provide a therapeutic environment and individualized services in the clinically least restrictive level of care that stabilize clients' mental illness, engage them in treatment, teach skills and behaviors that optimize functioning in jail and upon return to the community, promote release readiness and community reintegration,

and reduce criminal and psychiatric recidivism, in keeping with DMH's mission of "enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency". Emphasis will be placed on ensuring that community re-entry plans are carried out at the time of release. Additional treatment goals include diagnostic assessment, medication evaluation and prescribing with appropriate medical/laboratory and radiologic studies, development of sufficient client insight to accept oral medications or monthly injections, and stabilization of acute symptomatology to allow safe transition to lower levels of care.

Staff Experience and Training

The MHTP will be staffed by approximately 385 individuals, including JMHS Administration and program management/support staff. Over half will be existing Jail Mental Health Services (JMHS) staff, including psychiatrists, psychologists, social workers, psychiatric nurses, LASD nursing staff, psychiatric technicians, services coordinators, case workers that function as group leaders and case manager/release planners, substance abuse counselors, recreation therapists, other ancillary staff, support and administrative staff. All staff will have met the training and experience requirements for their job classifications as set forth by the Los Angeles County Department of Human Resources. All staff will receive orientation to the new facility and the treatment program, including training in evidence-based group and individual interventions that will be the focus of treatment, as well as training in correctional and safety issues specific to the new facility, provided by LASD.

On-going training for MHTP staff will be through in-service trainings at the facility, trainings in evidence-based interventions developed by the DMH Training Bureau specifically for clinicians working in forensic settings, and all other trainings offered by the Training Bureau or other organizations. JMHS currently has staff trained in a number of evidence-based modalities, including Seeking Safety. Cognitive Behavioral Therapy (CBT), WRAP (Wellness Recovery Action Plan), Moral Reconation Therapy (MRT), and Motivational Interviewing. Follow-up mentoring is provided for some of the modalities and training opportunities are repeated annually.

Treatment Programs

The CCTF facility design provides four levels of care for the MHTP: inpatient crisis care, intensive care, outpatient high observation and outpatient step-down.

- Inpatient Crisis Care expands the capacity of the Mental Health Unit of the Correctional Treatment Center (MHU CTC), JMHS' current acute inpatient program, from 46 to 60 beds.

- Intensive Care, a new level of care, adds 200 sub-acute inpatient beds that meet CTC physical plant licensing requirements. Intensive Care is planned to provide flexibility to convert its beds and augment staffing to meet inpatient crisis care requirements should the need arise.
- Outpatient High Observation level of care will expand JMHS' current High Observation Housing (HOH) capacity of approximately 550 beds (400 men and 150 women) to a total of 840 beds. 80%of the beds will be in single cells and 20% in double cells.
- Outpatient Step-down level of care will expand JMHS' current Service Area (SA)/Dormitory capacity of approximately 1550 beds (150 women and 1400 men) to a total of 2,235 beds. It should be noted that currently utilization of modules for either HOH or SA level of care is adjusted from time to time to provide care appropriate to the varying needs of the mental health population.

All MHTP levels of care will provide assessment, treatment planning, group and individual interventions, and development and implementation of release plans.

It should be noted that two JMHS programs will not be located in the CCTF. Due to the role the JMHS Inmate Reception Center (IRC) program plays in the LASD booking process, this program will continue to be located in the IRCs for the men's and women's jails. In addition, the Jail Mental Evaluation Team (JMET) program, which provides outreach, crisis intervention and medication management in the general and special population areas of the men's jails will continue to be housed in the jails the program serves.

B. Assessments

JMHS currently utilizes a variety of standardized assessments that will be incorporated in the MHTP. Assessments are individual interventions, to be conducted in areas affording as much privacy as possible within a forensic setting.

Initial Assessment

During the LASD booking process, LASD personnel screen all incoming inmates for medical and mental health issues and refer those that screen positive for mental health issues for further assessment by JMHS clinicians located in the IRCs. All referred inmates are provided an initial assessment to determine whether they require mental health treatment while incarcerated, develop preliminary treatment and release plans, address medication continuity needs and make recommendations to Sheriff's Custody regarding level of care and housing placement. An initial assessment guide is utilized to document the reason for referral, psychiatric history, history of present illness, medical

history, mental status examination, diagnosis, initial treatment plan with level of care recommendation, and preliminary release plan.

Full Evaluation

Following admission to an MHTP level of care, a full assessment is completed by the client's assigned clinician, supplementing/adding to the initial assessment done in the IRC and following a similar format. During this evaluation, the clinician also completes a release planning form that places the client in one of three release planning tiers and identifies needed resources based on individual circumstances. A psychiatric evaluation for all clients referred for psychotropic medication evaluation and prescribing is also completed. A multidisciplinary treatment plan is initiated as part of the full evaluation.

Suicide Risk Assessment

In accordance with the JMHS Suicide Prevention Policy and Procedures, all inmates evaluated in the IRC are screened for suicide risk, utilizing the Guidelines for Clinical Assessment of Suicide Risk, also known as the Suicide Risk Assessment Form (SRAF) that is included as a template in the medical record. Subsequent to IRC initial assessment, the SRAF is utilized whenever inmates/clients injure themselves, make threats to harm themselves or engage in other behaviors that indicate potential suicide intent. The SRAF addresses static, slow changing and dynamic risk factors, as well as protective factors, and is also utilized to determine when to remove a client from suicide precautions. Inmates/clients assessed as being at risk for suicide are either placed on Suicide Watch (S status) and admitted to Inpatient Crisis Care on an involuntary basis, or placed on Risk Precaution (RP status) and housed in the Outpatient High Observation level of care, where daily assessment as to suicidality is required. Absent custody safety and security limitations, RP clients will be housed in two-person cells.

Assessment Challenges

- Minimizing false negatives and positives during initial assessment and suicide risk assessment. Some inmates may either attempt to avoid identification (false negative) or to obtain what is perceived as more desirable housing or other secondary gains by incorrectly reporting or exaggerating history and symptoms (false positive)
- Assessing clients with co-occurring mental health and substance use disorders, including those undergoing substance withdrawal
- Severity of a client's mental illness that precludes thorough assessment
- Clients' inability and/or unwillingness to access available/offered services
- Safety issues

To address these challenges, ongoing in-service training on assessment and suicide prevention will be offered as the system evolves, and clinicians' access to information systems related to mental health treatment in the jail and in the community will be maximized to the extent possible.

C. Treatment Planning

JMHS currently utilizes a treatment plan template that provides standardized options plus a section to enter individualized problems, goals and interventions. This format will be modified to include measurable outcomes (behavioral changes); the specific group interventions agreed upon with each client; and release planning needs and planned interventions. There will be the expectation that every client is a participant in developing his/her treatment plan. Multidisciplinary treatment teams that include Custody, MSB and DPH personnel will meet regularly and be responsible for monitoring progress and meeting with clients to modify treatment plans when indicated. Treatment planning activities require space for individual and treatment team interventions with clients, as well as for the regular team meetings.

D. Interventions

The MHTP's primary treatment approach will be evidence-based group interventions, organized into Tracks that are tailored to the acuity levels and usual lengths of stay for the various levels of care in which the groups are offered. Groups will be led by various disciplines, dependent upon the topic, including, but not limited to psychiatrists, psychologists, social workers, psychiatric technicians, recreational and rehabilitation therapists, substance abuse counselors and medical case workers. Size and duration of the groups will vary in accordance with the group topic and the acuity level of the clients attending the group. Blocks of time will be reserved for group interventions for at least two hours in the mornings and two hours in the afternoons, six days per week. The following table summarizes the group offerings for the three Tracks.

Summary of Track Offerings

	Level of Acuity	Length of Stay	Therapeutic Intervention/Curriculum
Track 1	High (MHU CTC, HOH)	Short- Variable	a. Recreational Therapy b. Occupational Therapy c. Topic-specific, Brief Small Groups (substance abuse, medication management, financial benefits, adjustment to incarceration) d. Psycho-educational Groups e. Release/Re-entry Planning f. Community Meetings
Track 2	Medium (Outpatient Step-down/SA)	Short-Variable	a. Seeking Safety (core strategy) b. Motivational Interviewing c. Substance Use Interventions d. Wellness Recovery Action Plan (WRAP) e. Release/Re-entry Planning f. Community Meetings
Track 3	Medium (Outpatient Step-down/SA)	Long (AB 109 clients)	a. Seeking Safety (core strategy) b. Motivational Interviewing c. Substance Use Interventions d. WRAP e. CBT (Depression, Insomnia) f. Moral Reconation g. Release/Re-entry Planning h. Community Meetings

Cognitive Behavioral Therapy (CBT) is intended to assist people with becoming conscious of their thoughts and behaviors and then make positive changes to them. CBT addresses several problems linked to offenders' behavior, e. g. problem solving, critical reasoning, moral reasoning, self-control and impulse management. As such, CBT is the basis for the majority of evidence-based group interventions that will be utilized in the MHTP including the core strategy, Seeking Safety; MRT, Motivational Interviewing and WRAP. These interventions are provided in group settings and reinforced individually. In some instances, homework will be utilized as a way to measure motivation for change and reinforce concepts learned during group time.

Gender – Specific Programming

The MHTP will also provide gender-specific group interventions such as classes on family planning, pregnancy/pre-natal care (in collaboration with MSB OB/GYN clinic), child care and development, accessing community resources, and domestic violence.

Community In-reach

In order to facilitate engagement with mental health care and other providers in the community, address community readiness and build a health neighborhood within the jail and in the community, in-reach groups are also planned for the MHTP. In addition to mental health care providers, representatives from the Veterans Administration, faith based organizations, homeless/housing services, and vocational/employment services will be invited to co-facilitate groups.

Individual Interventions and Multidisciplinary Team Meetings

Individual interventions will include, but not be limited to initial evaluations and treatment planning, individual treatment, medication evaluation and prescribing, crisis intervention, benefits re-establishment and release planning. Multidisciplinary team meetings will be scheduled regularly at frequencies determined by the various levels of care.

E. Release Planning

The MHTP will place a strong emphasis on release planning, utilizing JMHS' current release planning process that assigns clients to one of three tiers for release planning purposes:

- Tier 1 – clients that require intensive, comprehensive planning; includes clients requiring mental health conservatorships
- Tier 2 – clients that require moderate release planning assistance; includes clients requiring assistance with obtaining adult residential care, residential treatment, Full Service Partnership enrollment
- Tier 3 – clients that require minimal assistance; have viable release plans for housing, mental health treatment and income/benefits

A release planning form is completed by the client's clinician or release planner during the evaluation and treatment planning process. The form is utilized to document the client's assignment to a release planning tier, the resources the client has in place, and the needed resources. The clinician or assigned release planner then works with the client to obtain needed resources, documenting all activities and plans in the release planning section of the medical record. Treating psychiatrists currently write release prescriptions for the medications the client is receiving at release; this will be done

electronically for the MHTP. Upon release, the client's clinician, or an IRC clinician if an afterhours release, is able to access the release plan and assist the client in implementing the plan. The MHTP will emphasize the importance of successful community re-entry by ensuring that an assigned clinician or release planner functions as case manager for release planning purposes throughout a client's incarceration. DMH also plans to place a psychiatrist, three release planners and two drivers in the Sheriff's IRC Release Center to ensure that needed resources are in place at the time of release and that clients are assisted in accessing them.

F. Treatment Programs – Levels of Care

Inpatient Crisis Care

The MHU CTC, licensed as part of the jail's Correctional Treatment Center, provides the MHTP's highest level of care, psychiatric inpatient crisis care. The MHU CTC is Lanterman-Petris-Short (LPS) designated in accordance with Welfare and Institutions Code, Section 5150 et. seq. to provide involuntary treatment to clients/patients that are dangerous to self or others and/or gravely disabled due to a mental disorder. The MHU CTC will have two nursing units with single cells for 30 patients per unit.

Focus of treatment will be on Track 1 group interventions that will be offered during two hours in the morning and two in the afternoon, six days per week. Rehabilitative and recreation therapists will provide the core services for gradual engagement and socialization, initially one-to-one and then advancing to small groups (2-4) and regular groups (6-8). Topic-specific, psycho-educational and release planning groups will be facilitated by therapists (psychologists and social workers) for patients that have advanced to that level of group activity. There will be a higher percentage of individual interventions in the MHU CTC than in the lower levels of care. All patients receive an assessment upon arrival by nursing staff for acute/emergent needs, level of monitoring and need for any safety precautions. Patients are evaluated by a psychiatrist on arrival or no later than 24 hours after admission and screened by a CTC physician or licensed medical practitioner to exclude the presence of an untreated medical cause for disordered behavior and to identify any other medical illnesses that will require treatment while in the MHU CTC. Nursing staff provide daily care and patients are seen regularly by their therapists for diagnostic assessment, evaluation of LPS involuntary status, evaluation and initiation of multidisciplinary treatment plans, individualized treatment and release planning. Multidisciplinary treatment teams make daily rounds to discuss each patient and meet formally as a treatment team on a weekly basis. The goal is to have patients out of their cells and involved in individual or group interventions whenever possible.

Intensive Care

This 200-bed level of care is designed to be CTC licensable as sub-acute inpatient care, providing flexibility should there be a need in the future for more licensed beds. Housing will be organized in 50-bed pods. Current plans are to initially utilize 100 beds for inmates with co-occurring mental health and substance abuse disorders (COD), and 100 beds for inmates with cognitive or behavioral disorders. Group interventions will be offered during two hours in the morning and two in the afternoon or evening. Staff will also provide individual interventions, including but not limited to medication evaluation and prescribing, crisis intervention, and release planning. It is anticipated that the Cognitive Disorders program will provide an alternative for long-term MHU CTC patients with cognitive or behavioral issues that currently cannot be successfully managed at lower levels of care.

Outpatient High Observation Care

Outpatient High Observation, the most intensive level of outpatient mental health care, will house 840 clients in pods of 50 beds each. This level of care is for clients that require intensive observation and care including risk precautions, but do not require hospitalization. The treatment approach is to facilitate active participation in the least restrictive environment by providing as much out of cell treatment as possible in order to enable clients to transfer to lower levels of care within the jail and to link to community services and supports upon release. Treatment goals are to provide hope and recovery, thereby reducing criminal and psychiatric recidivism. Focus of treatment will be on Track 1 group interventions that will be offered for two hours in the morning and two in the afternoon, six days per week. These interventions are intended for clients with high level acuity and short and variable lengths of stay in the Outpatient High Observation. Due to the level of acuity, for the most part group capacity will be 5 to 10 clients, and group duration will vary from 30 to 60 minutes. Staff will also provide individual interventions, including but not limited to initial evaluations and treatment planning, medication evaluation and prescribing, crisis intervention, benefits re-establishment and release planning.

Among the Outpatient High Observation clients are those that are refusing psychiatric medication, including offenders that have been adjudicated incompetent to stand trial. JMHS provides competency restoration services for clients charged with misdemeanors through its Misdemeanor Incompetent to Stand Trial (MIST) program, including a medication administration program that provides for court authorized medications. JMHS is currently exploring legal avenues to also provide medication pursuant to a court order for felony incompetents that are pending transfer to a State hospital for competency restoration services. Specialized individual and group interventions will

also be provided these clients with the goal of achieving voluntary compliance with court authorized medications.

JMHS has recently initiated a tele-psychiatry program that currently serves a limited number of inmates incarcerated at Pitchess Detention Center. Tele-psychiatry accommodations for the treating psychiatrists will be located in the CCTF, most likely in the High Observation area.

Outpatient Step-down

The Outpatient Step-down level of care will serve clients with a broad range of mental health diagnoses and functioning, whose mental health needs can be cared for in a less intensive and more open setting than the High Observation level of care, but preclude their tolerating general population housing. Treatment goals are stabilizing the mental illness; engaging clients in treatment for mental health and co-occurring substance use disorders; and immediately beginning to develop and/or solidify release plans for housing, mental health care, access to benefits, employment or education; and connecting or reconnecting with families and other community supports. The treatment strategy is to provide as much group treatment as logistically possible to alleviate symptoms, enhance functioning, prevent relapse and prepare clients to return to their communities and avoid jail or psychiatric recidivism. Groups will be available for at least two hours in the morning and two in the afternoon, six days per week. For the most part, group capacity will be 12 – 15 clients and group duration will be 45 to 60 minutes.

Track 2 and Track 3 group interventions will be provided, with Seeking Safety as the core group intervention. Track 2 interventions are intended for clients with medium level acuity and short and variable lengths of stay, while Track 3 interventions will be utilized for clients with longer lengths of stay - primarily clients incarcerated under the provisions of Assembly Bill 109, the Public Safety Realignment Act. Staff will also provide individual interventions, including but not limited to initial evaluations and treatment planning, medication evaluation and prescribing, crisis intervention, benefits re-establishment and release planning.

By providing a continuum of care, integrated with medical and substance abuse treatment and incorporating best practices in mental health care, the MHTP is designed to enable incarcerated individuals to achieve community re-integration, recovery and wellness.

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TREATMENT PROGRAM NARRATIVE

FOR THE OPERATION OF

CONSOLIDATED CORRECTIONAL TREATMENT FACILITY
SUBSTANCE USE DISORDER TREATMENT PROGRAM

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April 2014

Version I

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I. INTRODUCTION AND BACKGROUND

The County of Los Angeles (County), Department of Public Health - Substance Abuse Prevention and Control (DPH-SAPC) has the primary responsibility of administering contracts and program oversight of Substance Use Disorders (SUD) services throughout the county. In addition, DPH-SAPC directly operates the Antelope Valley Rehabilitation Center, a 300-bed residential SUD treatment facility for both males and females. DPH-SAPC's mission is to reduce community and individual problems related to SUD through Evidence Based Practices (EBPs) and policy advocacy.

Serving a jurisdiction of 10.4 million people, 88 cities and approximately 140 unincorporated areas this system is the largest and most complex in the nation.[1] The County Sheriff's Department (LASD) manages the largest jail population with nearly 19,000 inmates housed in eight county jails. The average inmate population has increased due to a substantial number of Non-violent, Non-serious, Non-sexual (N3) inmates serving their terms in County jail as mandated under Assembly Bill 109.[2] The most frequent types of crimes committed by inmates (male and female) held within the County Jail System are drug offenses followed closely by property offenses and violent offenses.[3] The most frequent types of drug charges are violations of the California Health and Safety Code 11530 (a) or possession of a controlled substance.[4] However, studies have shown that approximately 70 percent local jail populations meet the diagnostic criteria for SUD.[5] In addition, individuals that come into contact with the criminal justice system have higher rates of mental illness, unemployment, poor educational backgrounds, and homelessness which can contribute to higher rates of reoffending.[6]

To address the needs of inmates, the County Board of Supervisor's tasked the Chief Executive Office to contract with an independent consultant, Vanir Construction Management Inc., to conduct an analysis of an alternative concept proposing to replace one tower of Men's Central Jail with a Consolidated Correctional Treatment Facility (CCTF) to provide integrated medical, mental health, and SUD treatment services in one location. Providing integrated treatment services in-custody provides inmates the opportunity to address specific health needs in a controlled environment and can assist in reducing criminal recidivism and jail costs.

The U. S. Department of Health and Human Services - Substance Abuse and Mental Health Services Administration (SAMHSA) have long supported the concept that integrated behavioral health is a necessary component of treatment that can improve individual and overall public health.[7] Integrated treatment services are currently limited in the County jail system and as a result the health and wellness of inmates are not adequately met. Untreated mental health and SUD conditions correlates high recidivism rates and places a burden on prisons and jails in addition to healthcare delivery systems when inmates are released into the community.[8]

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[1] Los Angeles County Board of Supervisors. (2014). History of Los Angeles County. Retrieved from http://www. lacounty. gov/.
[2] Los Angeles County Sheriff's Department. (2013). *Education Based Incarceration*.
[3] Vanir Construction Management, Inc. (2013). Los Angeles County Jail Plan Independent Review and Comprehensive Report- Final Report.
[4] Vera Institute of Justice.(2011). Los Angeles County Jail Overcrowding Reduction Project.
[5] Ibid.
[6] Vera Institute of Justice.(2013). Making the Transition: Rethinking Jail Reentry in Los Angeles County.
[7] Substance Abuse and Mental Health Services Administration (2014). Retrieved from http://www. samhsa. gov/
[8] Ibid.

DPH-SAPC will oversee the SUD treatment program at the CCTF to include 500 dedicated beds. Treatment services will incorporate EBPs specific to inmates with SUD in three severity levels: 1) Level 1 – Clinically Managed Low Intensity; 2) Level 2 – Clinically Manage Medium Intensity; and 3) Level 3 – Clinically Managed High Intensity.

II. INMATE PROFILE

In March 2013 the County jail system inmate population averaged 18,573 with 86.5 percent males and 13.5 percent females.[9]

Research has found that the average profile of a County male inmate is as follows:[10]

- Average age is 34.3 years.
- The male population is predominately Hispanic (48.4 percent), followed by African-American (31.9 percent), Caucasian (16 percent) and other (3.7 percent).
- 93 percent of inmates have been sentenced on felony charges, with the remaining 7 percent in-custody for misdemeanor charges.
- 77.3 percent of the male population holds medium security classification.
- 28.8 percent of the male population has committed drug offenses.

Research has found that the average profile of a County female inmate is as follows:[11]

- Average age is 35.4 years.
- The female population is predominately Hispanic (39 percent), followed by African-American (34.1 percent), Caucasian (23.3 percent), and other (3.6 percent).
- 91 percent of inmates have been sentenced on felony charges, with 7percent in-custody for misdemeanor charges and 2percent in-custody for other charges.
- 71 percent of the female population holds medium security classification.
- 33.4 percent of the male population has committed drug offenses.

III. TARGET POPULATION

The target population is comprised of County jail inmates that have an extensive history of criminal activity and a severe SUD and are at high risk for recidivism. SUD treatment and recovery services will be provided during in-custody jail sentences to adult inmates age 18 and older. The target population may include elderly inmates, inmates with a history of trauma, inmates with disabilities, inmates with co-occurring disorders classified as low level mental health and high SUD, and inmates with long-term medical conditions (e.g., HIV/AIDS, Tuberculosis (TB), Hepatitis B and C).

[9] Vanir Construction Management, Inc. (2013). Los Angeles County Jail Plan Independent Review and Comprehensive Report- Final Report.
[10] Ibid
[11] Ibid

IV. GENERAL ADMISSION CRITERIA

Admission to the CCTF SUD treatment program shall be limited to those inmates who meet the following criteria:

1) Post-plea convicted inmates serving County jail time, with a minimum of a one year sentence left on their term
2) N3 classification
3) Inmates with a low mental health and high SUD Axis I diagnosis
4) Inmates determined suitable for SUD with at least a score of six or above on the Addiction Severity Index (ASI) (Attachment I), and the American Society of Addiction Medicine (ASAM) placement criteria based on dimension severity

V. DPH-SAPC EXPERIENCE AND REQUESTED LEVEL OF PROGRAM STAFF

Experience

DPH-SAPC maintains the primary responsibility for administering the county's complex range of SUD programs to meet County, State, and Federal regulations through the promotion, development, and maintenance of a comprehensive network of programs that respond to community needs, public policy, and regulatory requirements. DPH-SAPC currently maintains over 400 active contracts with more than 180 community-based treatment and support organizations, and successfully monitors compliance with contract requirements for all of these entities.

Program Staff

DPH-SAPC will administer and manage delivery of SUD treatment services at the CCTF. The following is the minimal level and classification of staff requested for this program:

Level of Staff

- 1 Center Program Manager
- 2 Assistant Center Program Manager
- 1 Rehab Therapy Chief
- 1 Staff Analyst, Health
- 1 Research Analyst III
- 5 Supervising Rehabilitation Counselor
- 2 Secretary II
- 2 Staff Assistant II
- 2 Senior Typist Clerk
- 25 Substance Abuse Counselor
- 10 Assistant Substance Abuse Counselor

- 1 Recreation Therapist I
- 3 Recreation Therapist Aide
- 1 Licensed Clinical Social Worker Supervisor I
- 3 Licensed Clinical Social Worker

VI. TOOLS , SCREENINGS, AND ASSESSMENT

Screening: Appropriate screening is critical for identifying inmates struggling with a SUD. The screening process is designed not only to collect information on SUD needs, but also to begin the process of determining eligibility/suitability for SUD services and explore additional needs to facilitate prompt entry into appropriate treatment services. DPH-SAPC will conduct initial screenings at the Inmate Reception Center to identify potential inmates for housing at the CCTF. DPH-SAPC will utilize the following SAMHSA Treatment Improvement Protocol (TIP) 45 recommended screening instruments specific to the criminal justice population:

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment is a comprehensive and integrated approach to the delivery of early intervention and treatment services for persons with SUD, as well as those at risk of developing a SUD. Inmates with low or moderate substance use risk will receive a brief intervention, and those with a high substance use risk will be referred for an SUD treatment service assessment.

Simple Screening Instrument for Substance Abuse

Simple Screening Instrument for Substance Abuse (SSI-SA) is used to initiate the process of assessment by identifying inmates SUD needs. The SSI-SA is a 16 item screening instrument that examines symptoms of both alcohol and/or drug dependence. SAMHSA recommends using this tool to identify the largest number of inmates who need treatment.

Clinical Assessment: Within 30 days from the initial screening, inmates will be assessed for suitability into the CCTF SUD program. DPH-SAPC will clinically assess the severity of the SUD and determine the appropriate level of treatment. Through structured inmate interviews and validated assessment instruments, the goal is to obtain information on support systems, medical illnesses, risk needs, and criminogenic factors. The assessment process will identify inmates with low level mental health and high SUD for participation in the proposed treatment program. The following clinical assessment tools will be utilized:

American Society of Addiction Medicine

The ASAM is a comprehensive guideline for placing individuals in SUD treatment. Placement criteria are widely used for individuals with SUD or COD into treatment. The placement criteria will address inmate's needs, challenges, and susceptibilities. The criteria are as follows: 1) Acute Intoxication and/or Withdrawal Potential will explore the inmate's past and current substance use and withdrawal; 2) Biomedical Conditions and Complications will explore the inmate's health history and current physical health; 3) Emotional, Behavioral, or Cognitive Conditions and Complications will explore the inmate's cognitions, emotions, and mental health issues; 4) Readiness to Change will explore the inmates readiness to change; 5) Relapse, Continued Use, or Continued Problem Potential will explore the inmate's relapse history and continued substance use or problems; and 6) Recovery/Living Environment will explore the inmate's recovery or living situation, his/her social circle, environment, and possessions. ASAM Criteria are objective and designed to remove the guesswork out of the placement process.

Addiction Severity Index

The ASI is a semi-structured interview tool designed to address seven potential problem areas for inmates with SUD: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. The ASI provides an overview of problems related to substance, rather than focusing on any single area. The ASI is a commonly used assessment tool in the SUD treatment field. The ASI is used in inpatient and outpatient SUD treatment settings to assess problem severity and need for treatment. The ASI has become the standard assessment tool used in most SUD treatment programs throughout the United States.

VII. EVIDENCE-BASED PRACTICE MODELS AND INTERVENTIONS

The SAMHSA National Registry of Evidence-based Programs and Practices (NREPP)[12] outlines nationally recognized EBP's identified to meet the needs of the SUD population. These EBP's have shown positive outcomes including, increased treatment engagement, program retention, and behavior modification. In selecting appropriate treatment activities for inmates, the treatment team will review the context of their culture, ethnicity, socioeconomic status, gender, age, sexual orientation, spiritual orientation, and any physical or cognitive disabilities, and recommend the appropriate EBP's to meet the needs of the inmate.

[12] Substance Abuse and Mental Health Services Administration. (2014). NREEP. Retrieved from http://www. nrepp. samhsa. gov/

The following EBP's will be utilized with descriptions obtained from the NREPP:

1. Interactive Journaling

Interactive Journaling is a goal-directed, client-centered model that aims to reduce substance abuse and substance-related behaviors, such as recidivism, by guiding adults and youth with substance use disorders through a process of written self-reflection. The model is based on structured and expressive writing techniques, principles of motivational interviewing, cognitive-behavioral interventions, and the integration of the transtheoretical model of behavioral change. The approach helps participants modify their behavior as they progress through the stages of change that underlie the transtheoretical model: 1) precontemplation (not intending to begin the change in behavior in the next 6 months); 2) contemplation (intending to begin the change in behavior in the next 6 months); 3) preparation (intending to begin the change in behavior in the next 30 days); 4) action (practicing the behavior for less than 6 months); and 5) maintenance (practicing the behavior for at least 6 months).

2. Matrix Model

The Matrix Model is an intensive outpatient treatment approach for stimulant 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. Individuals 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 therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the individual and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the individuals self-esteem, dignity, and self-worth. The program includes education for family members affected by addiction.

3. Motivational Interviewing

Motivational Interviewing (MI) is a goal-oriented, inmate counseling style for facilitating behavior change by helping inmate to resolve ambivalence across a range of problematic behaviors. MI uses an empathic and strategic approach in which the therapist provides feedback that is intended to strengthen and consolidate the inmate's commitment to change and promote a sense of self-efficacy. MI aims to elicit intrinsic motivation to change substance abuse and other behaviors by evoking the inmate's motivation and commitment to change, responding in a way that minimizes defensiveness or resistance.

4. Moral Reconation Therapy

Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among inmates by increasing moral reasoning. The cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Inmate's meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of three to six months.

5. Seeking Safety

Seeking Safety is a present-focused treatment for inmates with a history of trauma and SUD. The treatment was designed for flexible use: group or individual format, male and female inmate, and a variety of settings (e. g., outpatient, inpatient, and residential). Seeking safety focuses on coping skills and psycho-education and has five key principles: 1) safety as the overarching goal (helping inmate attain safety in their relationships, thinking, behavior, and emotions); 2) integrated treatment (working on both Post Traumatic Stress Disorder (PTSD) and substance abuse at the same time); 3) focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; 4) four content areas (cognitive, behavioral, interpersonal, and case management) and 5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

6. Twelve Step Facilitation Therapy

Twelve Step Facilitation Therapy (TSF) is a brief, structured, and manual-driven approach to facilitating early recovery from SUD. TSF is implemented with individual inmate's over 12 to 15 sessions. The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These principles include acknowledging that will power alone cannot achieve sustained sobriety, that surrender to the group conscience must replace self-centeredness, and that long-term recovery consists of a process of spiritual renewal. Therapy focuses on two general goals: 1) acceptance of the need for abstinence from SUD and 2) surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. The TSF facilitator assesses the inmate's SUD, advocates abstinence, explains the basic 12-step concepts, and actively supports and facilitates initial involvement and ongoing participation in AA. The facilitator also discusses specific readings from the AA/NA literature with the inmate, aids the inmate in using AA/NA resources in crisis times, and presents more advanced concepts such as moral inventories.

In addition, to the EBP's outlined above, the program will use specific cognitive behavioral approaches demonstrate effectiveness with inmate's having long criminal justice histories and long-term SUD dependence. The following EBP has been identified as appropriate for the criminal justice population:

Thinking for a Change[13]

Thinking for a Change is an innovative, evidence-based cognitive behavioral curriculum from the National Institute of Corrections that broadly influenced the correctional field and the way correctional facilitators work with inmates.

VIII. IN-CUSTODY SUD PROGRAMMING

The implementation of the SUD treatment component at the CCTF will build on existing rehabilitation efforts of LASD. Currently LASD operates Education Based Incarceration (EBI) throughout all eight county jails. The goal of EBI is to evaluate and assess educational and trade skills, provide an educational system to further enhance these skills to reduce the likelihood of recidivism upon the inmates release from incarceration. EBI offers the Maximizing Education Reaching Individual Transformation program which includes the following: adult basic education, behavior modification programs, life skills, computer skills, and job preparedness.

The program will be staffed by SUD treatment and mental health personnel who will provide a planned regimen of care in a 24-hour setting. Treatment is in a 24-hour setting where recovery specialized recovery services are made available to inmates who have a diagnosable SUD. Inmates are to be involved in no less than six (6) hours of planned treatment and recovery activities, in addition to set aside time for outdoor activities per day under the supervision of program staff (Attachment II-Sample daily schedule).

The following are the designated program levels, modeled after the ASAM criteria and outlines specific SUD treatment services to be provided:

Level 1 – Clinically Managed Low Intensity – Is directed towards applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the inmate into the community, educational setting, and family life. Inmates in this level have less severe SUD problems, greater social support, and resources.

Maximum duration of treatment is 60 days: services to be provided include, but not limited to:

1. Intake, orientation, and evaluation using evidenced-based SUD assessment tool (e.g., Addiction Severity Index)
2. Minimum of six (6) hours of planned treatment and recovery activities per day under the supervision of trained staff

[13] Bush, Jack, Glick Barry, Taymans Juliana. (2011). *Thinking for a Change: Integrated Cognitive Behavior Change Program*. National Institute of Corrections

3. Individual and group counseling sessions, including alcohol and other drug education, at a maximum of five (5) sessions per week
4. Participation in self-help meetings, at three (3) per week
5. Individualized treatment planning as appropriate (e.g., perinatal and special needs)
6. Random, observed drug testing, as clinically justified

Level 2 – Clinically Managed Medium Intensity – Provides a higher level of treatment in a structured, recovery environment. It is combined with clinical services to support recovery from SUD. The inmate's SUD is higher and level of impairment is more intense, where education, and or relapse prevention strategies are not feasible or effective. The functional deficits seen in this level are primarily cognitive and can be either temporary or permanent. When assessment indicates that the subject inmate is no longer cognitively impaired he/she can be transferred to more intensive or less intensive levels of care.

Maximum duration of treatment is 90 days: services to be provided include, but not limited to:

1. Intake, orientation, and evaluation using SUD and Criminogenic Assessment tools
2. Minimum of six (6) hours of planned treatment and recovery activities per day under the supervision of trained staff
3. Participation in self-help meetings at five (5) per week
4. Individualized treatment planning, as appropriate (e.g., perinatal and special needs)
5. Random, observed drug testing, as clinically justified

Level 3 – Clinically Managed High Intensity – Is designed for treating inmates who have significant psycho-social needs and require a safe environment for stabilization, intensive treatment, and an intensive recovery plan. The goals of this level treatment are to treat SUD and antisocial behavior, and effect a global change in the inmate's lifestyles, attitudes, and values. Appropriate inmates for this level have substance –related disorders, criminal activity, psychological disorders, impaired functioning, and/or disassociation with mainstream values.[14] These inmates may have serious and persistent Axis I Disorders (e.g., schizophrenia, bipolar disorder, and major depression, or Axis II personality disorders).

Maximum duration of treatment is 90 days: services to be provided include, but are not limited to:

1. Intake, assessment, and treatment plan development
2. Minimum of six (6) hours of planned treatment/recovery services per day
3. Participation in five (5) self-help meetings per week
4. Random, observed drug testing, as clinically justified
5. Intervention services
6. Two hours case management per month

[14] ASAM (2001). Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised

7. Relapse prevention
8. Skills development

Mental health treatment is integrated into Level 3 treatment with the following specific services to be provided to the COD population:

1. Comprehensive assessment
2. Individual psychotherapy at least 1 time a week
3. Monitor and manage psychotropic medication
4. Provide short-term therapeutic interventions
5. Customize intensive treatment plan
6. Develop specific recovery goals
7. Case conferences and discharge planning
8. Case management
9. Group therapy 3 times a week
10. Psychiatry

IX. CASE MANAGEMENT AND INDIVIDUALIZED TREATMENT PLANNING

Comprehensive Case Management - Based on SAMHSA's TIP 27, *Comprehensive Case Management for Substance Abuse Treatment,*[15] effective case management will address not only the inmate's SUD, but also the overall health needs therefore establishing a client-centered approach to fully enhance the treatment continuum. Case management focuses on helping the inmate acquire needed resources identified during their SUD treatment plan. It supports inmates as they move through the recovery continuum and reinforces treatment goals. The continuum is designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the inmate to maintain long-term sobriety while managing life in the community. Comprehensive case management ensures that treatment is structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case Management is an asset of social service functions that helps the inmate's access the resources they will need to recover from SUD.

Individualized Treatment Plans - Based on SAMHSA's TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice system,* treatment planning is a collaborative process that requires an inmate and his or her service team to work together to complete a comprehensive assessment, consider assessment information, set individual goals, and specify the means by which treatment can help the inmate achieve those goals. This person-centered approach to treatment will ensure that SUD treatment addresses each inmate's issues related to age, race, ethnicity, culture, language, disability, literacy, and gender (Attachment III-Sample treatment plan). SUD treatment involves activities that help inmates recognize their problems, acquire the motivation and skills to stay abstinent, and use the acquired tools to maintain sobriety.

[15] Center of Substance Abuse Treatment (2008). *Comprehensive Case Management for Substance Abuse Treatment.* TIP Series 27. DHHS Publication No. (SMA) 12-4215 . Rockville, MD: SAMHSA

Care Coordination - The care coordination will include the operations of the criminal justice and treatment system to work collaboratively based on the agreement of the inmate and the program protocols that define how each will manage the inmate. A coordinated effort will include a multi-disciplinary response that will take advantage of the wide range of treatment and rehabilitation options. The care coordination will include an assessment of the inmates' strengths, weaknesses, needs and the ability to remain crime and drug free, monitoring and reporting progress, and providing inmates with legal, social service, and medical systems in response to their needs.

Criminogenic Needs Assessment - Criminogenic needs are aspects of an individual's situation that when altered, are associated with changes in criminal behavior. Criminogenic needs may be understood as contributing towards criminal behavior and if effectively addressed, should decrease level of risk. DPH-SAPC will utilize the criminogenic needs assessment to determine areas such as substance abuse, antisocial attitudes, personality traits, associates, employment, marital and family relationships, and other theoretical issues that have been shown to correlate with criminal conduct and amenability to change. The following criminogenic needs assessment tool will be utilized

Global Appraisal of Individual Needs

The Global Appraisal of Individual Needs (GAIN) covers background, substance abuse, physical health, risk behaviors and disease prevention, mental/emotional health, environmental/living situation, legal, and vocational. GAIN addresses problems, services, attitudes, beliefs, and desire for services. GAIN also collects information on recent problems, breadth of symptoms, recent prevalence lifetime service utilization, recent utilization, and the frequency of utilization.

Treatment Discharge - The inmate will receive a comprehensive treatment and discharge plan that will describe what treatment the inmate requires, both in and out of jail. The treatment plan will include how the inmate will be connected with treatment and services in the community upon release. The discharge plan will be given to the inmate and explain their health and service needs and how to access services after release. The discharge planning process occurs while the inmate is still incarcerated, and prepares the re-entry into the community. The discharge plan will include an estimated discharge date, inmate's completed programs, medical records, post-release residence, and other community-based services (Attachment IV-Sample discharge plan).

X. COMMUNITY RE-ENTRY PLAN

Treatment engagement while in-custody can promote successful re-entry to the greater community upon release. For inmates completing their sentences and transitioning out of an in-custody setting, the coordination and collaboration between DPH-SAPC and contracted community-based organizations will build a stronger transitional support system. DPH-SAPC's Community Assessment Services Center (CASC) will assess and refer inmates to needed services through the LASD Community Recovery and Reintegration Center immediately after release by linking them to appropriate community-based treatment. Available SUD treatment services include the following:

1. **Alcohol and Drug Free Living Center (Sober Living)**

Alcohol and Drug Free Living Centers (ADFLCs) are housing facilities where participants recovering from alcohol and drug problems reside. ADFLCs are living environments where the presence of or use of alcohol and drugs, other than prescribed drugs, is prohibited. ADFLCs provide an opportunity for residents who have re-entered or are preparing to re-enter the labor force to pursue their own personal plan for recovery in an alcohol and drug free atmosphere, removed from normal social pressures and temptations to drink alcoholic beverages and abuse drugs. No direct treatment services are provided. However, residents of ADFLCs participate in an offsite treatment program. The residents often function as a mutually self-supportive group, reinforcing each other's efforts to remain alcohol and drug free, and may attend 12-step groups and other related activities outside the facility. Residents share the responsibility of house maintenance, food purchase and preparation, and development of house rules.

2. **Medication Assisted Treatment/Narcotic Treatment Program**

Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorder. MAT is clinically driven with a focus on individualized patient care. Program participants (including, but not limited to, homeless persons) must be 16 years or older deemed eligible for medication assisted treatment. Those who are between the ages of 16 and 18 require consent of parents or guardians. The minor must sign a consent form whereby he/she agrees that the treatment agency may contact his/her parent(s), caregiver, or guardian regarding the minor's history and that the agency may disclose to the parent(s), caregiver, or guardians that he/she is participating in a treatment program and is being referred for medication-assisted treatment.

3. **Outpatient Counseling Services**

Outpatient Counseling services are those alcohol and drug treatment and recovery services which are provided in a drug-free, non-drinking environment, directed towards alleviating and/or preventing alcohol and drug problems among individuals, or participants, pregnant and parenting women and their children, families, specific population groups, or the general community, which does not require residency at a provider's facility as part of the treatment and recovery process. Services include crisis intervention, individual/group/family counseling, urinalysis testing, case management, and referrals for ancillary services along with coordinated medical and mental health services. Services may also include referral of a participant for medical detoxification services, residential and recovery house services, methadone treatment program services, psychiatric services, or other treatment services deemed appropriate by Contractor.

4. **Outpatient Narcotic Treatment Program Detoxification Services**

Outpatient narcotic treatment program detoxification services are those substance use disorder treatment services which provide for the administering or furnishing of methadone, as a substitute narcotic drug, in decreasing dosage levels for a period not exceeding 21 days, to allow a patient who is dependent on heroin or other morphine-like drugs to withdraw from the use of such addicting drugs such outpatient detoxification treatment services shall be conducted in conjunction with an organized and coordinated program to aid the patient in altering his/her drug dependent life style, and to eventually eliminate dependency on drugs.

5. **Narcotic Treatment Program Services**

Narcotic treatment program services are drug treatment services which provides for the administration of methadone and/or levoalphacetylmethadol, at relatively stable dosage levels for a period in excess of 21 days, as an oral substitute narcotic drug accompanied by an ancillary social and medical services for individuals including, but not limited to, homeless persons, 18 years or older who have a history of two (2) or more years of dependence on heroin or other morphine-like drugs, and two (2) or more failures in alternative treatment programs.

6. **Residential Medical Detoxification Services**

Residential Medical Detoxification services are services directed towards the care and treatment of persons including, but not limited to, homeless persons suffering from the toxic effects of narcotics and/or dangerous drugs. Once a participant is admitted for detoxification, medical staff should perform a comprehensive assessment to determine the level of prior and recent use and to determine the level of substance abuse and dependence. These services shall be conducted within a facility licensed and approved by the State of California, Department of Health Care Services in accordance with current federal and State standards for such facility(ies).

7. **Residential Treatment Services**

Residential Treatment is a twenty-four (24) hour residential program where recovery services, and/or specialized recovery services are made available to persons who have alcohol and/or drug problems. Program participants are to be involved in no less than six (6) hours of planned treatment and recovery activities per day under the supervision of trained staff. Specialized recovery services may include therapeutic intervention by professional staff such as Licensed Clinical Social Workers and Marriage and Family Therapists. The alcohol and drug residential services program is an accessible resource to the community for information about alcohol and drug related issues, referrals to appropriate alcohol and drug services, and opportunities for volunteer activity.

XI. GENDER-SPECIFIC TREATMENT

Gender-specific treatment either in prison or in a community setting should have a positive impact on the recovery process.[16] Although men make up the majority of inmates, gender-specific treatment takes into account the fact that men and women have vastly different physical and emotional responses to SUD and require treatment to meet the specific needs of their gender. Gender-specific treatment has explored how gender affects the different stages of the treatment processes including the following: 1) initiation to treatment; 2) treatment engagement; 3) continuation in treatment; and 4) completion of mandated treatment program services.[17] Gender-specific treatment should establish appropriate relapse prevention strategies and prepare inmates for later stages of recovery.

Male Specific Treatment

Treatment concerns with male inmates often center on: 1) fathering; 2) intimate partner violence; 3) child custody; 4) lack of job training skills to maintain a crime free lifestyle; 5) risky sexual behavior; 6) suicide; 7) depression; 8) trauma; 9) other health problems, including cancer and HIV; and 10) Sexually Transmitted Diseases (STD). A main challenge to the male inmate population is to understand that these males have difficulty establishing healthy relationships which can hinder treatment engagement if not properly addressed.[18] Effective treatment should engage males in learning interpersonal skills that will not only aid in the therapeutic process, but also assist in developing positive relationship skills. SUD treatment programming specific to the male population correlates to lower recidivism rates, encourage sobriety, and ultimately promote better public health.

Female Specific Treatment

Treatment concerns with female inmates often center on: 1) pregnancy; 2) immediate risks for self-harm, suicide, and violence; 3) past and present mental disorders, including Post-Traumatic Stress Disorder (PTSD) and other anxiety disorders, mood disorders, and eating disorders; 4) past and present history of violence and trauma, including sexual victimization and intimate partner violence; and 5) health screenings, including HIV/AIDS, Hepatitis B and C, TB, and STDs. Women face many difficulties in accessing SUD treatment services and also require specific needs while in treatment. According to SAMHSA 34 percent of women needing SUD treatment could not cover treatment costs due to inadequate or nonexistent health insurance.[19] Barriers to accessing treatment include low economic status, need to fulfill the role of primary caretaker for minor children, a greater frequency of trauma, and the social stigma of SUD.[20]

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[16] Center of Substance Abuse Treatment (2005). *Substance Abuse Treatment for Adults in the Criminal Justice System.* TIP Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: SAMHSA

[17] Green, C. A. (2006). Gender and use of substance abuse treatment services. *Alcohol Research and Health*, 29(1)

[18] Center of Substance Abuse Treatment (2005). Substance Abuse Treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration

[19] Center for Substance Abuse Treatment (2009). *Substance Abuse Treatment: Addressing the Specific Needs of Women*. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration

[20] Ibid

XI. CONFIDENTIALITY/COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996:

Health Insurance Portability and Accountability Act (HIPAA) requires a covered entity to protect Patient Health Information (PHI) from unauthorized disclosure for any purpose not permitted in the HIPAA Privacy rule. Additionally, Title 42 Code of Federal Regulations (CFR) Public Health Chapter 1: Public Health Service, Department of Health & Human Services Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records, are regulations that cover the following subjects : statutory authority for confidentiality of drug and alcohol abuse patient records, reports of violation, criminal penalty for violation, minor patients, incompetent and deceased patients, security for written records, undercover agents and informants, restrictions on the use of identification cards, disposition of records by discontinued programs, relationship to State laws and to Federal statutes protecting research subjects, notice to patients, patient access and restrictions on use, written consent, disclosures to elements of the criminal justice system that have referred patients, medical emergencies, research activities, audit, and evaluation activities.[21]

DPH-SAPC is a covered entity and is bound by HIPAA and 42 CFR to protect client health records and client privacy. In addition, treatment services conducted in a correctional institution shall be considered a covered entity and required to follow HIPAA rules pertaining to disclosures of PHI.

XII. EVALUATION

Evaluation is a critical component of SUD treatment in the criminal justice system. Evaluation will be used for program monitoring and for ongoing decision making by program staff, administrators, and policy makers. DPH-SAPC will establish an evaluation design upon implementation of the SUD treatment program at the CCTF, identify appropriate benchmarks, and target performance outcomes. Evaluating the program will provide accountability, and identify strengths and weaknesses in the program. Evaluation will examine the following:

1) **Implementation –** This phase of the program will identify problems and accomplishments during implementation to assist with feedback for process improvement.

2) **Process –** This phase will identify the assessment and the overall effects of the program on the inmates while in treatment. Components of the process will analyze the type and level of services, the number of inmates who are screened, admitted, reviewed, and discharged.

3) **Outcome –** This phase will involve assessing inmates' community reintegration and recidivism. Specified design to be determined.

[21] SAMHSA. Retrieved from: http://www. samhsa. gov/legislate/Sept01/01907_42cfr_part2.html

XV. ATTACHMENTS

APPENDIX INDEX

VOLUME 2

E — MENTAL HEALTH TREATMENT PROGRAM
Prepared by the Los Angeles County Department of Mental Health

F — SUBSTANCE USE DISORDERS TREATMENT PROGRAM
Prepared by the Los Angeles County Department of Public Health

G — **EDUCATION BASED INCARCERATION PROGRAM PROPOSAL**
Prepared by the Los Angeles County Sheriff's Department, Education Based Incarceration Bureau

H — MEDICAL SERVICES/PATIENT CARE PROGRAM PROPOSAL
Prepared by the Los Angeles County Sheriff's Department, Medical Services Bureau

I — ASSESSMENT OF PROPOSED INTEGRATED JAIL MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT PROGRAMS
Prepared by RJS Justice Services, LLC

Consolidated Correctional Treatment Facility

Programs Proposal

Los Angeles County Sheriff's Department

Education Based Incarceration Bureau

March 2014

WEB

450 Bauchet Street, Los Angeles, CA 90012

www.lasd.org

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Consolidated Correctional Treatment Facility

BACKGROUND

The Los Angeles County Sheriff's Department (LASD), Department of Mental Health (DMH), and the Department of Public Health (DPH) partnered to create the Consolidated Correctional Treatment Facility (CCTF), designed for the housing and treatment men and women inmates who are mentally ill and/or suffer from drug/alcohol addictions. The current county facilities are not suitable to provide acute care for the chronically mentally ill and those suffering from severe addiction problems. Failure to meet the needs of these populations increases the likelihood of recidivism, endangers public safety, and potentially violates the federal civil rights of the inmate. [1]

LASD is one of the largest mental health providers in the nation. In fact, between Los Angeles County; Cook County, in Illinois; and New York City, more than 11,000 [mentally ill] prisoners are under treatment on any given day, representing "…28% of all beds in the nation's 213 state psychiatric hospitals…"[2] Currently, LASD houses over 3,400 diagnosed mentally ill patients, representing 18% of those incarcerated in Los Angeles County. In addition, there are over 64% incarcerated inmates on addiction charges. Even though many inmates are referred to treatment centers for addictions upon release from jail, LASD offers limited treatment during time of incarceration. Lack of services while incarcerated almost ensures the inmates will recidivate.

Unfortunately, the current Los Angeles County jail facilities were not designed to meet the needs of these two populations. As a result, in 1999, the U.S. Department of Justice (DOJ) found LASD was negligent in 44 compliance areas, violating the federal civil rights of mentally ill inmates. Negligence was primarily due to facility limitations. Additionally, in 2013, the state added over 6,000 AB-109 state inmates to the LA County jails creating an unmanageable situation of overcrowding and services degradation.

EBI REHABILITATION AREAS

EBI will provide supportive educational services to qualified inmates housed within the Mental Health "step-down" outpatient sections, intensive Substance Abuse Disorder (SUD) sections, and general population high

[1] LA County Sheriff's Department MOA: *US Department of Justice (DOJ) Recommendations. (1999)*

[2] Fields, G., & Phillips, E. (2013). *The new asylums: jails swell with mentally ill*. Retrieved from http://online.wsj.com/news/articles/SB10001424127887323455104579012664245550546

security sections of CCTF. Program participation will depend on referrals from DPH and DMH. Referred students will be placed in one of three program areas:

Mental Health Step Down

LASD projects housing up to 2,235 inmates in the Step Down section. While many of these inmates are using psychotropic medications, many should be able to participate in educational programming. EBI will provide appropriate programs for this population. All classes will be taught in small groups (no more than 10) and/or independent study. Participation will depend on need and interest level.

Intensive SUD Treatment

LASD projects housing up to 500 inmates with substance abuse disorders. EBI will focus programs on the Clinically Managed Low Intensity (Level 1) and the Clinically Managed Medium Intensity (Level 2) inmates. Since DPH will only provide 60 days of services to both levels 1 and 2, EBI services will be limited to only Cognitive Behavior Therapy (CBT) structured courses, working closely with DPH within their 3-day per week self-help meetings. Inmates soon to be released to the jail's general population will be given an academic assessment to determine their academic needs. Where applicable, inmates needing further education will be transferred to an EBI dormitory and provided with GED, High School, College, or other educational services.

General Population High Security

LASD projects housing up to 600 general population inmates in high security single cells. EBI will provide appropriate educational programs for this group through independent study and small group instruction (no more than 10).

PROGRAM PLACEMENT

Men and women housed at CCTF will be placed in programs that best meet their criminogenic risk and needs (See Figure 1). EBI programs include Cognitive Behavior Therapy (CBT), drug education, anger management, relationships, parenting, spiritual growth, literacy education, English as a Second Language (ESL), high school diploma/GED, Career Technical Education (CTE), and community college. To ensure offender's needs are targeted, case management plans will be developed to create proper programming for each inmate. Needs will be assessed through a variety of tools including: Northpointe Assessments for criminal needs; and the Test of Adult Basic Education (TABE) for academic needs.

Figure 1 – Risk/Needs Indicators

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Class selections will be determined based on the students risk to recidivate, need for services, and student interest level. Gender responsive needs for women will also be considered for proper program placement. Gender Responsive Rehabilitation (GRR) model focuses on both gender-neutral factors associated with criminal offending (e.g., such as mental illness and substance abuse), and gender differences (e.g., trauma from sexual and/or physical abuse and self-esteem). Other factors more specific to female offenders are the importance of relationships, caring for children, and lack of education and employment training. "Structured social-learning programs where new skills are taught and behaviors and attitudes are consistently reinforced; cognitive behavioral programs that target attitudes, values and beliefs, peers, substance abuse, anger, etc.; and family-based interventions that train family members appropriate behavioral techniques."[3]

EDUCATIONAL DELIVERY MODELS

Educational delivery models will include education through use of tablet computers, internet based courses in a computer lab setting, independent study workbooks, and face-to-face instruction. "…Studies have shown that offenders who receive their GED, vocational training or post-secondary education had a significant reduction in recidivism. The higher the degree of education, the lower the recidivism."[4] CCTF educational offerings include Adult Basic Education (ABE), English As A Second Language (ESL), GED preparation and testing, High School Diploma, Career Technical Education, and Community College classes leading to an AA degree. "…Studies have shown that offenders who receive their GED, vocational training or post-secondary education had a significant reduction in recidivism. The higher the degree of education, the lower the recidivism."[5]

[3] Latessa, Edward J. Ph.D. (2006) "What Works in Reducing Recidivism?" *University of St. Thomas Law Journal*: Vol 3: Iss. 3, Article 7. Available at: http://ir.stthomas.edu/ustlj/vol3/iss3/7. P. 524

[4] Skrobecki, D. (2014) Similarities and differences between male and female offenders. *Corrections Today*. Jan/Feb 2014.

[5] Skrobecki, D. (2014) Similarities and differences between male and female offenders. *Corrections Today*. Jan/Feb 2014.

REHABILITATIVE/THERAPUTIC PROGRAMS

Cognitive Behavioral Therapy (CBT)

CBT programs provide evidence-based treatment addressing dysfunctional emotions, maladaptive behaviors and cognitive processes; using monitoring and progress assessment to assist offenders in reaching their prescribed goals. Available programs will include: Substance Abuse Treatment by the Department of Public Health (DPH), Criminal Thinking, Anger Management, Parenting and Family Relationships, and Child Development courses. Participating students will be exposed to evidence based curriculums such as Thinking for a Change, Cage Your Rage, Breaking Barriers, and A Plus Guide to Re-Entry. Professionally trained teachers, LASD staff, volunteers will teach this program, and inmate peer mentors.

Adult Basic Education

All students will be given the Test of Adult Basis Education (TABE) to determine program placement. Students in need of reading and math remediation will be placed in appropriate classes to build basic skills in preparation for GED or high school diploma courses.

English as a Second Language

Students whose primary language is other than English will be encouraged to take Basic English courses to prepare them for community re-entry and higher education. Additionally, LASD is working through the Mexican Consulate to provide GED equivalent programming recognized in Mexico and other Latin American countries for inmates subject to deportation. (Ceneval Exam).

GED Preparation and Testing

GED Preparation courses will be offered to those with limited number of high school credits or a short sentence. GED testing will be offered on site. Students returning to Mexico, Central, or South America after release will be given the opportunity to study for the Ceneval exam in Spanish. Passage of the Ceneval provides high school proficiency in Latin American countries.

High School Diploma

Traditional high school courses will be offered both in a classroom and online environment. Core classes of language arts, mathematics, history, and science will provide the basis of program. Additionally, elective course will be offered as needed. All high school courses are paid for by State Average Daily Attendance (ADA) funds and cost neutral to LASD.

Career Technical Education (CTE)

CTE programs, otherwise known as vocational education, will be provided to students who have already completed their high school diploma or GED. Some students may qualify to be concurrently enrolled in CTE and High School, counting CTE courses as high school electives. The purpose of each CTE program is to provide training leading to employment with a living wage. Some courses require all day instruction and others only partial day. Careful consideration was taken to ensure companies are hiring those with criminal histories in these industries.

Consolidated Correctional Treatment Facility

EBI will develop a strategic partnership with EDD to research successful programs models from around the country and target job markets where ex-offenders are employable. The following CTE courses would be suitable for instruction inside a jail facility:

Cisco Networking Academy

Modeled after Denver Colorado's Women's Correctional facility, LASD will create a Cisco Networking Academy focusing on the following three core certifications: IT Essentials, CCNA® (Cisco Certified Networking Associate) Discovery, CCNA Exploration, and CCNA Security. According to the US Department of Labor Statistics, the need for computer IT related skills will increase by 13% during the next four years. Students will be able to take industry certified exams through the LASD Pearson Vue testing center. The average beginning salary for this certification is $34.88 per hour.

Social Media Management and Marketing/Office Assistant

Small businesses need qualified office assistants in the area of basic clerical skills and social media management. Skills taught in this certification would consist of keyboarding, business writing, marketing, Word Press blogging and programming, and skill development in the creation and updating social media sites such as Facebook, Twitter, YouTube, and Pinterist. Social media management and marketing allows for men and women to work from home if needed and obtain clients anywhere in the world. LinkenIn.com is currently advertising for 8,349 social media marketing jobs. The social media program would be divided into 6-week certifications allowing for student transiency. According to the Bureau of Labor Statistics, jobs for office assistants are expected to grow by 14% from 2010 to 2020 and pay and average of $12.49 per hour.

Custodial Technician

This course is designed to provide knowledge, training and practical work experience for students preparing for employment in the building and home custodian industry. The course covers the areas of Chemistry of Cleaning, Cleaning and Maintaining of Hard Floor Surfaces, and Cleaning of Upholstery and Carpeted Surfaces. Students who successfully complete and pass the examination from the Cleaning Management Institute will receive a certificate of Achievement. The certification indicates the individual has secured a certificate as a "Custodial Technician."

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According to the Bureau of Labor Statistics, jobs for custodian industry are expected to grow by 12% from 2010 to 2020 and pay and average of $10.73 per hour.

Computer Coding

This class is available to interested students in the evening. Students must meet minimum technology requirements. The class meets 2 times per week for instruction, and the participants are required to dedicate a minimum of 10 hours per week to independent lab time. Specific sessions utilize a WebEx connection, which facilitates virtual instruction. The students will have access to a "white listed" selection of research web sites. Two of the primary sites are: Stack Overflow (stackoverflow.com) and Mozilla Developer (developer.mozilla.org) the computer language featured in the program is Java Script. Java Script engineers are in high demand and these basic language skills can be leveraged to learn additional programming languages. Coding is also a career that can be done in the home. According to the Bureau of Labor Statistics, jobs for computer coding pay and average of $35.71 per hour.

Small Business Entrepreneurship

Participants read books by digital media experts and interact with guest speakers and mentors from technology companies. They are also active contributors to social media sites. Through weekly tweets, blogs, and answering Quora questions, each participant develops an online presence and "personal brand" outside of their label as "prisoner." As participants don't have online access, their content is handwritten or typed, then uploaded by volunteers. Each participant is taught how to write a business plan and create a marketing pitch for potential investors. This class will be offered two evenings per week. Students much have at least a GED or high school diploma to qualify.

Community College

A 2010 National Institute of Corrections study found "…there is a relationship between increased level of educational achievement and an increased probability of employment."[6] Furthermore, "…studies have shown that female offenders who receive their GED, vocational training or post-secondary education had a significant

[6] Alemagno and Dickie, (2005) Alemagno, S., and J. Dickie. 2005 "Employment Issues of Women in Jail." *Journal of Employment Counseling.* 42:67-74.

reduction in recidivism. The higher the degree of education, the lower the recidivism.[7] CCTF will offer community college programs to those planning to attend college upon release and women with longer sentences. College offerings will be both for degree completion as well as individual courses.

Associate of Arts Degree

Community college classes will be offered through LA Mission College to students desiring to complete an Associate of Arts degree or enter college upon release. Some high school students will be allowed to concurrently enroll in high school and community college fulfilling requirements for both the high school diploma while obtaining college credits. The degree will be in Entrepreneurship and Small Business Management Associate in Science. This degree will teach students the management skills unique to the successful operation of a small business enterprise, including financial, marketing, and management strategies.

General Education

Students not interested in a business degree will be given the opportunity to take a variety of liberal arts and other general education classes through Coastline Community College. Courses are offered through mail correspondence.

OTHER PROGRAMS

Pre-Natal Programs

Expectant mothers will be housed together to receive proper training and support. A supportive and therapeutic environment will be provided to allow the women the opportunity to focus on the needs of their child and prepare to be a mother.

Volunteer Programs

Students will also be allowed to volunteer for programs presented by Community and Faith Based Organizations such as, Alcoholics Anonymous, Narcotic Anonymous, Hannah's Gift, Malachi Men and other faith based organizations.

[7] Women's Prison Association. (2005). A portrait of women in prison. Retrieved from www.wpaonline.org.

Peer Mentoring

Qualified inmates will be trained to teach basic life skills courses to general population inmates, work as classroom assistants, and serve as academic tutors.

Physical Education

We will provide a recreation area allowing the inmates to exercise through group activities such as yoga or palates, independent workout sessions, nutrition education, and recreational activities. Exercise and healthy lifestyles will be taught as an alternative to substance abuse.

Dance

Combined elements of dance and music will offer challenges in coordination, rhythm, and cardiovascular fitness. A multi-level class will be geared to challenge bodies of any age, gender, or fitness background. Exercises can be modified for beginners, prenatal clients or clients with injuries. Exercises can also be amplified for advanced clients looking for an extreme challenge in a dance workout. This total body workout serves to strengthen, lengthen, and stretch the body from top to bottom, and from inside out.

Arts and Crafts

Arts and crafts programs will be available in the recreation areas during non-classroom periods. The purpose of this program is to provide a therapeutic environment where inmates can learn to express themselves through the arts recreation program area.

Book Club

Qualified and interested inmates will be invited to participate in a weekly book club. Club members will read character building novels and classical literature and meet to share their feelings and discuss what they have learned.

Re-Entry Center

The Re-Entry Center is the first resource available for people in need of emotional and psychological support. Case managers will be available for individuals seeking information within the following categories, Academic Advising, Career Counseling, Personal Counseling, Interest assessments, and Referrals to community resources. The center is intended to provide inmates an opportunity to address personal and/or lifestyle-related issues, which may have either directly or indirectly led to their incarceration. Through a combination of services, inmates can receive assistance in a wide variety of matters; including drug and alcohol abuse, anger management, and employment skill training. In addition to providing direct counseling intervention services, the center will also assist individuals in identifying community-based resources which will be available upon their release from custody. In collaboration with the DMV, the re-entry center will provide the opportunity for inmates to renew their driver's license prior to release.

Men and Women's Advisory Council

In this facility, the inmates are expected to be accountable and responsible members of a rehabilitative community. As such, an inmate advisory council will be established whereby inmates will be encouraged to work with custody staff to communicate their needs in a positive and productive manner. Town hall meetings will also be held where inmates voluntarily participate to voice questions and concerns about the schedule and daily life in the facility.

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Consolidated Correctional Treatment Facility

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APPENDIX INDEX

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E — MENTAL HEALTH TREATMENT PROGRAM
Prepared by the Los Angeles County Department of Mental Health

F — SUBSTANCE USE DISORDERS TREATMENT PROGRAM
Prepared by the Los Angeles County Department of Public Health

G — EDUCATION BASED INCARCERATION PROGRAM PROPOSAL
Prepared by the Los Angeles County Sheriff's Department, Education Based Incarceration Bureau

H — **MEDICAL SERVICES/PATIENT CARE PROGRAM PROPOSAL**
Prepared by the Los Angeles County Sheriff's Department, Medical Services Bureau

I — ASSESSMENT OF PROPOSED INTEGRATED JAIL MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT PROGRAMS
Prepared by RJS Justice Services, LLC

Consolidated Correctional Treatment Facility

Programs Proposal

DR

Los Angeles County Sheriff's Department

Medical Services Bureau, Options 1a, 1b, 2, and 4

March 2014

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MEDICAL SERVICES BUREAU

Mission

All individuals in custody with the Los Angeles County Sheriff's Department requesting or requiring medical services will be treated as patients with respect and dignity, and the highest level of care will be provided to those individuals.

History

The Medical Services Bureau originated under former Sheriff Eugene Biscailuz during the early 1930's. The initial contingent of staff was assigned to the Hall of Justice Jail and the Wayside Honor Rancho. The Medical Services Bureau grew rapidly with the addition of each new jail facility.

Currently

The Los Angeles County Sheriff's Department Medical Services Bureau is the largest correctional medical services provider of its type in the world. It is the largest bureau in the Los Angeles County Sheriff's Department with more than 1,400 employees in over 88 different job classifications. We provide medical services to over 140,000 inmates booked into the Los Angeles County Jail system every year.

This includes over 140,000 Tuberculosis screening X-rays, 6.5 million doses of medication delivered, 205,000 Nurse Clinic assessments and over 35,000 pre-scheduled physician appointments.

The Medical Services Bureau provides health care services for all inmates housed within the Los Angeles County Sheriff's Department jail system. These services are based on the 1976 United States Supreme Court case of *Estelle v. Gamble*. This landmark case serves as the foothold to an inmate's "constitutional right" to health care access. Medical Services Bureau personnel are responsible for the quality of health care in all of the Los Angeles County Sheriff's Department medical facilities. Along with physicians and nurses, the Medical Services Bureau provides the services of dentists, pharmacies, laboratories, radiology, and health information management services.

Our bureau has become a leader in innovative technology, implementing programs such as Jail Health Information System Technologies/Jail Health Information System (JHIS), Automated Drug Packaging (Auto Med), Picture Archiving Communications System (PACS), and Telemedicine. Currently over 13,000 inmates receive prescribed medications on a daily basis. This, combined with the growing number of daily nursing evaluations and treatments, has resulted in over 8 million inmate contacts per year in all the medical units within the Los Angeles County Sheriff's Department.

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PATIENT CARE SERVICES

Medical Clinic:
This is a centrally located area within a facility wherein health care is provided via various provider lines, nurse clinics, walk-ins, scheduled appointments, and emergencies. This area is usually manned by nursing and provider staff. Depending on the facility, the clinic may operate 24 hours a day, seven days a week.

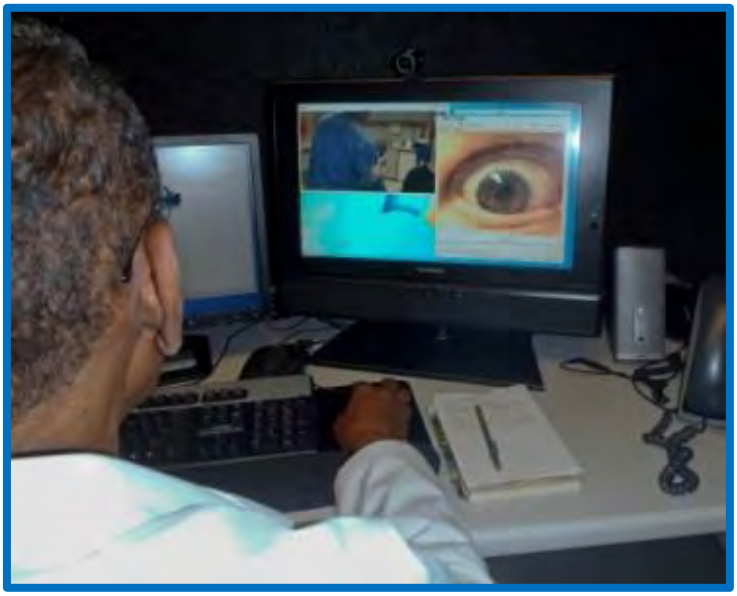
Urgent Care:
Provides care/services for urgent, non-life threatening medical conditions. Starting July 29, 2013, Urgent Care was staffed with medical providers from Los Angeles County + University of Southern California (LAC+USC) Medical Center and supported by LASD nursing personnel. The Urgent Care is open 7 days a week, 16 hours each day from 0600 hours to 2200 hours. From July 29, 2013, to February 14, 2014, a total of 4,870 patients were evaluated and treated who would have otherwise been transferred to LCMC Jail ER. In addition, orthopedic services are being provided – casts and splints are applied as necessary. As a result, the number of hours the Jail ER has closed has consistently declined. This has allowed patients to receive timely urgent evaluations and treatment which would have otherwise been delayed due to previous Jail ER closures.

MD/RNP 24/7:
Also known as the Medical On-call Doctor (MOD), any time a provider is not on duty in a facility, this provider is located at the Tower 2 Clinic and is available to all jail facilities via telephone. This provider responds to calls from nursing staff at the various facilities that have urgent patient care needs to address, some of which ultimately require evaluation at the Urgent Care clinic, or transportation to an acute care hospital for further evaluation and treatment.

Nurse Clinic:
The Nurse Clinic operates to ensure that all inmates have access to medical/mental health care in compliance with Title 15 Regulations for Sick Call. Registered Nurses provide Nurse Clinic Services by performing nursing assessments up to and including the initiation of standardized procedures, which provide patient access to basic health care services, in order to meet the health care needs of the inmate population. Patients requesting medical/mental health services at any time may be referred to the main medical clinic in the facility for Nurse Clinic Services.

Pill Call:
This is the administration of medication by a nurse at the prescribed time as ordered by a health care provider. Pill call is held in the various housing areas at 0800, 1200, 1600, and 2000 hours each day. Depending on the physical layout of the housing area, the nurse administering the medication may conduct pill call by walking from cell to cell, at the entrance door of the pod, or next to the custody control booth inside the module.

Telemedicine:
Provides medical evaluation utilizing videoconferencing technology. Any patient can be virtually evaluated by a provider regardless of physical location. There are three provider workstations, which are located in Tower II; and 13 carts distributed throughout the jail facilities. The Telemedicine program, in conjunction with the electronic medical record, enables the patients to receive an optimal level of medical care in a timely manner, without compromising security issues. In the year 2013, 19,888 patients were evaluated using Telemedicine.



Pharmacy:
The pharmacy is responsible for maintaining a formulary of prescribed medication and keeping such drugs in stock, for the provision of patient care. Pharmacists and Pharmacy Technicians are responsible for the operation of the pharmacy. The main pharmacy is located at TTCF, with two additional pharmacies at CRDF and MCJ. Currently, medication for the PDC facilities is provided by the main pharmacy.

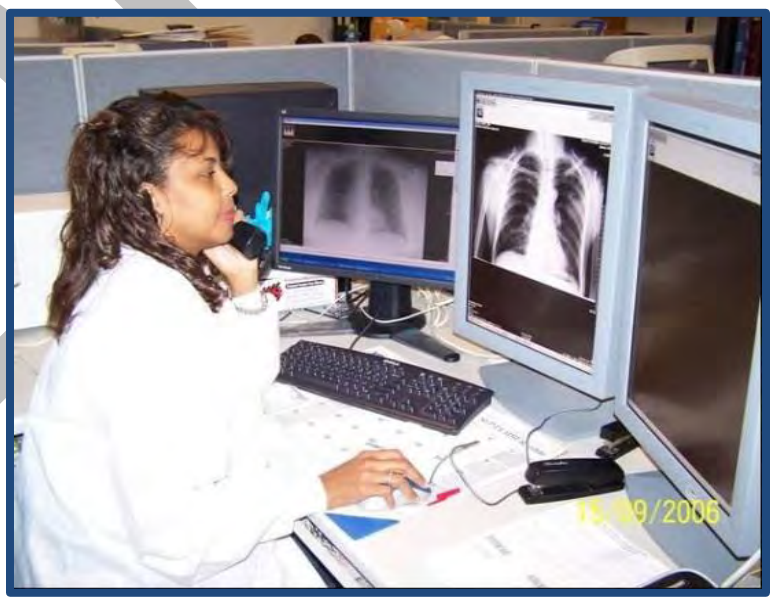
Infection Control:
This unit is staffed with a physician, public health nurses and an epidemiologist. Its function includes identifying and reporting of communicable/infectious diseases. They develop and implement preventive (i.e. vaccinations, patient health teaching) and corrective programs (i.e. surveillance to investigate and control the prevalence of infectious diseases, education to staff and inmates regarding transmission of disease, monitoring the laboratory results of patients) designed to mitigate the potential for infection. The Infection Control Unit works closely with the LA County Department of Health – Public Health and Tuberculosis Control specialists.

Laboratory - Clinical Science Support Services (CSSS):
CSSS provides laboratory and phlebotomy services to the patient population based on a provider's order. Most specimens are sent to Quest laboratory for processing. Whether the test requested is to be done "routine" (results within 24 hours depending on test ordered), "as soon as possible" (results within 6 hours), or "stat" (results within 4 hours), the CSSS staff are on duty to meet the needs of the patients.

LCMC Coordinator:
This nurse is responsible for coordinating the routine LCMC clinic appointments with the staff at LCMC. Obtaining and following up on clinic appointments with LCMC staff via phone and email communication is necessary to ensure patients get their required appointments. Ensuring patients scheduled for clinic appointments are actually sent as scheduled, is another necessary duty to ensure the care is provided.

Draft

Radiology:
Radiology staff is available 24 hours a day, 7 days a week to provide radiology (x-ray) services to the inmate population. Radiology technicians are responsible for performing a chest x-ray on every inmate that is booked into the Inmate Reception Center to screen for Tuberculosis. The radiology staff also provides diagnostic testing for those patients who have been ordered such by a medical provider. Diagnostic testing includes but is not limited to: x-rays for fractures, abdominal or chest wall abnormalities, and foreign bodies. Radiologists are responsible for reviewing each x-ray and determining if there are any abnormalities. Any abnormal x-ray requires an alert to be generated and communicated with the facility clinic wherein the patient is housed.



Health Information Management (HIM):
HIM is responsible for maintaining the patient health care records. Any hard copies of documents that must be retained in the medical record (AKA: hard chart) are filed and maintained by HIM staff. Any requests by patients or authorized persons/entities for copies of medical records are processed by HIM. Additionally, HIM assigns Diagnosis Related Grouping codes for the Correctional Treatment Center records based on the diagnoses and care provided. This facilitates the retrieval of records for some medical billing, various peer reviews, and Quality Assurance studies. HIM also checks for appropriateness of bills from outside facilities, and identifies records for various reporting requirements.

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MEDICAL LINES

Dental Line:
Dentists, with the assistance of Dental Assistants, provide dental exams to those patients who are in need of oral/tooth care. Routine exams, as well as those for complaints of tooth decay, physical injury, and/or oral mucosa related issues are addressed by the dentists.

In addition to the medical services provided at each of the facilities, our dental section also provides services in 7 dental clinics with 8 dentists and 10 dental assistants. The dental services provide mainly emergency dental treatment, but includes oral exams, oral x-rays, medications, and tooth extractions.

Dermatology Line:
Is a specialized physician line for the diagnosis and treatment of skin diseases such as dermatitis (inflammation of the skin), acne, psoriasis, skin cancer, fungal infection, warts, etc. The Dermatologist performs a punch biopsy (examination of tissue by removing a small cylindrical specimen) to aid in precise diagnosis. There is one Dermatologist on staff and referral for evaluation on this line is made by an MD or RNP.

Eye Line:
Ophthalmologists provide appropriate and necessary eye exams to patients. Patients may be seen for a myriad of reasons, including: routine eye exam, physical injury, and/or disease processes leading to problems involving the eyes.

HIV Line:
HIV+ patients are evaluated on this provider line. The patients' signs and symptoms, physical assessment, and diagnostic results are evaluated by an HIV specialist, in order to formulate an appropriate treatment modality that is patient specific. There are currently two HIV specialists on staff.

MD Line:
Evaluation and treatment of general medical problems are addressed on this provider line. It provides for the rendering of general medical care to a patient by a Medical Doctor, Registered Nurse Practitioner, or Physician's Assistant. Any health care concerns that require a specialist are referred as appropriate to that specific line in-house. If

necessary, a referral to the MSB Urgent Care Unit or to the appropriate LAC+USC specialty clinic may be done.

Neurology Line:
Neurology Line provides evaluation and treatment of conditions affecting the brain, spinal cord and nerves. This line is run by a Neurologist. Examples of medical concerns that may be referred to the Neurologist for evaluation are: seizures or epilepsy, spinal cord injuries, stroke, paralysis and/or weakness of the extremities.

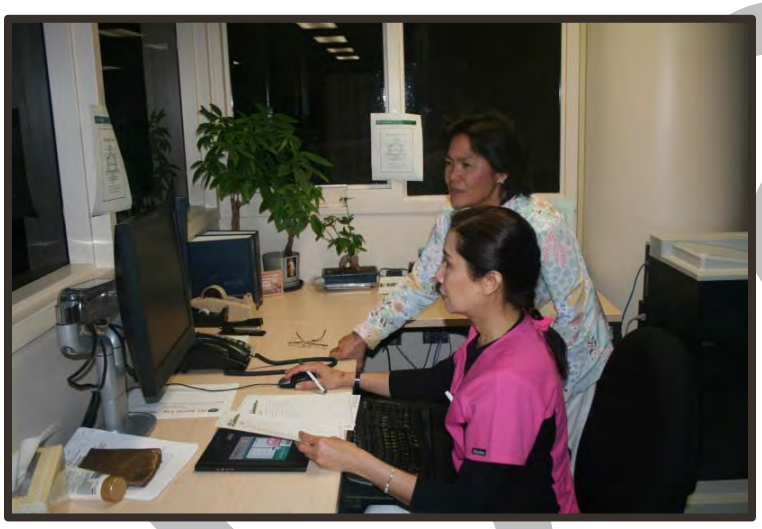
Obstetrics (OB) / Gynecology (GYN) Line:
This line is concentrated on providing services to the female patients. It is staffed by Registered Nurse Practitioners who focus on the treatment, diagnosis and care of the female reproductive system, including pregnancy. They provide preventive health care, including prenatal care to pregnant females, PAP smears, and diagnosis and treatment of sexually transmitted diseases.

Orthopedic (Ortho) Line:
This line specializes in the diagnosis and treatment of conditions of the bones, ligaments, tendons and joints. An Orthopedist and an Orthopedic Technician are responsible for running this line and ensuring patients are evaluated for their orthopedic related concerns. The Orthopedist and Orthopedic technician apply casts and/or splints to immobilize a limb, necessary for healing of the bone, ligament, tendons and joints.

Outpatient Procedures Line:
Conducts minor surgical procedures, such as removal of ingrown toe nails, warts, small cysts; and incision and drainage of abscesses. It is staffed by a Physician's Assistant and a Medical Doctor with a specialty in surgery.

Tattoo Removal Program
The Tattoo Removal program started in February 2012 as a collaborative partnership that continues to expand with the oversight and dedications of members of Medical Services Bureau, Inmate Services Bureau, and the Education Based Incarceration Unit. The program is overseen by trained medical personnel and initially began with 25 volunteer inmates. The program has grown and currently has treated 356 male inmates and 341 female inmates totaling 697 for 2013.

Administrative/Support Units



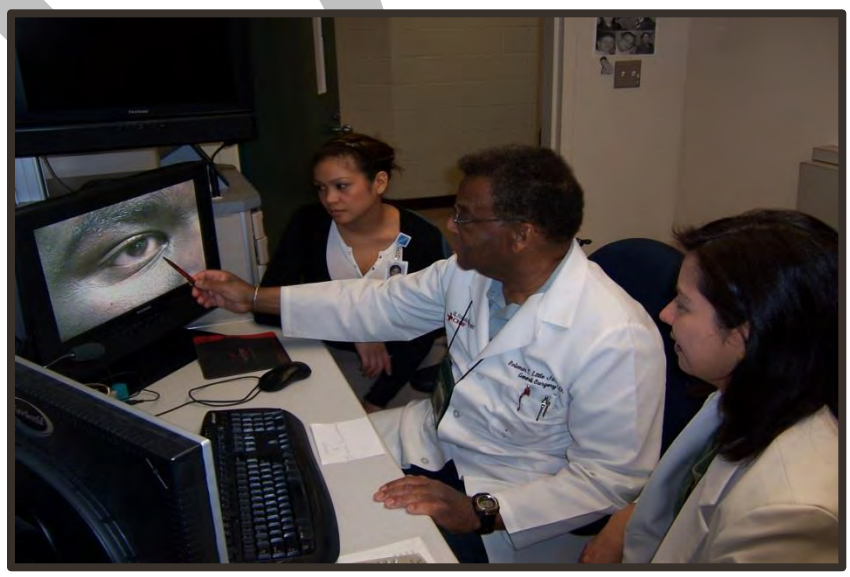
Medical Command Center:
The MCC operates 24 hours a day, 7 days a week to handle and coordinate Medical Services Bureau (MSB) administrative and direct patient care functions. It is designated to receive verbal, telephonic, and/or electronic communications which are intended for administrative and medical continuity of care. The MCC staff provides a central command hub for administrative and clinical operation support, for the provision of medical care, and has the authority to act on behalf of the MSB Unit Commander. The MCC may be compared to a facility main control booth where the on-duty Watch Commander is located.

Comprehensive Care Team:
The Comprehensive Care Team (CCT) is part of the Quality Management Unit and is responsible for the continuity of care for Medical Services Bureau (MSB) patients throughout their incarceration, as well as their placement upon release from custody. The team has provided case management for Sheriff's patients in acute care hospitals, including the Los Angeles County + University of California Medical Center and local private hospitals by working directly with the Chief Physician for acceptance for discharge and admission to the Inmate Reception Center, Correctional Treatment Center and Century Regional Detention Facility. The Comprehensive Care Team chairs the inter-disciplinary Alternative Resource Management Committee which meets monthly and works on patients who are identified that have special release or placement needs.

Continuous Quality Improvement:
Continuous Quality Improvement (CQI) Unit reviews documentation in the medical record of every patient that is transferred to an outside facility in need of receiving a higher level of care than can be provided on site. They review the documentation in the medical record to ensure Medical Services Bureau policies and procedures, Title 15, and Title 22 standards are followed.

Central Scheduling Unit:
The Central Scheduling Unit manages 13 routine medical and seven dental appointment lines. This unit receives an average of 285 medical and 80 dental referrals daily. They schedule an average of 390 medical appointments and 120 dental appointments daily. The staff also reschedules an average of 344 appointments daily.

Risk Assessment Team:
The Risk Assessment Team (RAT) is part of Quality Management Unit and is responsible for reviewing and providing written response to claims, lawsuits, and in-custody deaths. The team works in collaboration with Sedgwick CMS, defense attorneys, Civil Litigation Unit, and Custody Support Services to ensure that we continue to run an effective risk management program that will mitigate liabilities for Medical Services Bureau. RAT assists in Department of Justice and Facility Command inspections.



Court Order Unit:
The Court Order Unit processes Medical Court Orders in order to address requests and provide written responses to the courts. In addition, they process Medical/Mental Health Clearances for Extradition in order to facilitate continuity of care for the TRI-County transfers, state to state transfers, US Marshals Service, FBI, ATF and Police Departments.

Jail Health Information System (JHIS):
Manages and maintains the electronic medical record, AKA: PowerChart. The JHIS staff is responsible for the update, revision, build and development of electronic medical forms. This staff

also monitors PowerChart for any performance issues, and addresses those issues within their area of expertise. A Cerner Corporation representative is also on site working with JHIS to address any performance issues that relate to the software or the maintenance of the system which is remotely maintained at Cerner Corporation in Kansas City, MO.

Staff Development:
Staff Development Unit assesses the learning needs of the Los Angeles County Sheriff's Department Medical Services Bureau health care personnel in regards to patient care. They coordinate and provide all new hire employee orientation. They plan and develop training programs, and utilize methodology designed to meet the identified needs and program objectives. This unit provides formal didactic training to employees. It also formally evaluates the effectiveness of training programs through interaction with participants and management. They also participate in accreditation teams and other patient care committees, such as CQI & RAT. This unit strengthens the clinical and professional competencies of the nursing personnel by providing patient care educational courses that meet community standards.

John Scott, Sheriff

Terri McDonald, Assistant Sheriff

David L. Fender, Division Chief

Kelley S. Fraser, Commander

Kevin Kuykendall, Captain

Consolidated Correctional Treatment Facility

Programs Proposal

DR

Los Angeles County Sheriff's Department

Medical Services Bureau, CCTF Option 3

March 2014

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Currently

The Los Angeles County Sheriff's Department Medical Services Bureau is the largest correctional medical services provider of its type in the world. It is the largest bureau in the Los Angeles County Sheriff's Department with more than 1,400 employees in over 88 different job classifications. We provide medical services to over 140,000 inmates booked into the Los Angeles County Jail system every year.

This includes over 140,000 Tuberculosis screening X-rays, 6.5 million doses of medication delivered, 205,000 Nurse Clinic assessments and over 35,000 pre-scheduled physician appointments.

The Medical Services Bureau provides health care services for all inmates housed within the Los Angeles County Sheriff's Department jail system. These services are based on the 1976 United States Supreme Court case of *Estelle v. Gamble*. This landmark case serves as the foothold to an inmate's "constitutional right" to health care access. Medical Services Bureau personnel are responsible for the quality of health care in all of the Los Angeles County Sheriff's Department medical facilities. Along with physicians and nurses, the Medical Services Bureau provides the services of dentists, pharmacies, laboratories, radiology, and health information management services.

Our bureau has become a leader in innovative technology, implementing programs such as Jail Health Information System Technologies/Jail Health Information System (JHIS), Automated Drug Packaging (Auto Med), Picture Archiving Communications System (PACS), and Telemedicine. Currently over 13,000 inmates receive prescribed medications on a daily basis. This, combined with the growing number of daily nursing evaluations and treatments, has resulted in over 8 million inmate contacts per year in all the medical units within the Los Angeles County Sheriff's Department.

PATIENT CARE SERVICES

Correctional Treatment Center (CTC)

The two proposed inpatient treatment centers would be the largest CTC licensed operation anywhere within California and would demonstrate the Department's commitment to providing quality mental health care within the correctional environment. The Los Angeles County Sheriff's Department is currently tasked with providing health care services to all incarcerated prisoners within a jail system which at present exceeds 18,500 inmates. This population tends to have numerous preexisting health problems related to their lifestyle choices, including drug addiction, poor physical condition, and mental health issues, to name only a few. The proposed inpatient treatment centers, both downtown Los Angeles and within the Pitchess Detention Center (PDC), would enhance a partnership between LASD Medical Services Bureau personnel and the staff of the Los Angeles County Department of Mental Health, as well as provide patient care not seen anywhere else in a correctional setting.

The California State CTC regulations are a recently adopted chapter under Title 22, the same division of the regulations that cover acute care hospitals, acute psychiatric hospitals, and nursing homes. The CTC regulations cover medical and psychiatric care in jails and prisons, and Los Angeles is the first county in the state to be granted a license as a CTC. Medical Services Bureau provides care and treatment for inmates requiring inpatient medical and or psychiatric care in the existing CTC 196-bed rated medical unit located in the Twin Towers Correctional Facility in downtown Los Angeles. As mentioned, the inmate population is an unwell population, largely due to the lifestyle choices of the inmates which often include substance abuse, violence, and homeless living on the streets of Los Angeles. They require the same basic medical care that all residents of Los Angeles County require, including routine illness treatment to advanced medical issues such as TB, AIDS/HIV+, heart disease, diabetes, dialysis, paraplegics, and acute mental health problems. Additionally, problems associated with aging are becoming common as the jail population increasingly includes older inmates.

The Sheriff of Los Angeles County has the statutory requirement to provide for all of the basic needs of an inmate in jail. This includes food, clothing, hygiene needs, and health care. The Sheriff's Medical Services Bureau has the responsibility to provide for the health care needs of the entire inmate population within the jail system, based again on *Estelle v. Gamble*. State law sets the frequency for certain rights afforded to inmates, such as hot meals, the opportunity to shower, have visitors, and receive medical care.

In a recent television documentary, the Los Angeles County Jail was identified as the largest provider of mental health care in the United States. In addition to mental health services provided to the general inmate population, the existing CTC has a 46-bed acute Forensic In-Patient unit (FIP), staffed with psychiatrists, psychologists, licensed psychiatric technicians, and nursing staff. As this inmate population has grown exponentially, a new CTC dedicated to mental health care is long overdue. This proposal includes not only a new mental health CTC in downtown Los Angeles, but also a dual purpose (medical and mental health) facility on the existing Pitchess Detention Center (PDC) in

Castaic. The PDC treatment center would house 40 medical inpatients as well as 80 mental health inpatients.

The CTC licensure addresses the Sheriff's commitment to Workforce Excellence by enhancing public and employee confidence in the importance and honor of public service. The current licensure was the culmination of several years of facility planning, personnel adjustment, training, the Sheriff's personal commitment, and an overall organizational effort.

The proposed CTCs will address the Sheriff's Department Service Excellence Goals for "Effectiveness, Efficiency, and Responsiveness." The program's licensure will be an acknowledgment of the success of the continuous quality improvement built into the program as well as the responsiveness to changing demands in the custody environment demanded by the public.

Medical Clinic:
This is a centrally located area within a facility wherein health care is provided via various provider lines, nurse clinics, walk-ins, scheduled appointments, and emergencies. This area is usually manned by nursing and provider staff. Depending on the facility, the clinic may operate 24 hours a day, seven days a week.

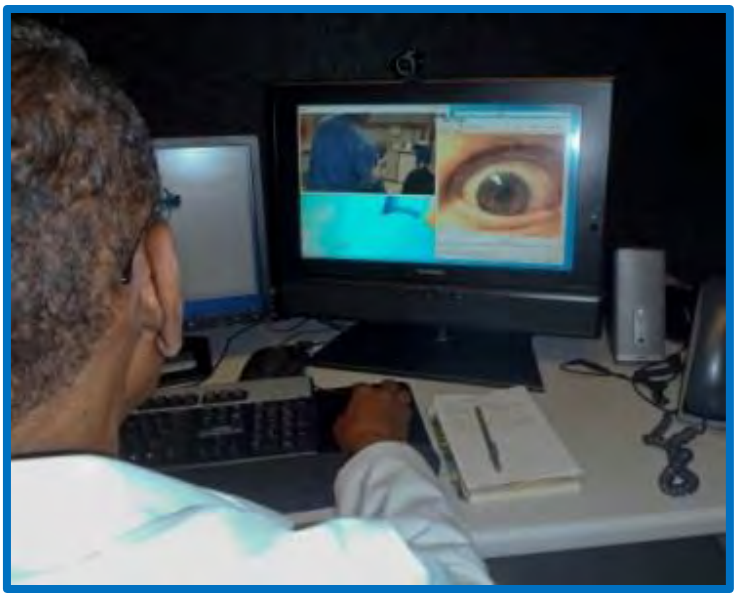
Urgent Care:
Provides care/services for urgent, non-life threatening medical conditions. Starting July 29, 2013, Urgent Care was staffed with medical providers from Los Angeles County + University of Southern California (LAC+USC) Medical Center and supported by LASD nursing personnel. The Urgent Care is open 7 days a week, 16 hours each day from 0600 hours to 2200 hours. From July 29, 2013, to February 14, 2014, a total of 4,870 patients were evaluated and treated who would have otherwise been transferred to LCMC Jail ER. In addition, orthopedic services are being provided – casts and splints are applied as necessary. As a result, the number of hours the Jail ER has closed has consistently declined. This has allowed patients to receive timely urgent evaluations and treatment which would have otherwise been delayed due to previous Jail ER closures.

MD/RNP 24/7:
Also known as the Medical On-call Doctor (MOD), any time a provider is not on duty in a facility, this provider is located at the Tower 2 Clinic and is available to all jail facilities via telephone. This provider responds to calls from nursing staff at the various facilities that have urgent patient care needs to address, some of which ultimately require evaluation at the Urgent Care clinic, or transportation to an acute care hospital for further evaluation and treatment.

Nurse Clinic:
The Nurse Clinic operates to ensure that all inmates have access to medical/mental health care in compliance with Title 15 Regulations for Sick Call. Registered Nurses provide Nurse Clinic Services by performing nursing assessments up to and including the initiation of standardized procedures, which provide patient access to basic health care services, in order to meet the health care needs of the inmate population. Patients requesting medical/mental health services at any time may be referred to the main medical clinic in the facility for Nurse Clinic Services.

Pill Call:
This is the administration of medication by a nurse at the prescribed time as ordered by a health care provider. Pill call is held in the various housing areas at 0800, 1200, 1600, and 2000 hours each day. Depending on the physical layout of the housing area, the nurse administering the medication may conduct pill call by walking from cell to cell, at the entrance door of the pod, or next to the custody control booth inside the module.

Telemedicine:
Provides medical evaluation utilizing videoconferencing technology. Any patient can be virtually evaluated by a provider regardless of physical location. There are three provider workstations, which are located in Tower II; and 13 carts distributed throughout the jail facilities. The Telemedicine program, in conjunction with the electronic medical record, enables the patients to receive an optimal level of medical care in a timely manner, without compromising security issues. In the year 2013, 19,888 patients were evaluated using Telemedicine.



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Consolidated Correctional Treatment Facility

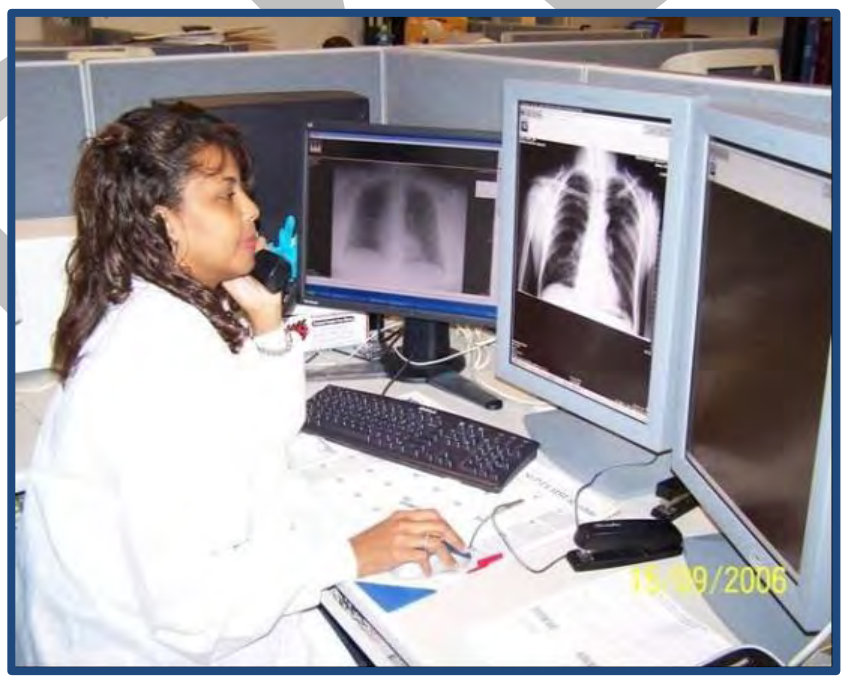
Pharmacy:
The pharmacy is responsible for maintaining a formulary of prescribed medication and keeping such drugs in stock, for the provision of patient care. Pharmacists and Pharmacy Technicians are responsible for the operation of the pharmacy. The main pharmacy is located at TTCF, with two additional pharmacies at CRDF and MCJ. Currently, medication for the PDC facilities is provided by the main pharmacy.

Infection Control:
This unit is staffed with a physician, public health nurses and an epidemiologist. Its function includes identifying and reporting of communicable/infectious diseases. They develop and implement preventive (i.e. vaccinations, patient health teaching) and corrective programs (i.e. surveillance to investigate and control the prevalence of infectious diseases, education to staff and inmates regarding transmission of disease, monitoring the laboratory results of patients) designed to mitigate the potential for infection. The Infection Control Unit works closely with the LA County Department of Health – Public Health and Tuberculosis Control specialists.

Laboratory - Clinical Science Support Services (CSSS):
CSSS provides laboratory and phlebotomy services to the patient population based on a provider's order. Most specimens are sent to Quest laboratory for processing. Whether the test requested is to be done "routine" (results within 24 hours depending on test ordered), "as soon as possible" (results within 6 hours), or "stat" (results within 4 hours), the CSSS staff are on duty to meet the needs of the patients.

LCMC Coordinator:
This nurse is responsible for coordinating the routine LCMC clinic appointments with the staff at LCMC. Obtaining and following up on clinic appointments with LCMC staff via phone and email communication is necessary to ensure patients get their required appointments. Ensuring patients scheduled for clinic appointments are actually sent as scheduled, is another necessary duty to ensure the care is provided.

Radiology:
Radiology staff is available 24 hours a day, 7 days a week to provide radiology (x-ray) services to the inmate population. Radiology technicians are responsible for performing a chest x-ray on every inmate that is booked into the Inmate Reception Center to screen for Tuberculosis. The radiology staff also provides diagnostic testing for those patients who have been ordered such by a medical provider. Diagnostic testing includes but is not limited to: x-rays for fractures, abdominal or chest wall abnormalities, and foreign bodies. Radiologists are responsible for reviewing each x-ray and determining if there are any abnormalities. Any abnormal x-ray requires an alert to be generated and communicated with the facility clinic wherein the patient is housed.



Health Information Management (HIM):
HIM is responsible for maintaining the patient health care records. Any hard copies of documents that must be retained in the medical record (AKA: hard chart) are filed and maintained by HIM staff. Any requests by patients or authorized persons/entities for copies of medical records are processed by HIM. Additionally, HIM assigns Diagnosis Related Grouping codes for the Correctional Treatment Center records based on the diagnoses and care provided. This facilitates the retrieval of records for some medical billing, various peer reviews, and Quality Assurance studies. HIM also checks for appropriateness of bills from outside facilities, and identifies records for various reporting requirements.

Draft

MEDICAL LINES

Dental Line:
Dentists, with the assistance of Dental Assistants, provide dental exams to those patients who are in need of oral/tooth care. Routine exams, as well as those for complaints of tooth decay, physical injury, and/or oral mucosa related issues are addressed by the dentists.

In addition to the medical services provided at each of the facilities, our dental section also provides services in 7 dental clinics with 8 dentists and 10 dental assistants. The dental services provide mainly emergency dental treatment, but includes oral exams, oral x-rays, medications, and tooth extractions.

Dermatology Line:
Is a specialized physician line for the diagnosis and treatment of skin diseases such as dermatitis (inflammation of the skin), acne, psoriasis, skin cancer, fungal infection, warts, etc. The Dermatologist performs a punch biopsy (examination of tissue by removing a small cylindrical specimen) to aid in precise diagnosis. There is one Dermatologist on staff and referral for evaluation on this line is made by an MD or RNP.

Eye Line:
Ophthalmologists provide appropriate and necessary eye exams to patients. Patients may be seen for a myriad of reasons, including: routine eye exam, physical injury, and/or disease processes leading to problems involving the eyes.

HIV Line:
HIV+ patients are evaluated on this provider line. The patients' signs and symptoms, physical assessment, and diagnostic results are evaluated by an HIV specialist, in order to formulate an appropriate treatment modality that is patient specific. There are currently two HIV specialists on staff.

MD Line:
Evaluation and treatment of general medical problems are addressed on this provider line. It provides for the rendering of general medical care to a patient by a Medical Doctor, Registered Nurse Practitioner, or Physician's Assistant. Any health care concerns that require a specialist are referred as appropriate to that specific line in-house. If

necessary, a referral to the MSB Urgent Care Unit or to the appropriate LAC+USC specialty clinic may be done.

Neurology Line:
Neurology Line provides evaluation and treatment of conditions affecting the brain, spinal cord and nerves. This line is run by a Neurologist. Examples of medical concerns that may be referred to the Neurologist for evaluation are: seizures or epilepsy, spinal cord injuries, stroke, paralysis and/or weakness of the extremities.

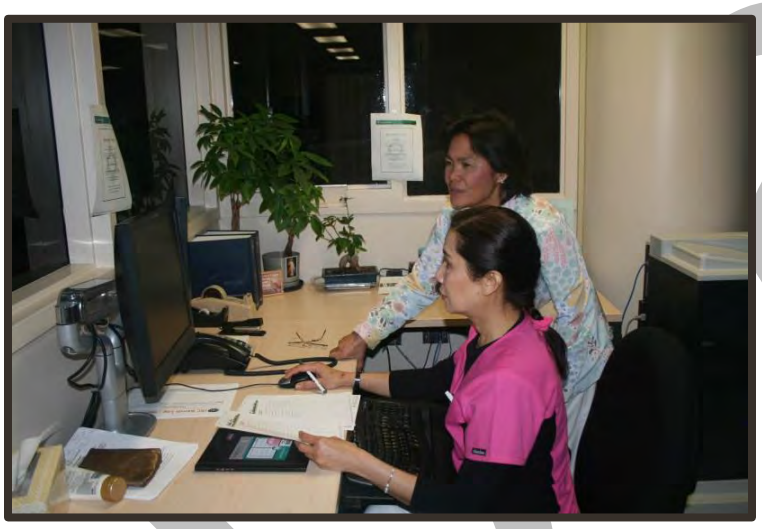
Obstetrics (OB) / Gynecology (GYN) Line:
This line is concentrated on providing services to the female patients. It is staffed by Registered Nurse Practitioners who focus on the treatment, diagnosis and care of the female reproductive system, including pregnancy. They provide preventive health care, including prenatal care to pregnant females, PAP smears, and diagnosis and treatment of sexually transmitted diseases.

Orthopedic (Ortho) Line:
This line specializes in the diagnosis and treatment of conditions of the bones, ligaments, tendons and joints. An Orthopedist and an Orthopedic Technician are responsible for running this line and ensuring patients are evaluated for their orthopedic related concerns. The Orthopedist and Orthopedic technician apply casts and/or splints to immobilize a limb, necessary for healing of the bone, ligament, tendons and joints.

Outpatient Procedures Line:
Conducts minor surgical procedures, such as removal of ingrown toe nails, warts, small cysts; and incision and drainage of abscesses. It is staffed by a Physician's Assistant and a Medical Doctor with a specialty in surgery.

Tattoo Removal Program
The Tattoo Removal program started in February 2012 as a collaborative partnership that continues to expand with the oversight and dedications of members of Medical Services Bureau, Inmate Services Bureau, and the Education Based Incarceration Unit. The program is overseen by trained medical personnel and initially began with 25 volunteer inmates. The program has grown and currently has treated 356 male inmates and 341 female inmates totaling 697 for 2013.

Administrative/Support units



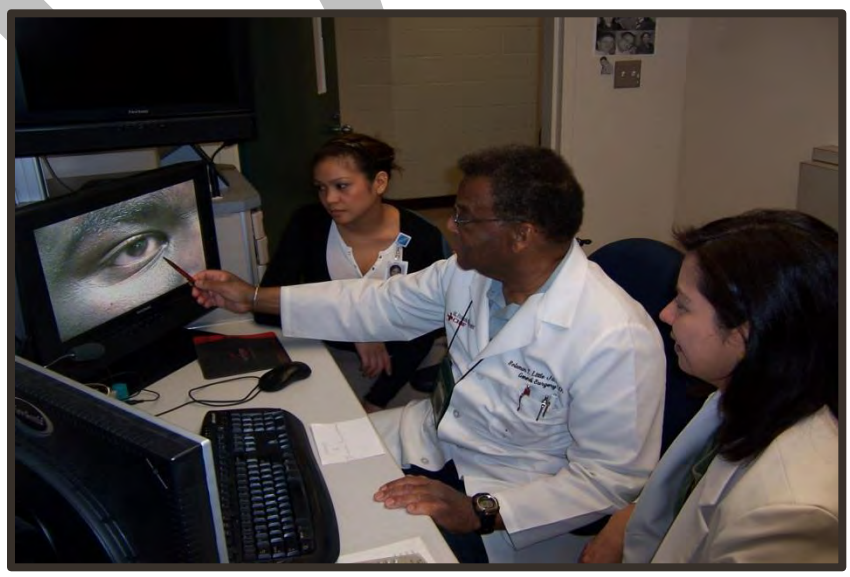
Medical Command Center:
The MCC operates 24 hours a day, 7 days a week to handle and coordinate Medical Services Bureau (MSB) administrative and direct patient care functions. It is designated to receive verbal, telephonic, and/or electronic communications which are intended for administrative and medical continuity of care. The MCC staff provides a central command hub for administrative and clinical operation support, for the provision of medical care, and has the authority to act on behalf of the MSB Unit Commander. The MCC may be compared to a facility main control booth where the on-duty Watch Commander is located.

Comprehensive Care Team:
The Comprehensive Care Team (CCT) is part of the Quality Management Unit and is responsible for the continuity of care for Medical Services Bureau (MSB) patients throughout their incarceration, as well as their placement upon release from custody. The team has provided case management for Sheriff's patients in acute care hospitals, including the Los Angeles County + University of California Medical Center and local private hospitals by working directly with the Chief Physician for acceptance for discharge and admission to the Inmate Reception Center, Correctional Treatment Center and Century Regional Detention Facility. The Comprehensive Care Team chairs the inter-disciplinary Alternative Resource Management Committee which meets monthly and works on patients who are identified that have special release or placement needs.

Continuous Quality Improvement:
Continuous Quality Improvement (CQI) Unit reviews documentation in the medical record of every patient that is transferred to an outside facility in need of receiving a higher level of care than can be provided on site. They review the documentation in the medical record to ensure Medical Services Bureau policies and procedures, Title 15, and Title 22 standards are followed.

Central Scheduling Unit:
The Central Scheduling Unit manages 13 routine medical and seven dental appointment lines. This unit receives an average of 285 medical and 80 dental referrals daily. They schedule an average of 390 medical appointments and 120 dental appointments daily. The staff also reschedules an average of 344 appointments daily.

Risk Assessment Team:
The Risk Assessment Team (RAT) is part of Quality Management Unit and is responsible for reviewing and providing written response to claims, lawsuits, and in-custody deaths. The team works in collaboration with Sedgwick CMS, defense attorneys, Civil Litigation Unit, and Custody Support Services to ensure that we continue to run an effective risk management program that will mitigate liabilities for Medical Services Bureau. RAT assists in Department of Justice and Facility Command inspections.



Court Order Unit:
The Court Order Unit processes Medical Court Orders in order to address requests and provide written responses to the courts. In addition, they process Medical/Mental Health Clearances for Extradition in order to facilitate continuity of care for the TRI-County transfers, state to state transfers, US Marshals Service, FBI, ATF and Police Departments.

Jail Health Information System (JHIS):
Manages and maintains the electronic medical record, AKA: PowerChart. The JHIS staff is responsible for the update, revision, build and development of electronic medical forms. This staff

also monitors PowerChart for any performance issues, and addresses those issues within their area of expertise. A Cerner Corporation representative is also on site working with JHIS to address any performance issues that relate to the software or the maintenance of the system which is remotely maintained at Cerner Corporation in Kansas City, MO.

Staff Development:
Staff Development Unit assesses the learning needs of the Los Angeles County Sheriff's Department Medical Services Bureau health care personnel in regards to patient care. The coordinate and provide all new hire employee orientation. They plan and develop training programs, and utilize methodology designed to meet the identified needs and program objectives. This unit provides formal didactic training to employees. It also formally evaluates the effectiveness of training programs through interaction with participants and management. They also participate in accreditation teams and other patient care committees, such as CQI & RAT. This unit strengthens the clinical and professional competencies of the nursing personnel by providing patient care educational courses that meet community standards.

John Scott, Sheriff

Terri McDonald, Assistant Sheriff

David L. Fender, Division Chief

Kelley S. Fraser, Commander

Kevin Kuykendall, Captain

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F SUBSTANCE USE DISORDERS TREATMENT PROGRAM
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G EDUCATION BASED INCARCERATION PROGRAM PROPOSAL
Prepared by the Los Angeles County Sheriff's Department, Education Based Incarceration Bureau

H MEDICAL SERVICES/PATIENT CARE PROGRAM PROPOSAL
Prepared by the Los Angeles County Sheriff's Department, Medical Services Bureau

I **ASSESSMENT OF PROPOSED INTEGRATED JAIL MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT PROGRAMS**
Prepared by RJS Justice Services, LLC

Technical Assessment Report

Assessment of Proposed Integrated Jail Mental Health & Substance Abuse Treatment Programs Los Angeles County, CA Jail

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DEDICATION TO PUBLIC SAFETY, INDIVIDUAL & COMMUNITY WELLNESS

Kenneth A. Ray, MED Ronald M. Shansky, MD

Submitted to the:
Board of Supervisors
Los Angeles County, California

March 31, 2014

Kenneth A. Ray
JUSTICE SERVICES
"Assess, Analyze, Actualize"
PO Box 1481 Ashland, KY 41105-1481 Phone: 606-694-3031

EXECUTIVE SUMMARY

Los Angeles County operates the largest jail system in the United States with seven facilities, more than 20,000 beds, and an average daily population of approximately 18,000 inmates. It is estimated that on any given day as many as 15,000 Los Angeles County inmates have a diagnosed or diagnosable mental illness, substance abuse and/or co-occurring disorder. Many of these inmates also have co-morbid medical conditions that include chronic and/or communicable diseases. The Los Angeles County Jail system has arguably the largest behavioral health care facilities in the nation.

Cognizant of their moral and constitutional obligation to provide adequate care and custody of this "special needs" inmate population, combined with a fervent desire to ensure sustainable public safety and to ultimately reduce criminal recidivism throughout the community, Los Angeles County officials have embarked on the extraordinary effort to determine the feasibility of constructing a 5,000 bed Consolidated Correctional Treatment Facility (CCTF). County officials believe that one important aspect in determining CCTF feasibility is to ensure that behavioral health treatment programs proposed by the Los Angeles County Sheriff's Department, and the Departments of Mental Health and Public Health are evidence-based best practices for the effective assessment, treatment, care, and management of CCTF inmates. To this end, Mr. Kenneth A. Ray, M.Ed. and Dr. Ronald M. Shansky, M.D. were retained to conduct a short-term technical assessment of the proposed CCTF behavioral health programs. Mr. Ray and Dr. Shansky both possess extensive experience in correctional health care, administration, and consulting, and are considered national topic experts by the U.S. Department of Justice, National Institute of Corrections, and National Commission on Correctional Health Care. Additionally, both Mr. Ray and Dr. Shansky have served as federal court-appointed inmate civil rights compliance monitors, and are licensed clinical practitioners experienced in the areas of community and correctional medicine and behavioral health.

This short-term technical assessment involved several activities including 1) onsite meetings and interviews with officials from the Los Angeles County Sheriff's Department, Los Angeles County Departments of Mental and Public Health, and Vanir, 2) tours of Twin Towers and Men's Central Jail facilities, and 3) review of proposed programs and related documents. Finally, proposed program core concepts were clarified and vetted against a careful review of the literature and the Consultants' professional experience and qualifications in an effort to assess programmatic efficacy. In addition to comparing proposed programs with the relevant literature, the proposed programs were vetted against the following measures recommended by the National Institute of Corrections for determining program efficacy:[1]

[1] http://www.nicic.gov/pubs2004/019342.pdf.

1.&The program and/or treatment employs valid and reliable assessment and treatment methods and processes for health, behavior management, and for risk of recidivism and criminogenic needs.
2. The program and/or treatment engages inmates in a manner that promotes intrinsic motivation as a favorable treatment alliance.
3. Target interventions and treatment priorities according to the risk, need, and responsivity principles from meta-analysis of interventions.
4. Emphasize on cognitive-behavioral treatment in providing interventions.
5. The program and/or treatment uses increasing systematic (i.e., immediate, certain) application of reinforcements.
6. A variety of mechanisms are mobilized for improving internal and external social support within the inmates' community.
7. The program and/or treatment measures, monitors, and assesses relevant behavioral performance, skills, and practices.
8. Objective feedback on performance is ongoing, consistent, and supportive.

Mr. Ray and Dr. Shansky, following the above described process, firmly believe that the programs and various program components being proposed by the Los Angeles County Sheriff's Department and Departments of Mental and Public Health are, in fact, evidence-based best practices for the delivery of effective behavioral health services to the CCTF target inmate population. The proposed programs and their various methods and processes are affirmed in the literature, meet the criteria listed above, and are consistent with our professional experience in regard to evidence-based best practices in the treatment, care, and management of special needs inmate populations.

Additionally, we are convinced that the Los Angeles County CCTF project and proposed programs, if fully implemented, will likely advance timely resolution of the current CRIPA Memorandum of Agreement (MOA) with the United States Department of Justice Civil Rights Division. This belief is based on our examination of this MOA, review of CCTF preliminary design concepts and capacity options, the integrated behavioral health programs proposed, and our experience as federal court monitors in similar cases.

In conclusion, we wish to sincerely thank everyone involved for this unique and interesting honor, and we extend our sincerest appreciation for all the assistance and cooperation provided during this assessment process. The citizens of Los Angeles County are truly fortunate to have such dedicated, competent, and forward-thinking elected and appointment public servants.

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PURPOSE OF THIS ASSESSMENT

The fundamental purpose of this assessment, as stated by LA County representatives, was to assist LA County officials:

1) Assess whether the behavioral health programs being proposed for the CCTF by the LA County Sheriff's Department, LA County Department of Mental Health, and LA County Department of Public Health are consistent with "best practices" and appear to be "evidence-based."

2)&Provide a qualified opinion, based on assessment activities and findings, and the Consultants' professional qualifications and experience, whether proposed programs are likely to produce outcomes favorable to improving the care and custody of the designated inmate population.

3) Provide qualified recommendations with regard to proposed program planning, development, and implementation where indicated.

Agreed Scope of Work

Los Angeles County officials categorized this project as a short-term technical assessment due to its very narrow scope and rapid turnaround expectations. Therefore, the following scope of work was agreed to as being the most effective for meeting these requirements:[2]

1. *Review and compare the proposed programs to programs offered by other counties and states throughout the nation whereby Los Angeles County will have some reassurance that the intended treatment programs are at least consistent with industry standards, best practices, etc.*
2. *Engage dialogue to advise of exemplary programs or models they might look to for ideas and examples. To review and report potential outcomes, efficiencies, etc. that the county might reasonably expect as a result of implementing these treatment programs.*
3. *To complete this review and final report by the end of February, 2014.*
4. *Possibly attend a follow-up onsite visit to LA to be available for questions from interested parties, representatives of the BOS, etc. about the results of the report*

In addition, during the onsite assessment we were asked to provide a general opinion with regard to any beneficial impact that the proposed CCTF and related programs might have on resolving the active CRIPA Memorandum of Agreement between Los Angeles County and the United States Department of Justice.

[2] *Project Scope of Work letter dated January 7, 2014*

ASSESSMENT ACTIVITIES & METHODOLOGY

Activities

This technical assessment project includes activities performed before, during, and following the on-site visit. On-site work was performed February 3-7, 2013. However, due to air travel cancelations caused be severe weather, Mr. Ray arrived in Los Angeles on February 4th.

Pre-Visit Activities:

- Communication with project representatives
- Collect information and documents relevant to work scope
- Submission of project budget and confirmation to proceed
- Onsite logistics coordination
- Consultant travel

On Site Activities:

- Meetings and interviews with designated project officials and staff
- Collection of relevant documents
- Tours of Twin Towers mental health housing units, Men's Central Jail
- General review of preliminary CCTF plans
- Exit meeting and wrap-up

Post Visit Activities:

- Review of notes and provided documents
- Email submission of information requested by Sheriff's Department Officials regarding best practice guidelines for Staff Analysis, and New Facility Transition Planning
- Review of evidence-based and best practices literature
- Other related research
- Draft report writing and assembly
- Draft report submission

On Site Activity Agenda

The following itinerary was used as a template for onsite activities, but was ultimately revised throughout the assessment process to maximize participant availability and onsite work time.

Date	Times	Participants	Activity / Outcome	Materials
Tues 2/4	**9am-5pm**	**VANIR**	**Clarify week events, review project history and progress, expectations.** ***"The Big Award" Exercise***	**Background reports, design concepts, existing design concept drafts, population data if available**
Wed 2/5	**9am-11:30am**	**1-5 below**	**Intros, project overview, define integrative components, needs and challenges, clarify roles and responsibilities**	**Prepared to discuss relevant history, needs and challenges, program intentions, previous needs assessment work, target population – demand and resource capacities**
	1:30pm-3:30pm	**LASD Custody**	**Review jail operations components related to project and intended outcomes**	**Population data relevant to 1) BH delivery system support needs, security needs, perception of integrated delivery system, custody roles and challenges**
Thurs 2/6	**9am-11:30am**	**DMH**	**Review existing and proposed programming, target population data regarding needs, numbers, comorbid**	**Population data and reports evidencing program size, treatment modalities, integration, etc.**
	1:30pm – 3:30pm	**DPH**	**Review existing and proposed programming, target population data regarding needs, numbers, comorbidity**	**Population data and reports evidencing program size, treatment modalities, integration, etc.**
Fri 2/7	**9am – 11am**	**LASD Medical Bureau Medical**	**Review existing and proposed programming, target population data regarding needs, numbers, comorbidity**	**Population data and reports evidencing program size, treatment modalities, integration, etc.**
	1:30pm – 5pm	**LASD Custody**	**Tour Twin Towers and Men's Central Jail**	

Assessment Participation

Assessment of proposed Los Angeles County Jail behavioral health programs involve the following entities:

1. LA County Jail Custody Division Representatives
2. LA County Jail Medical Division Representatives
3. LA County Department of Mental Health Representatives
4. LA County Department of Public Health Representatives
5. VANIR Project Representatives

Specifically, the following Los Angeles County officials and staff participated in the onsite assessment:

Participant	Representing
1. Anthony Peck, County Counsel	LASD
2. Brant Choate, Director	LASD Education Based Incarceration
3. Candyce Roberts	Vanir
4. Dave Fender, Chief	LASD
5. Deborah McLean, Clinical Nursing Director	LASD Medical Services Bureau
6. Eric Parra, Chief	LASD
7. Holly McCravey, Director	LAC Department of Public Health
8. Janet Abreu, District Chief	LAC Department of Mental Health
9. Joe Mirkovich, MS, Supervising Psychiatrist	LAC Department of Mental Health
10. John Sheehe, SU Integration	LAC Department of Mental Health
11. Joseph Dempsey, Lieutenant	LASD
12. Kelley Fraser, Commander	LASD
13. Kevin Kuykendall, Captain	LASD
14. M. Salcedo, SAPC Mgmt. Fellow	LAC Department of Public Health
15. Marjory Jacobs, Lieutenant	LASD
16. Mark Reinmiller	Vanir
17. Marvin Southard, Director	LAC Department of Mental Health
18. Michael Maloney, MHCDC	LAC Department of Mental Health
19. Mike Bornman, Captain	LASD Education Based Incarceration
20. Nick Teophilov, MD, Chief Physician	LASD Medical Services Bureau
21. Rob Nash, CCTF Project Manager	Vanir
22. Roderick Shaner, MD, Medical Director	LAC Department of Mental Health
23. Roger Granbo, Asst. County Counsel	LAC Board of Supervisors
24. Sara Hough, Clinical Program Head	LAC Department of Mental Health
25. Stephen Shea, JMHS	LAC Department of Mental Health
26. Steve Smith, Lieutenant	LASD
27. Tab Rhodes, Lieutenant	LASD Medical Services
28. Terri Mc Donald, Asst. Sheriff	LASD
29. Victor Allende, Lieutenant	LASD
30. Wesley Ford, SAPC Director	LAC Department of Public Health
31. Yanira Lima, Criminal Justice Coord.	LAC Department of Public Health

Mr. Ray and Dr. Shansky want to especially thank all the unnamed jail staff for allowing us to interrupt their work day to ask questions and tour facilities.

Assessment Methodology

The following primary methods were employed to complete the assessment of proposed jail behavioral health programs:

- Individual and group interviews of officials and staff from participating departments
- Review of proposed program documents and related materials
- Tour of the Twin Towers Mental Health Housing Unit
- Tour of Men's Central Jail
- Limited, but salient, literature review of evidence-based programming and best practices

The following primary sources were accessed for the literature review of evidence-based programming and best practices:

- National Institute of Corrections Electronic Library, http://nicic.gov/
- Research Gate, http://www.researchgate.net
- SAMSHA National Registry of Evidence-based Programs and Practices, http://www.nrepp.samhsa.gov/
- Council of State Governments Justice Center, http://csgjusticecenter.org/reentry/local-programs-database/
- US National Library of Medicine NIH, http://www.ncbi.nlm.nih.gov/pubmed
- United States Department of Justice Bureau of Justice Statistics, http://www.bjs.gov/
- United States Department of Justice National Criminal Justice Reference Service, https://www.ncjrs.gov/Library.html
- American Psychiatric Association, Psychiatry Online, http://psychiatryonline.org/collections.aspx
- University of California Los Angeles Integrated Substance Abuse Program, http://www.uclaisap.org/
- Los Angeles County Sheriff's Department Website, http://shq.lasdnews.net/pages/tgen1.aspx?id=as1
- Los Angeles County Department of Mental Health Website, http://dmh.lacounty.gov/wps/portal/dmh
- Los Angeles County Department of Public Health Website, http://dmh.lacounty.gov/wps/portal/dmh
- Recent reports and studies complete by Dr. James Austin

Primary documents for proposed programs were provided while onsite by participants for examination and onsite discussion purposes:

- Questionnaire(s) To Determine Medical and Mental Health Needs for Inmates (Medical, Mental Health, Substance Abuse).
- Proposal for Community-Based Alternative to Custody Substance Abuse Treatment Services Program – LAC/DPH
- Proposed CCTF Mental Health Programming – LAC/DMH.
- Proposed CCTF Substance Abuse Programming – LAC/DPH
- Education Based Incarceration Annual Report – LASD/EBI
- Proposed Level of Acuity Management Matrices.)
- CCTF Population and Bed Counts for All Jail Plan Options
- 2008 CRIPA Memorandum of Agreement Between Los Angeles County and the United States Department of Justice Civil Rights Division

IMPRESSIONS AND BRIEF DISCUSSION

During the four days in Los Angeles, the Consultants met with leadership from Custody, the Jail Medical Services Bureau, Departments of Public and Mental Health, and LASD Jail Education Based Incarceration. We were exceptionally impressed with many of the ideas articulated by each of the different stakeholders with regard to the needs of the program in providing adequate services to inmates, as well as the depth and breadth of existing behavioral health programs currently operating within the Los Angeles County Jail and community. We also toured both the Men's Central Jail and the Twin Towers Correctional Facility. Design and layout of both facilities presents significant challenges for leveraging cost efficiencies and best programmatic outcomes as proposed. Administrative, program, and housing space proximities and adjacencies in both facilities would not likely allow for maximum program integration and staffing level efficiencies. The Consultants dissuade Los Angeles County officials from using either of these facilities for consolidated care programming.

When professionals, including health care professionals and custody officers, perform their work in an appropriate environment, the quality of their work is much more likely to be elevated. This includes the manner in which they interact with the inmates. The extent to which cases of inappropriate use of force have occurred can in some way be connected to facility design and layout. On the other hand, despite having worked in that environment, we were impressed with the whole host of ideas proposed for a new consolidated correctional treatment facility.

Medical, mental health, substance use and custody all independently proposed an integrated team model for the provision of services in the proposed Consolidated Correctional Treatment Facility (CCTF). It is well known in medical, behavioral health, and correctional literature that an integrated team approach to illness and inmate management as well as other inmate health and behavioral problems has been correlated with improved outcomes, in and out of jail. Despite this knowledge, in many jails in 2014, the team approach has not yet been implemented. In fact, in many jails, medical, mental health, custody and substance use disorder are like ships passing in the night, each heading in the same direction but with minimal interaction. We want to highly commend these officials for their forward thinking and vehement desire to ensure that their proposed programs are delivered in a cohesive, unified, and integrated manner.

An example that is illustrative is found in the overwhelming majority of jails. When patients enter the jail and are screened and identified as being in need of detoxification from a substance such as alcohol or opiates, the medical program utilizes a guideline or algorithm that focuses exclusively on the pharmacologic approach to detoxification. However, when the detoxification has been completed, there is no effort to address the underlying substance use disorder and thus, when the patient is released back to the streets, the cycle is reinitiated and the detainee has a

high likelihood of reentering the jail. Even though a certain percentage of detainees will only stay a short period of time, which may not be long enough to support substance use intervention, others will stay longer and could in fact benefit from such programming.

Similarly, it is not uncommon for patients with serious mental illness to also have serious co-morbid medical problems. It is also not uncommon for the medical team to view the major issue as a mental one and their role as secondary while the mental health program may see their role as secondary and the medical program's as primary. The end result, which we have seen, is inadequate responses from the disciplines, sometimes leading to extreme negative outcomes such as hospitalization or death. We can't emphasize enough the advantages of a multidisciplinary team working together from an integrated care management model in developing a comprehensive treatment and discharge plan that addresses all of the patient's medical, behavioral, and psychosocial needs.

We understand that in the design of the housing units in the new facility, each housing unit would have space where medical, mental health and substance use issues could be addressed without the inmate ever having to leave the housing unit. It is well known that providing services within the housing unit (Unit Based Inmate Management) reduces the dependency on officers to provide escorts to the service area outside of the housing unit. Additionally, we understand that the new facility will include space for specialists from the Los Angeles County Department of Health Services to see their patients, as well as space for technology, such as a CT scanner. Bringing all of these services inside the new facility will have a significant impact on the number of officers required to escort inmates offsite. This is particularly cost efficient and much safer when dealing with high-security inmates and, of course, diminishes the risks for public safety. Thus, a strategy of providing primary medical and behavioral health care services within the housing units and secondary care services, such as specialty or radiologic procedures, within the facility is, in terms of custody escorts, a very cost efficient design and significantly reduces risks of harm to staff, inmates, and the community. The current facilities, especially the Men's Central Jail facility, do not allow for such efficiencies to be created.

We were especially impressed with the fact that all of the disciplines were committed to reentry planning beginning when the inmate enters the jail. As we understand it, in the new facility as someone is being released from the jail, they will be able to go to an adjacent area in the new facility where substance use treatment and/or medical or mental health clinic follow up can be arranged and housing and job needs can also be addressed. If in fact this comprehensive approach is created within the release area of the jail, Los Angeles County could become a national model for effectively beginning to address the revolving door of high recidivism rate syndrome. We know that mentally and medically ill patients who are connected to resources in the community and who follow up with those resources are less likely to return to jail. We also know that when substance use is addressed and housing issues are addressed and employment

is addressed, the likelihood of recidivism is also significantly diminished. If these plans are implemented with the support of the County supervisors, Los Angeles County could become the national leader in successfully addressing the social problems, which have historically been combated only with criminal justice solutions.

CCTF design and proposed programmatic planning concepts would appear to create the opportunities for Los Angeles County to become a leader in effectively and efficiently dealing with this myriad of complex social problems.

Adequate Jail-Based Management of Inmates with Serious Behavioral Health Disorders

Effective care and custody of inmates with serious behavioral health disorders involves the integration of three fundamental elements that include adequate and appropriate:

1) Jail-based assessment, treatment, management, and discharge of the inmate population
2) Jail physical environments and accommodations
3) Community behavioral health supports and delivery systems

Effective care and custody of inmates of this inmate population requires collaborative integration of all three elements listed above. Each element, individually, is not adequate conditions for the provision of constitutional care. Collaborative integration of these components maximizes the potential for best health care, criminal justice, and resource utilization outcomes. Therefore, all components must be evidence-based, fully functional, and strategically developed.

Management Overview

The course of behavioral illness (mental illness, substance abuse, co-occurring), in general, is variable, with some people having exacerbations and remissions, some eventually recovering more or less completely, and others remaining chronically ill. The nature of the inmates' current symptoms, comorbid medical conditions, associated functional impairments, and mental health history should be assessed when determining the severity of the specific person's illness, which will assist in determining the level of mental health treatment needed (e.g., outpatient, intermediate, crisis stabilization, inpatient) and in making appropriate housing recommendations.

Jail health care and custody staff should be diligent in monitoring an inmate's clinical and jail status in order to provide timely interventions. Additionally, mental health staff should provide all correctional staff with specific training so they can assist in the monitoring of inmates with

mental illness, including suicide prevention, and can more effectively and humanely manage and interact with these individuals.

Program Treatment Goals

Treatment goals and ultimately a treatment plan should be developed in an integrated, multidisciplinary fashion, which includes the active and ongoing participation of custody staff and leadership. The treatment programming attempts to address biological, interpersonal, social, environmental, and cultural factors affecting the inmate's adjustment to the jail environment. In developing treatment goals for mental illness, understanding the course of the illness is essential. Ordinarily, the course of mental illness can be divided into three broad phases: acute phase, a stabilization phase, and a stable phase. While somewhat arbitrary, these phases provide a structure for integrating treatment program approaches, which often involve different levels of mental health care and housing at different points.

During the acute phase, the goal of treatment is to eliminate or reduce acute symptoms and decrease functional impairment. Specific treatment goals are to prevent harm to self or others; control disturbed behavior; suppress or eliminate symptoms; reduce anxiety and unrealistic fears; establish and maintain appropriate hygiene, grooming, and other adult daily living skills; develop a therapeutic alliance; and formulate short and long-term treatment plans throughout incarceration.

During the stabilization phase, the goals of treatment are to help the inmate effectively manage stress, provide a supportive environment and education about the illness to decrease the likelihood of relapse, promote psychosocial rehabilitation, foster the acquisition of relevant skills, and continue symptom management and prepare the inmate for reentry into the community.

The goals of treatment programming during the stable phase are to maintain or improve the person s level of functioning, effectively treat symptoms associated with the onset of acute clinical exacerbations, and continue medication monitoring. Psychosocial rehabilitation, which includes helping people learn how to live with their condition, should continue as needed.

Assessment on Entry to the System

Standards and guidelines developed by the National Commission on Correctional Health Care (NCCHC) and a task force of the American Psychiatric Association recommend that all inmates be assessed during the intake screening process with follow-up mental health evaluation, if indicated, to identify and engage inmates requiring mental health treatment. In addition, both the NCCHC and APA guidelines recommend mental health screening procedures (which

include mental health rounds) for all inmates who are placed in housing units that are segregated from the general inmate population (e.g., mental health units). This may include new admission housing in jails, reception center housing in prisons, or administrative segregation settings in both, which can include punitive/disciplinary cells or protective custody. While brief screening instruments are useful for screening purposes, the routine use of more extensive psychological testing is typically not warranted and should be reserved only for special clinical cases where it might be helpful in clarifying a confusing differential diagnosis.

It is important for a procedure to be developed and implemented that makes a reasonable attempt to obtain relevant past mental health records, especially inpatient psychiatric admission and discharge summaries for both diagnostic and treatment planning purposes.

Frequency of Follow-up Visits

In general, treatment during the acute phase involves daily contact between the inmate and treating clinician. Contacts with clinicians are often reduced in frequency during the stabilization phase. However, contact should be increased following significant changes such as housing transfers from one yard to another or to a different correctional institution, periods of stressful intervening events, and substantial changes in the inmate's treatment (e.g., medication changes). On average, clinical contacts during the stabilization phase will occur at least monthly, and often more frequently if psychosocial rehabilitation is more intensive or if an intervening event occurs that can cause relapse.

Inmates generally require less frequent clinical contact during the stable phase, although there are wide individual variations related to the person's clinical course, history, and changes within the correctional environment. For example, inmates usually require more frequent visits during prolonged lockdowns. More frequent contact will initially be required when significant changes in the person s life occur such as transfers to another prison or yard, being sentenced in court or a significant loss experienced by the inmate. In general, the frequency of visits with inmates during the stable phase should be at least once every 30 to 90 days depending on need.

Content of Follow-up Visits

<u>Assessment</u>

The specific content of follow-up visits is a function of the treatment plan and the nature of the clinical contact (e.g., medication management session, individual psychotherapy session, group therapy session, etc.). However, in each case, change from the last visit should be assessed and documented.

A mental status examination should be performed during each follow-up visit with specific questions being asked, as clinically appropriate (e.g., presence or absence of auditory hallucinations, presence of suicidal thinking, decompensation). If a person is receiving psychotropic medications, questions should be asked concerning relevant side effects, therapeutic effects, medication distribution issues, and whether or not they are taking the prescribed medications as ordered. In many correctional facilities, inmates with serious illnesses, including mental illness, are often housed together in mental health units or are concentrated in designated general population housing units. Under these circumstances, it is often important to solicit information from others knowledgeable about the inmate's functioning including such people as housing officers, program staff, or (in some cases) other inmates.

Due to the nature of many of these questions and the need for reasonable confidentiality, it is important for the clinician to meet with the inmate in a setting that is both safe and private, at least with regard to protecting patients from having other people overhear interviews. Obviously, exceptions to this principle may be necessary for safety reasons. For example, cell front contact, which may be an acceptable screening practice for inmates without significant mental health impairment in segregated housing units, may be inadequate when more significant mental health impairments are involved. At each follow-up visit, the clinician should assess and document in the appropriate record the level of control achieved.

Levels of Function

This section encourages the use of a level of function tool to bring as many patients as possible into good level of function, recognizing that many patients may only achieve a fair level of function even with all appropriate interventions. It is believed that greater standardization of information collection among clinical and custody staff can result in greater accountability for the professionals, and ultimately better care for the patients. This has proven to be the case when using this approach with common chronic medical diseases and is believed that it may have the same impact on inmates with mental illness.

To effectively use this conceptual model, the clinician should apply the following rules:

1. Under any level of function, if all numbered parameters are not met, the level of function is assessed at the next lower level.

2. In determining whether a numbered parameter is met, it is not necessary that all examples described as part of the numbered parameter be present for the numbered parameter to be met.

3. To be reclassified as an improved level, (a higher level of function), the patient must meet all numbered parameters at the higher level.

Good Level of Function

1.&Patient is a willing partner in the treatment plan. This can be judged by such attributes as: good medication compliance, attendance at all scheduled treatment sessions, understanding of disease process, and/or expresses support for the treatment process. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

2.&Patient does not require daily contacts with qualified mental health staff.

3.&Patient can function appropriately and autonomously in the general inmate population. This can be judged by such examples as appropriate, non-bizarre behaviors and social contacts, self-reports of reductions in troublesome schizophrenic symptoms, regular attendance at/participation in available correctional programs, and/or participation in correctional work assignments with normal levels of staff supervision, maintenance of incident-free behavior, and/or positive staff reports regarding patient's adjustment. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

Fair Level of Function

1. Patient functions marginally in general population with fairly regular crisis situations or functions satisfactorily in an intermediate care unit or special housing unit with its added staff supervision and program structure.

2. Patient requires daily contact by qualified mental health staff.

3. Patient reports a return of or an increase in symptoms.

4. Staff reports of patient behavior indicate deteriorating mental status. This can be judged by such examples as declining personal hygiene, increases in misconduct reports based on mental condition, increases in observable bizarre or deviant behaviors and/or complaints from other inmates about inmate's behaviors. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

5. Patient does not fully cooperate with treatment process. This can be judged by such examples as: a general lack of understanding regarding the illness process, a general distrust or resistance to the treatment process, intermittent compliance with medication regimen,

missed treatment sessions. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

Poor Level of Function:

1. Patient displays active symptoms of illness. This can be judged by such examples as: deterioration in personal hygiene, hallucinations and/or delusions, social withdrawal, alienation, and or other interpersonal problems, immobile, vegetative state or agitated, aggressive state, bizarre, inappropriate behavior and/or suicidal and/or homicidal thoughts, gestures, or actions. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

2.&Patient is unable to function in the general population, an intermediate care unit or special housing unit, due to severity of symptoms and their disruptive effect on the orderly running of the unit.

3.&When use of restraints and/or seclusion is sometimes required to manage symptoms. Patient is totally noncompliant with medication regimen and treatment process/recommendations and/or patient threatens or victimizes other inmates, or is threatened or victimized by other inmates as a function of symptoms of mental illness.

Use of the Assessment to Guide Treatment Efforts

Each clinical contact should generally result in reassessment of the current treatment plan, which should include a careful evaluation of the inmate's clinical status. If the inmate's clinical condition has either worsened or not improved as expected, the treatment plan needs to be revised as appropriate. Treatment plan revisions will often include changes in diagnosis, changes in the general therapeutic modalities being used, and changes in the frequency and nature of clinical contacts, changes in work and/or housing assignments, and, at times, an increased level of mental health care. The clinician may decide to observe for a period without changing the treatment if the clinical reasoning is documented.

Continuity of Care

For continuity of care to be effectively implemented across the facility and community agencies, support from management/administrative staff, both within and across agencies, is essential. Without this support, systemic obstacles are often difficult to overcome.

Continuity of care is clinically very important for establishing and maintaining a therapeutic alliance, for conducting ongoing assessment and monitoring, for maintaining treatment

successes, and for reducing recidivism. Frequent changes of clinicians interrupt continuity of care and interfere with treatment efficacy. When clinicians are inconsistent, inappropriate changes in diagnosis and medications are common, and psychosocial therapy and monitoring tend to be superficial.

Frequent re-incarceration can also interfere with continuity of care where lack of community mental health services is inadequate or non-existent. This discontinuity can be reduced by both written (which should include timely transfer of medical records) and oral contact between the appropriate mental health staff at each care delivery component. Policies and procedures that establish a communication process between custody and mental health staffs, relevant to transfers of people in the mental health caseload, and community providers will help to facilitate such a process.

Problems with continuity of care are common when the level of mental health care is changed. This problem can be minimized by both oral and written communication between the inmate's various primary and mental health providers.

Continuity of care also includes planning discharge to the community. Active involvement and collaboration between mental health staff and case management/classification staff is essential for mental health staff to be able to identify an inmate's actual discharge date in a timely fashion. Inmates who are well-adapted to the correctional setting often experience increased stress as their release date approaches. Jail health care clinicians and custody staff should monitor this period closely and adjust the treatment plan accordingly.

Discharge planning requires that a process be in place for establishment of linkages with primary care and mental health services in the community, social services, and housing. Policies and procedures should include guidelines for effective discharge planning within specified time frames, as well as the provision of medications at discharge and the establishment of an appointment with an aftercare provider in the community. The collaboration between mental health staff, community social services, duly involved criminal justice/court staff is also a vital component in helping the soon-to-be discharged person obtain necessary housing and available entitlements. Newer electronic technologies (e.g., tele-health, barcoded charts, electronic records, etc.) may prove helpful in creating smoother linkages between correctional and community mental health treatment providers.

Treatment Strategies

As in the non-incarcerated community, inmates with mental illness benefit from a variety of treatments, including medications, individual and group interventions. Pharmacologic treatments are generally an essential component of the treatment and are often necessary to facilitate participation in helpful psychosocial interventions. In general, symptoms of mental illness are more responsive to psychotropic medications when counseling and social support services accompany treatment.

Noncompliance with treatment, during incarceration or post-release, especially with psychotropic medications, is a common difficulty. Managing this problem includes assessing the reasons the person is not taking medication, evaluating any delusions about the medications, treating side effects, etc. In some instances, court intervention may be required to mandate medication compliance.

Psychosocial interventions are essential in treating mental illness in correctional settings. The correctional environment includes severe environmental stressors such as overcrowding, high stress levels, poor housing conditions, and frequent prolonged stays in lockdown units. Adapting to these stressors is especially difficult for many individuals with mental illness, especially psychotic and bipolar illnesses. Lockdown is especially troublesome, as it prevents mentally ill inmates from using social interaction to correct their faulty reality testing and practice pro-social behaviors. Many psychosocial interventions are most effectively provided in a group setting that occurs out of an inmate's cell and in a safe treatment setting that allows for appropriate confidentiality and privacy. This is especially true in jail reception centers, which tend to be more regimented and whose housing units are more routinely locked down, as compared to most other correctional settings. Treatment of co-occurring substance use disorders is also an important component of the rehabilitation program, since remission of substance abuse improves prognosis of many mental illness.

Housing considerations have profound impact in the correctional setting. Inmates with serious mental illnesses, particularly when associated with significant paranoia, mania, or other psychotic symptoms disturbing to other inmates, should be carefully evaluated prior to placement in double-celled (two-person) housing as well as dormitory housing for the potential impact of such placement on their illness. Treatment in the least restrictive setting consistent with the inmate's custody classification should occur. The least restrictive setting for some inmates with mental illness in a jail setting will require an intermediate and adequate level of mental health care throughout their incarceration. Many other inmates with mental illness will be able to live in the general population within a correctional setting for much of their incarceration, if adequate mental health providers are available and an appropriate treatment plan is developed and implemented.

Inmates with mental illness should generally not be placed in 22-24 hours/day lockdown for behaviors that directly result from severe mental illness, absent imminent risk of harm to self or others, because such an intervention is not likely to reduce the risk of the clinically relevant behaviors in question, and often exacerbates the person's underlying psychiatric condition due, in part, to lack of access to important treatment modalities and the increased stress associated with these environments. When it is necessary for an inmate with acute symptoms to be housed in such a setting, the institution is not relieved of its duty to provide treatment, despite the difficulty in bringing treatment to segregation settings. For this reason, it is seldom appropriate to house such inmates in disciplinary or administrative segregation units.

Safety of the correctional environment is a primary goal of correctional administrators and custody officers and should also be for correctional mental health providers. Individuals with mental illnesses constitute special circumstances, which should result in security aspects for correctional safety applied to the treatment environment and/or an appropriate treatment regimen applied to the lockdown environment. This may include inmates with mental illness in lockdown status having more out-of-cell time and clinical contacts than would be ordinarily expected in a lockdown setting, or may include more custodial interventions and control in a treatment setting than would ordinarily be expected in such a setting. This may result in designation of specialized mental health lockdown cells or units and/or individually managed treatment and custodial planning.

Mental illness is a condition that is associated with many symptoms that can cause significant functional impairments. Treatment of most inmates involves a multidisciplinary approach to reduce the frequency and severity of episodes and to decrease associated morbidity and mortality. Such treatment is frequently lifelong and is facilitated by maintenance of a therapeutic alliance between the inmate and clinical staff and custody staff. Involvement by community volunteers and organizations can provide care and support during incarceration and following reentry into the community.

An important treatment strategy is to provide education to both the inmate and custody staff about the need for a long-term treatment approach. Mental health clinicians should advocate with policymakers and administrators for needed resources, which will enable the provision of adequate mental health treatment to inmates with serious mental illness.

Because many mentally ill inmates have comorbid medical and mental health conditions, jail-based integrated care management is strongly recommended. This care management approach often includes a physician or nurse practitioner, psychiatrist, mental health clinicians, infection/chronic care nurses, custody staff, and a layman advocate. This model is often successful in coordinating a treatment approach that involves staff from general and mental health care, custody (including classification staff), and other professional personnel (e.g.,

teachers), and the community. This case management function will help to minimize people "falling through the cracks" within a correctional system. This treatment team should meet on a regular basis with the frequency determined by the inmate's clinical condition and level of mental health care required. Additionally, proactive efforts for identifying, treating, and monitoring incarcerated people with mental illness will result in a decreased morbidity and mortality associated with this serious illness.

Environmental Controls

Correctional settings vary significantly in terms of inherent stress depending on many different variables that include the size of the jail or prison, level of security (e.g., minimum or super-max), nature of the housing unit (e.g., dormitory, double-celled, lockdown unit), and the nature of the physical plant (e.g., built in the late 1800s or in the late 1990s).

Inmates with mental illnesses do much better clinically in correctional environments that attempt to minimize stressors and provide a more positive and supportive treatment approach. The mental health staff should provide consultation and training to custody staff pertinent to behavioral principles that include the importance of positive reinforcement for desired behaviors. A more therapeutic milieu can be established in an intermediate level of care setting over time as a result of mental health and correctional staff developing good working relationships with each other.

Due to limited resources, mental health and correctional staff generally need to be very creative in identifying positive reinforcements that are actually available to people with serious mental illness in a correctional setting. Within an intermediate level of care setting, access to television sets, increased yard time, first housing unit to be served dinner, etc. are simple but frequently effective positive reinforcements for specific desired behaviors. So-called token economies, when appropriately managed, may have an important place in long-term care. Scheduled large-group meetings with all inmates and staff often add structure and stability to the inmates lives as well as an opportunity to address common stressors. Some systems use a therapeutic community or inmate government model in addition to other variants.

Inmates in mental health units should have at least as much out-of-cell time as general population housing inmates, and equivalent yard (outside) time. This requires collaboration between clinical and custody staff, particularly to support therapeutic interventions on the units, while maintaining as much of a normalized activity schedule as possible to reduce the stigma of being on a mental health unit. Out-of-cell time, including recreational time, religious services, and visitation are extremely important to inmates; and if these are compromised by treatment activities, treatment refusal rates may be unnecessarily high. For an effective treatment program to exist within a correctional setting, there may be an additional requirement

for consistent custody support on the units as well as in the yards, and may in fact include the necessity for a separate or segregated yard for people with serious mental illness and/or higher custodial presence to assure these people are not victimized by other incarcerated people.

Stigma associated with mental illnesses continues to be problematic, especially in a correctional environment. Training and supervision of correctional staff relevant to people with mental illness will be an initial step in reducing such stigma.

Correctional Barriers

The most common correctional barriers to providing adequate treatment to inmates with mental illness include the following:

1. Failure of top administrative staff to recognize and endorse treatment as an essential part of the agency's overall mission.

2.&Inadequate numbers of mental health staff (both clinical and clerical staff) that is frequently related to rural settings of many correctional facilities or non-competitive salaries.

3.&Limited understanding of mental illness by correctional officials resulting in obstacles to the provision of mental health care.

4.&Poor or inadequate training of correctional staff.

5.&Inadequate numbers of other health-care staff (e.g., nurses, pharmacists, etc.), which results in significant medication distribution difficulties.

6.&Inadequate number of correctional officers for escort purposes, which results in inmates with serious mental illnesses not having reasonable access to needed mental health treatment.

7.&Inadequate physical plant resources (e.g., lack of office space and programming space for activity and group therapies as well as individual treatment.

8.&Inadequate numbers of inpatient psychiatric beds, crisis stabilization beds, and/or intermediate level of care units.

9. Overcrowded housing units, older facilities with inadequate climate control mechanisms etc.).

10. Lockdowns that result in access problems.

11. Lack of an adequate computerized management information system, which results in untimely responses to referrals, poor follow-up to missed appointments, other scheduling problems, and an inefficient quality improvement process.

12. Fiscal issues exacerbated by the cost of the newer psychotropic medications and increased funding constraints.

Simple Quality Improvement Monitors

The following quality improvement monitors are suggested, but are not intended to be a complete list to ensure a successful treatment program for inmates with mental illness in a correctional setting. It is not intended that every program be required to measure all of the following annually:

1. Policies and procedures have been implemented that result in timely identification of inmates with mental illness. These procedures will include receiving screening, intake assessments, comprehensive mental health evaluations, a referral process, and mental health rounds in lockdown units.

2.& Indicators should include the percentage of the correctional facility population that has been diagnosed as having a serious mental illness, with the diagnostic categories being specified on a percentage basis, and the time frames required for completion of the various screening and evaluation processes.

3.& Continuity of care is provided as characterized by medications being delivered on a regular basis, timely medication renewals, and inmates on the mental health caseload not frequently having changes in their assigned mental health clinicians.

4.& Appointments with mental health clinicians should be monitored relevant to timeliness, frequency and missed appointments.

5.& The number of mental health caseload inmates that are noncompliant with prescribed psychotropic medications should be monitored. Additionally, whether timely inmate referrals to the psychiatrist are initiated relevant to such inmates and, if so, whether a timely and clinically appropriate intervention subsequently occurs should also be assessed

6.& The percent of inmates on atypical or mood stabilizing medications, whose medications expired without reorder or whose medications were reordered but without psychiatric evaluation.

7.& Treatment plans are appropriate to the inmate's clinical condition as well as to policies and procedures. Documentation is present in the healthcare record that confirms the treatment plan is being implemented.

8.& Number of inmates referred to a more intensive level of mental health care on a monthly basis, and the percentage of those referred who are accepted to the higher level of care. Other relevant indicators include the time frame between referral and actual transfer and percentage of inmates admitted to a crisis stabilization unit or psychiatric hospital that have had three or more such admissions during six consecutive months.

9. Number of inmates whose diagnoses have changed from a schizophrenic disorder to either malingering or a personality disorder and vice versa. An analysis should be performed relevant to the documentation and basis for making such a change.

10. Number of rule violations (by severity) among inmates with mental illness on a monthly basis. An analysis should be performed relevant to whether mental health input was obtained concerning inmates with mental illness who received rule violation reports and, what impact, if any, these mental health assessments had on the disciplinary process. Another analysis should assess whether there was any relationship between these rule infractions and the person's mental illness(es).

11. Average number of hours per week of out-of-cell structured therapeutic activity offered to inmates in intermediate levels of mental health care, and average number of hours actually used per inmate per week.

12. Number of mentally ill inmates currently housed in segregation units as compared to the total number of inmates in these units. An additional analysis should determine the nature of the mental health programming, if any, available to these inmates.

13. The number of inmates referred from lockdown units to crisis beds or hospital care as acute emergencies per month.

14. Number of inmates who are receiving psychotropic medications on an involuntary basis.

15. Number of mentally ill inmates who are restrained for any reason on a monthly basis. The duration of restraints and documentation relevant to clinical indications should also be assessed.

16. Use of force incidents involving inmates with serious mental illnesses should be reviewed to determine whether the person had been receiving appropriate mental health treatment and whether appropriate interventions occurred prior to any non-emergency use of force.

17. All suicides and suicide attempts should be reviewed with a focus on issues relevant to identification, monitoring, and treatment.

18. Assaults involving mentally ill persons should be reviewed with a focus on issues relevant to medication, monitoring, and treatment.

19. Appropriate laboratory testing for mood stabilizing medications is ordered, results available to clinicians and appropriate intervention performed when clinically indicated.

20. Percentage of mental health caseload inmates who receive prescribed psychotropic medications immediately prior to discharge from the correctional system, and whether an adequate supply of such medications upon discharge is given.

21. Percentage of patients in each level of function at the end of each quarter.

22. Study of patients on each class of psychotropics and their weight change over 6 months.

23. Study of patients to be released for documented follow-up appointments in the community.

Jail Design Impacts Behaviors of Mentally Ill Inmates

The following will briefly discuss how jail design can impact inmate behavior, therapeutic and correctional outcomes.

Note that the research is drawn from studies in jails (which unfortunately are few) and in mental and medical health care facilities, and from interviews with national experts. Here is a summary of the findings.

Views of Nature. In a recent study by long time jail environment and behavior researchers Jay Farbstein, Melissa Farling and Rich Wener, findings showed that views of nature help reduce stress levels of inmates and staff. Hence, it is likely that views of nature also reduce tension and the likelihood of aggressive behavior and destruction of property. Lower stress is also likely to result in improved physical and mental health, a reduced need for sick leave, and perhaps less staff turnover.[3]

While views of "real" nature are considered best, the Farbstein, et. al., study showed that where windows with views are not possible, as was the case in the place of the study, that murals of nature also have a very positive impact on reducing stress.

Capacity of Housing Units. Evidence from both the literature and anecdotal sources is very slim on optimal inmate/patient numbers. The Environment and Behavior literature offers the most information on unit sizes, but focuses mainly on Alzheimer's patients and those in some form of assisted living.

For the mentally impaired populations not in correctional settings, the most therapeutic environments tend to be smaller, with eight to ten residents in non-institutional, home-like settings that have private rooms. Such settings seem to offer the most normative environments which facilitate healing. The implication from this is that "smaller is better" for patients in correctional mental health units.

For the mentally impaired who only need minimal assistance in daily living, the numbers can be somewhat larger – but the type of housing recommended for these populations is still less institutional. Numbers of up to approximately 26-36 residents in units, each with their own

[3] Developing the Evidence for Evidence-Based Design: The Impact of Simulated Nature Views on Stress in a Correctional Setting." Jay Farbstein, Melissa Farling, and Richard Wener.

dayrooms and close proximity to program areas is supported by the research.

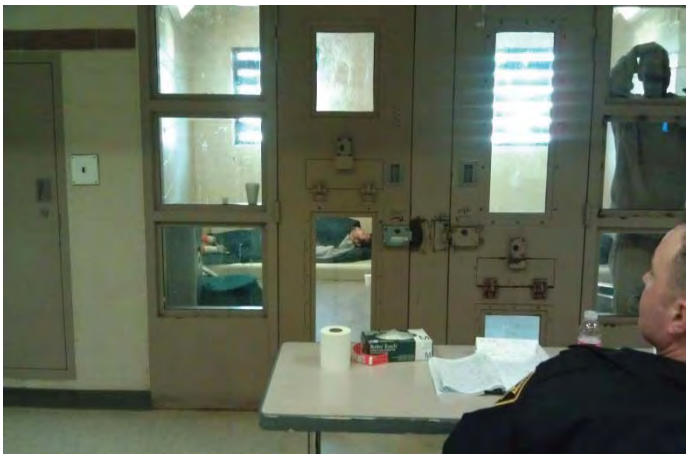
In short, mental health care research indicates that "smaller is better." Recognizing that it is also vital for mental health units to be continuously staffed, the units need to be large enough so that jurisdictions can afford to provide staff 24/7. For example, it is better to have a 20-bed unit with continuous direct supervision than to have two 10-bed units that are staffed using indirect supervision, with staff in the units intermittently.[4]

Another major advantage of smaller units is that populations who should not mix (e.g., male/female, 16-18 year olds/19+ year olds, violent/vulnerable) can more readily be kept apart from others.

Capacity of Cells. Los Angeles County realizes the many benefits of single cells compared with multiple-occupancy cells and dormitories for all inmates. Environment and Behavior research supports single cells, especially for mentally ill inmates. Reasons include:

- Reduces inmates' levels of stress and anxiety, which facilitates healing.
- Facilitates manageability by staff.
- Reduces unwanted noise, facilitating better sleep.
- Reduces unwanted light, also facilitating better sleep.
- Promotes accountability should there be any damage.
- Minimizes risk of physical, verbal, and sexual assaults.
- Better enables some personalization of space (e.g., how items on shelves are arranged), which promotes self-esteem and well-being.
- Results in better physical health too (e.g., less likelihood of infections from others).

Observation. Some Mentally ill inmates, especially those likely to harm themselves, require continuous ovservation, with staff having direct views 24/7. Here is an example from another state that requires staff to sit a few feet away from suicidal inmates 24 hours per day, seven days per week. This is obviously extremely staff intensive, with a staff: inmate ratio of five staff to every one or two inmates.



[4] Research Impacting the Design of Secure Facilities in California Intended to Support Patients' Physical & Mental Health, For the California Prison Receivership, 2008, Mark Goldman & Dita Peatross.

Healing Environments. The types of settings that appear to be most successful in supporting good mental and physical health are[5]:

- Enriched – with color, art, music, views of nature, opportunities for positive stimulation, etc.
- Normative – allowing patients to maintain as complete a behavioral repertoire as before incarceration.
- Supportive – designed so as not to diminish the scope and range of behavioral repertoires; i.e., cueing, way-finding, recognizable.
- Familiar and meaningful – so as to offer the fullest possible support to inmate/patient's strengths with opportunities for information, choice, and activity within a recognizable (even though secure) environment.
- Soft, normative finishes and living quarters are appropriate and often not abused by the mentally ill. These environments can be less expensive to build than highly secure, institutional settings and they can work. They can also provide cues to patients as to the expected normative behavior.
- Meeting, congregating and multi-purpose spaces are important for socialization and treatment-oriented activities.
- Access to outside spaces and fresh air is beneficial to mental and physical health.
- Indoor air quality is very important for the functioning and health of residents and staff.
- Natural and full spectrum lighting improves health outcomes, lowers stress and depression, can shorten length of stay, and helps retain staff. Daylight and soft, non-direct, non-institutional lighting is preferable.
- Inmates/patients' mental health can benefit from the inmates having choices throughout the day and some control within their living quarters (turning lights on/off, moving a chair).
- Quieter environments lessen stress in residents and staff.

Environments that Support Staff. Secure Mental and Physical Health environments not only have an enormous impact on patients, but also on staff, who spend substantial portions of their lives in these environments. A review of the literature in this area finds that many of the same features that impact patient behavior and lessen stress can also improve staff morale and lessen stress in staff. In addition to other factors, limiting noise-related stressors and providing ample natural light and views to the outside when feasible can help to keep staff stress levels to a minimum. It is also important to provide staff with places to rest and "recharge."

[5] Research Impacting the Design of Secure Facilities in California Intended to Support Patients' Physical & Mental Health, For the California Prison Receivership, 2008, Mark Goldman & Dita Peatross.

Other characteristics of the physical environment that appear to support staff well-being and job performance include:

- Small unit sizes. These facilitate good access, visibility and observation, and communications between staff and patients.
- Conveniently located storage and support spaces to reduce staff walking and stress.
- Decentralized staff stations that are close to patient areas.
- Well-organized units that limit the amount of time that staff are required to spend searching for supplies and materials.

Ultimately, effective management and treatment requires that staff in correctional health care settings circulate throughout housing areas frequently and interact with and observe patients.

With concern over being able to attract and retain good, trained medical and mental health professionals and custody and security personnel, providing quality work environments for staff that will positively impact performance and contribute to the therapy and rehabilitation of patients should be a high priority.

INTRODUCTION

Nationwide, public officials struggle to balance budgets while providing necessary human and public safety services. Many states have slashed public mental health funding and closed state-operated mental health facilities. Resulting cuts to local mental health and substance abuse treatment services further reduces access to care, increases and prolongs suffering, destabilizes family systems, unnecessarily overloads finite law enforcement resources, increases crime, overburdens already packed court dockets, and overcrowds jails that are ill designed and inadequately staffed and funded to provide adequate levels of care and management for this inmate population. The aggregate impact of reduced community behavioral health funding levels, combined with Los Angeles County's obligation to ensure the provision of constitutionally adequate care and protection to this inmate population, presents very serious and time-sensitive challenges. To its credit, however, Los Angeles County has made this issue a top priority; it clearly understands the importance in preemptive and deliberative planning and has a proven record of accomplishment for solving serious problems that jeopardize quality of life for its community and precious tax dollars.

Brief National Perspective

Current research indicates that, on any given day, approximately 64 percent of people booked into our Nation's 3,200 local jails are diagnosed or have a diagnosable mental illness or problem. The high prevalence of mentally ill inmates can be traced to the deinstitutionalization of mental health programs throughout the country, draconian reductions in community mental health funding, and the closing of public mental health facilities resulting in an unprecedented incarceration of the mentally ill.

Many of these inmates also have other risk factors associated with a higher incidence of violent behavior (e.g., substance abuse, neurological impairment, poor impulse control) that is often exacerbated by psychotic symptoms. Because of their idiosyncratic and sometimes unpredictable behaviors, people with serious and pervasive mental illness may be at higher risk of victimization or harming others in correctional settings and often have their clinical conditions exacerbated by overcrowding, hostility, and loss of basic freedoms.

Providing timely and adequate jail conditions and treatment to inmates with mental illness not only helps the individual avoid disruptive and dangerous behaviors but may also reduce suffering and improve facility safety and security. Developing and maintaining effective jail-based treatment and case management services for inmates with mental illness is a constitutional obligation of local officials. The following provides concepts and direction for developing and maintaining jail-based mental health programs and service.

***Brief Backdrop* – LA County Jail Consolidated Correctional Treatment Facility (CCTF)**

Los Angeles County is currently considering the development and construction of a 5,000 bed integrated behavioral health treatment facility (CCTF). Conceptually, this facility would consolidate into one jail facility an integrated care and custody delivery model involving the following "*special needs"* inmate populations:

1) Inmates having chronic illness, serious mobility impairments, serious neuro-sensory impairments, and or other medical conditions requiring clustered housing and specialized care and services.

2)&Inmates undergoing alcohol or substance detoxification requiring more intense monitoring and close care services.

3)&Inmates with certain medical conditions that place them at risk when housed in the general population.

4)&Inmates suffering from serious mental illness and/or substance abuse disorders who require more intense, frequent, and specialized treatment regimens, and care.

5)&Inmates presenting risk of suicide/self-harm requiring safe housing, increased monitoring, targeted treatment to ameliorate suicidal/self-harm intentions and risks, adequate discharge planning prior to returning to another housing area or reentry into the community.

6)&Other inmate populations requiring safe housing due to specific concerns and/or risks not directly related to medical and/or behavioral health issues.

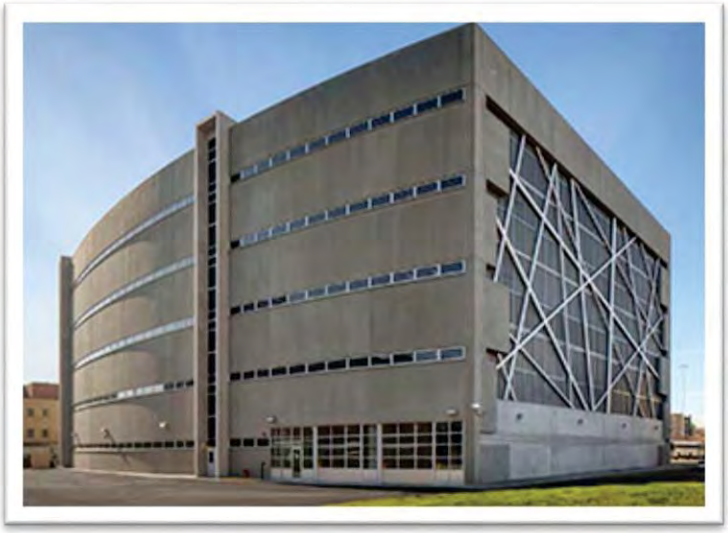
Generally speaking, the proposed CCTF and programs being assessed herein are conceptualized by LA County officials to 1) improve and ensure the adequacy of care and protection of inmates presenting serious and/or special health care and/or personal safety needs, 2) improve and sustain the cost effectiveness of jail health care delivery systems using an integrated care management model, and by consolidating designated inmate cohorts into one facility to leverage economies of scale in the delivery of care and protection services, 3) to facilitate successful inmate reentry into the community, which should result in a positive impact on criminal recidivism for program participants, and 4) to ensure that inmates are provided levels of care and protection that meet or exceed Constitutional requirements.

The purpose or scope of this assessment was not to determine or make recommendations with regard to the specific need for CCTF construction, but to only assess behavioral health programs being proposed for a CCTF should it gain approval and funding for construction and operation. However, effective assessment of proposed programming requires us to consider the context and physical

environment in which those programs are intended – a CCTF. Therefore, the following brief discussion regarding the jail environment is included to provide basic context for assessing the likely effectiveness of the proposed integrated behavioral health programs.

A CCTF is not a new concept in contemporary corrections. Small, large, and mega jail systems throughout the United States embrace this idea; many have effectively operated such facilities and/or inmate care-management models for years; many have committed to this concept and are in various stages of planning, development, construction, and/or implementation. The Consultants have been involved in various stages of the following recent projects that are very similar to LA County's proposed CCTF:

Cook County, IL (Chicago): Cook County Department of Corrections in Chicago recently opened its new Residential Treatment Unit (RTU) in June 2013. The RTU is part of the Cook County Jail's 276,450-square-foot addition project built to accommodate a growing jail population. The five-story facility is seeking LEED Silver certification.



The RTU provides treatment for substance abuse, mental illness and general health screenings and evaluations for inmates at the jail. It contains 979 medical beds, separate male and female intake units, a medical and psychiatric screening facility, 24-hour crisis and intervention services, a correctional psychiatric care clinic and secured exterior recreation yards. The medical and psychiatric screening facility is a key part of the RTU. Doctors and psychologists from Cermak Hospital will provide services to the inmate patients.

The RTU is part of the Cook County Board's modernization plan to create a more effective and humane criminal justice system. According to the Cook County Bureau of Economic Development blog, more than 85 percent of the jail population tested positive for drugs. The county jail is also one of the largest mental health care providers in the state because of the high number of inmates who suffer from mental illness.

In addition to the RTU, the Reception Classification Diagnostic Center (RCDC) Intake Center was also a part of the expansion project. It replaces the services of the old intake center, which was housed in the basement of another division at the jail. The jail accommodates close to 10,000 inmates per

day. That number fluctuates as the jail both processes and discharges around 300 to 400 detainees a day.

Sustainability features at the building include a mechanical system designed to achieve energy cost savings through advanced air handling units and the facility's more than 200 thermostatic control zones, and the latest in building automation control technology. Plus, the building's green roof was designed and installed to reduce the building's heat island effect as well as its rainwater runoff.[6]

This facility is expected to significantly contribute to resolving the County's current jail federal civil rights Settlement Agreement with the United States Department of Justice.

***Dallas County, TX (Dallas)**: Dallas County, Texas, the Dallas County Sheriff's Office, and the County's Parkland Health and Hospital System have partnered for the design, construction, and activation of one of the Nation's most innovated and important projects of its kind. Together, and with the professional assistance of private sector architectural and construction experts, they have designed and will soon operate, one of the country's most contemporary and cost effective jail medical and mental health facilities. This project involves renovation in excess of 150,000 square feet of mostly unused jail space for the integration of administrative, health care services and housing, and programming purposes. This will be accomplished without constructing new buildings or by expanding the footprint of the existing jail. This "Med-Mod" project, as it is called, will add an additional 283 acute and seriously ill medical and mental health beds on two floors of an existing facility. In addition, the project will improve health care programming space, provide for better care of inmates, and improve facility security. The new design allows for improved daily collaboration and cooperation among jail and health care staff while strengthening continuity and timeliness of inmate care. This facility is expected to significantly contribute to resolving the County's current jail federal civil rights Settlement Agreement with the United States Department of Justice.[7]

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[6] *http://www.hconews.com/articles/2013/08/14/cook-county-jail-expands-medical-facilities*

[7] *Technical Assistance Assessment of the Dallas County Med Mod Project by Kenneth A. Ray and Mark Goldman, National Institute of Corrections, 2013, Dr. Ronald Shansky currently serves as the jail medical consultant to this project and has provided recommendations for the integrated health delivery model and environmental design.*

Lake County, IN (Crown Point):

The 1,100 bed Lake County Jail is currently undergoing significant renovation to operate a 90-bed, integrated special health care unit. Renovation involves reconstruction of four housing units for male and female inmates with behavioral health needs similar to those proposed by the LA County CCTF. The new design co-locates correctional, medical, and behavioral health staff to maximize effective communications while improving inmate access to care and protection services. The new Unit is expected to be operational in October 2014. This facility is expected to significantly contribute to resolving the County's current jail federal civil rights Settlement Agreement with the United States Department of Justice.[8]

Onondaga County, NY (Syracuse): County officials have completed Technical Assessments of jail space and health care services programming for the planning of a new integrated inmate health care facility similar to LA County's CCTF concept. Although County officials remain in feasibility planning stages, they are actively engaged in efforts to create a theraputic jail milieu and specialized medical and behavioral health programing for special needs inmates.[9]

[8] *Lake County Sheriff's Department Mental Health Unit Implementation Concept Report, Kenneth A. Ray, Project Coordinator, 2012.*

[9] *Technical Assistance Assessment of the Onondaga County, NY Jail Health Care Project by Kenneth A. Ray and Mark Goldman, National Institute of Corrections, 2013*

McLean County, IL (Bloomington)

Following two technical assessments of jail facility and program concerns related to the care and custody of inmates with behavioral health disorders, county and community officials have moved forward to develop strategic options and opportunities to better meet the needs of inmate and community population with serious behavioral health disorders. Officials are now engaged in a comprehensive study process to determine additional jail capacity and design requirements, and to determine capacity and program needs for the construction of a community behavioral health crisis facility. County and community officials firmly believe that a comprehensive approach to integrated care requires 1) integration of all systems impacted by, and that impact, this inmate population (criminal justice, law enforcement, corrections, health care, social services, courts, community, etc.), and 2) adequate emergency mental health bed-capacity in the community. [10] McLean County's forward thinking in treatment of mental ill inmates, and its firm desire to provide community capacity for its mentally ill citizens suffering from acute episodes will undoubtedly pay social and economic dividends in the short and long term.

[10] *Technical Assistance Assessment of the McLean County, IL Jail Health Care Project by Kenneth A. Ray and Mark Goldman, National Institute of Corrections, 2013*

ASSESSMENT OF PROPOSED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

Los Angeles County Departments of Mental Health and Public Health propose specific inmate treatment programming for the Consolidated Correctional Treatment Facility (CCTF). During the onsite visit, participants from these agencies seemed very well prepared to discuss these programs and provided documents relevant to understanding program core concepts and primary care delivery models. This information provided the Consultants a solid basis for developing their research and conclusions.

Mental Health and Substance Abuse Programming proposals provided specific information about each program component, justification, and efficacy. However, due to the limited turn-around-time allowed for this assessment and report, the Consultants decided to limit assessment parameters and literature reviews to only the "core concepts" shared within the proposed programs.

In general, both program models share common core treatment concepts and are based on similar delivery models. These include:

1. Integrated Behavioral Health Concept
2. Wraparound Services Concept
3. Illness Recovery Concept
4. Psychosocial Rehabilitation Concept
5. Cognitive Behavioral Therapy Concept
6. Motivational Interviewing Concept
7. Education Based Incarceration (LASD)
8. Medication Assisted Treatment Concept MH/SUD)

Brief Description of Core Concepts/Models

A brief description of proposed program core concepts/models is provided in the context described by participants and in the documents each discipline provided for this assessment.

Integrated Behavioral Health

Jail-based programming proposed by DMH/DPH/LASD includes the systematic coordination and delivery of primary and behavioral healthcare and custody services. This will involve ongoing collaboration among mental health, substance abuse, primary care, and custody (security) services to produce the best care, safety, and security outcomes.

A 2008 report by Funk and Ivbijaro cited seven reasons for integrating mental health into primary care. Each must be considered in any effort to design or implement a collaborative approach, partial integration, or a fully integrated model.[11]

1.&*The burden of mental disorders is great.* Mental disorders [among jail inmates] are prevalent in all societies and create a substantial personal burden for affected individuals and their families. They produce significant economic and social hardships that affect society as a whole.

2.&*Mental and physical health problems are interwoven.* Many people suffer from both physical and mental health problems. Integrated primary care helps to ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.

3.&*The treatment gap for mental disorders is enormous.* In all countries, there is a significant gap between the prevalence of mental disorders and the number of people receiving treatment and care. Coordinating primary care and mental health helps close this divide.

4.&*Primary care settings for mental health services enhance access.* When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping families together and allowing them to maintain daily activities. Integration also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals.

5. *Delivering mental health services in primary care settings reduces stigma and discrimination.*

6. *Treating common mental disorders in primary care settings is cost-effective.*

7. *The majority of people with mental disorders treated in collaborative primary care have good outcomes*, particularly when linked to a network of services at a specialty care level and in the community.

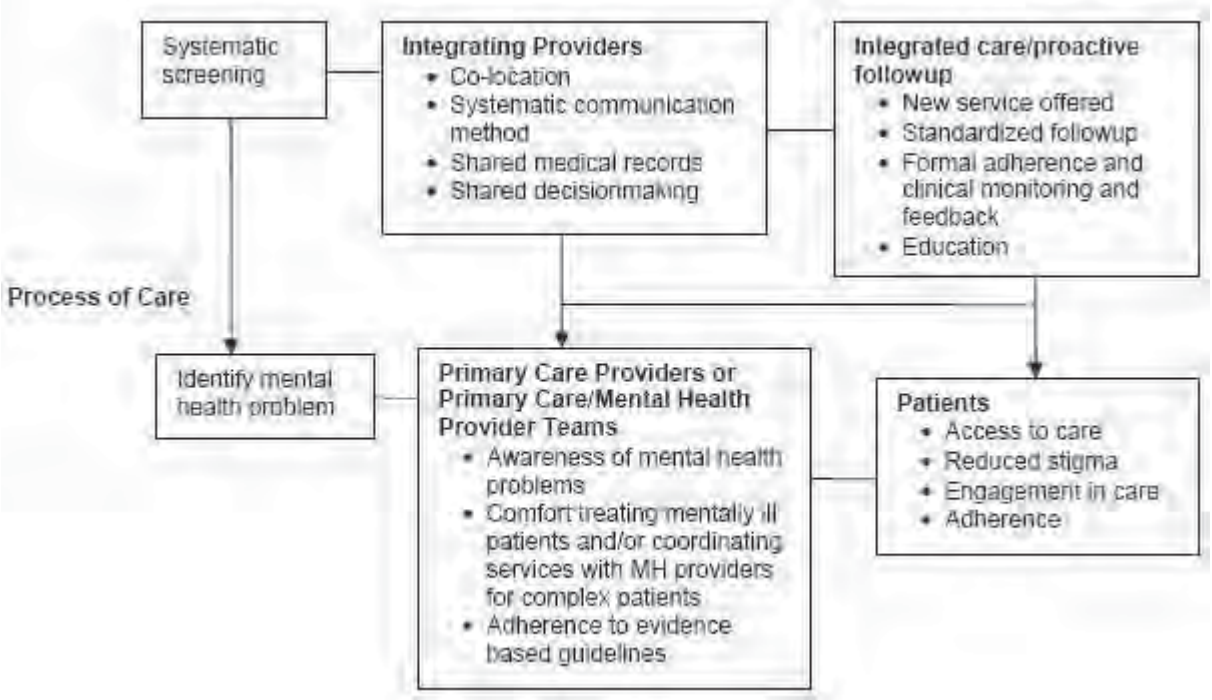
Figure 1 below illustrates a standard integrated behavioral health care model generally applied in community care settings.[12] However, participant interviews and program documents expand and deepen integration of inmate care using cross discipline collaboration that balances inmate health care needs with facility safety and security.

[11] http://www.milbank.org/publications/milbank-reports/32-reports-evolving-models-of-behavioral-health-integration-in-primary-care#intro
[12] http://www.ncbi.nlm.nih.gov/books/NBK38636/?report=printable

Community IBH Model (see Figure 1)	Proposed Program IBH Model
Systematic Screening	Systematic screening at intake that includes medical, substance abuse, mental health, security risk and needs components.
Integrating Providers • Co-location • Systematic Communications methods • Shared medical records • Shared decision making	Adds: Co-location of administration, staff, inmates according to needs and risks. Shared health and jail records/information/data Decision making includes security risks and needs
Identification Awareness of mental health problems. Comfort treating mentally ill, coordinating services with MH providers for complex patients, adherence to evidence-based (health care) guidelines.	Adds: Identification and awareness of medical, psychosocial, substance abuse, and security problems and risks. Medical, mental health, substance abuse, and security staff are comfortable treating and managing inmates, adhere to evidence-based health care and security guidelines.
Integrated care/proactive follow-up • New services offered • Standardized follow-up • Formal adherence and clinical monitoring and feedback • Education	Adds: • New services but are currently proven effective in Los Angeles County community delivery systems. • Standardized follow-up includes security classification assessment, discharge to general population where indicated, community reentry. • Formal adherence includes clinical, programmatic, security management monitoring and feedback. • Education includes inmates and program providers and custody staff.
Patients • Access to Care • Reduce Stigma • Engagement in Care • Adherence (to treatment)	Adds: • Access to jail-based care that bridges to community services upon reentry. • Reduced stigma among inmate population. • Engagement in care motivated by integrated provider relationships (includes custody staff) and supportive interaction with those providers and custody staff.

	• Adherence to treatment is motivated by positive communication with program and custody staff, clarity in behavioral expectations, rewards.

Figure 1 – Community-Based Integrated Care Delivery Model



Findings: The proposed programs involved full development and implementation of an integrated jail-based inmate care and management model. The efficacy of this care delivery model is well-affirmed in the literature as an evidence-based best practice.

Wraparound Services Concept

Los Angeles County has provided Wraparound to families and their children with multiple, complex and enduring needs since 1998. Wraparound is an integrated, multi-agency, community-based planning process grounded in a philosophy of unconditional commitment to support families to safely and competently care for their children. The single most important outcome of the Wraparound approach is a child thriving in a permanent home and supported by normal community services and informal supports. The Los Angeles County wraparound process has been developed through a collaborative partnership between the County and the Wraparound Agencies (WAs). This partnership, through regular meetings and solicitation of community and family input, maintains high standards, measures the achievement of outcomes and ensures voice, choice and access for all stakeholders.[13]

[13] http://www.lacdcfs.org/katieA/wraparound/index.html

Complementing proposed program integration is the Departments' intent to include targeted wraparound services for target inmate population in proposed programs. These services would address not only health care and security management risks and needs, but also include services addressing psychosocial, educational, vocational, housing, financial, and family issues. These risks and needs would be assessed at intake and included in jail-based treatment and reentry planning. Before release, inmates would have access to wraparound service providers at the intake center before release. Marshalling these service providers in a "one-stop-shop" at the intake center, inmates will be better prepared to access and engage community and natural supports though intensive case management and therapeutic interventions upon reentry. These services are proposed to be 1) comprehensive, 2) individualized, and 3) include health care, substance abuse, social, education, housing, transportation, and financial services supports.

Findings: Wraparound services is a well proven model for delivering integrated care and support services in community social services and health care settings. This model has been affirmed for decades as a best practice. As a component of the proposed programs, there is every reason to believe that wraparound services will support the intended outcomes of the proposed programs.

Illness Recovery Concept

Proposed programs incorporate Illness Recovery/Psycho-Social Rehabilitation Models as core concepts. Both models are well-affirmed in the literature as evidence-based best practices in treating medical, mental health, substance abuse, and psycho-social problems.

Illness Recovery Concept: The fundamental components of Recovery include:

- Hope
- Medication/Treatment
- Empowerment
- Support
- Education/Knowledge
- Self Help/Self Efficacy
- Employment/Meaningful Activities.

Proposed programs, as described by the Department's officials, intend to improve inmate quality of life upon release in the following areas:

- Stable, safe, and decent housing
- Family and social relationships
- Employment/education/meaningful work
- Financial independence and adequate income

- Integration into one's community
- Physical and psychological health and safety
- Spiritual beliefs and religious practices
- Talents and interests - leisure activities

Findings: The literature endorses the Illness Recovery Model as proposed by the Departments for medical, mental health, substance abuse, and psycho-social treatment. Regarding the 18-22% of jail inmates suffering from severe and persistent mental illness (Schizophrenia, Bi-Polar Disorder, Major Depression), Richard Warner, Clinical Professor of Psychiatry, Colorado Addiction Recovery Center editorialized his literature review on the effectiveness of the Recovery Model:

> *"The recovery model refers both to subjective experiences of optimism, empowerment and interpersonal support, and to the creation of positive, recovery-oriented services. Optimism about outcome from schizophrenia is supported by the research data. One of the most robust findings in schizophrenia research is that a substantial proportion of those with the illness will recover completely and many more will regain good social functioning. Much recent research suggests that working helps people recover from schizophrenia and advances in vocational rehabilitation have made this more feasible. A growing body of research supports the concept that empowerment is an important component of the recovery process and that user-driven services and a focus on reducing internalized stigma are valuable in empowering the person with schizophrenia and improving the outcome from illness. Further controlled studies of empowerment-oriented interventions are required to demonstrate convincingly that a focus on this factor will yield better outcomes in psychosis."*[14]

The Recovery Model, with or without a Psycho-Social Rehabilitation concept, is affirmed in the literature as an evidence-based best practice. Proposed programs are likely to produce desired treatment outcomes by including the Recovery Model as a core component of care.

Rehabilitation (Psycho-Social) Concept

The Psycho-Social Rehabilitation treatment is well known in the behavioral health and long-term care industries as an effective mental health treatment. The literature indicates that this model can yield the following outcomes in the treatment of behavioral health disorders when properly applied:

A Literature review on clinical, social and cost benefits of psychiatric rehabilitation services carried by the Commonwealth of Pennsylvania, Department of Public Welfare 1999, analyzed fifteen articles published between 1984 and 1998 that described and evaluated psychosocial programs. Their overall

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[14] Does the scientific evidence support the recovery model? *The Psychiatrist Online January 2010 34:3-5; doi:10.1192/pb.bp.109.025643, at* http://pb.rcpsych.org/content/34/1/3.full

conclusion was that participation in the programs improved 'functioning' of the participants. The most commonly reported areas of improved functioning with psychosocial rehabilitation were: improved Global Functioning (5 of 6 studies), increased Employment (10 of 12 studies), increased Independent Living (7 of 10 studies), Social/Community Adjustment (4 of 7 studies), decreased Use of Community Resources (2 of 2 studies), decreased Hospital Admission Rates (7 of 9 studies), decreased Time in the Hospital (11 of 13 studies), and decreased Mental Health or Societal Costs (9 of 9 studies).[15]

The literature also indicates that this treatment model can be effective with other populations housed in the Los Angeles County Jail system.

- Geriatric
- People from cultural and linguistically diverse backgrounds
- Gender differences
- Psychological trauma survivors

Finally, this treatment model positively supports previously discussed proposed program core concepts for jail-based treatment.[16]

Findings: The Psycho-Social Rehabilitation concept as proposed by the Departments is affirmed in the literature as an evidence-based best practice for effective treatment of behavioral health problems in jail and community settings.

Cognitive Behavioral Therapy (CBT) Concept

Cognitive Behavioral Therapy (CBT) is the "standard" evidence-based treatment used in behavioral health for the treatment of mentally illness and behavioral problems. In-fact, CBT is one of very few treatment modalities that stands on its own for Medicaid / Medicare mental health treatment reimbursement.

Cognitive behavioral therapy (CBT) is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with mental illness can modify their patterns of thinking to improve coping. CBT is a type of psychotherapy that is different from traditional psychodynamic psychotherapy in that the therapist and the patient will actively work together to help the patient recover from their mental illness. People who seek CBT can expect their therapist to be problem-focused, and goal-directed in addressing the challenging symptoms of mental

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[15] http://www.slideshare.net/snigdhasamantray/seminar-on-psychosocial-rehabilitation-of-psychiatric-patients

[16] Best Practice in Mental Health . Summer2005, Vol. 1 Issue 2, p100-132. 33p. at http://essential.metapress.com/content/uk5446h1092t1578/

illnesses. Because CBT is an active intervention, one can also expect to do homework or practice outside of sessions.

CBT has been proven as a best practice in treating severe and chronic mental illness, mood and anxiety disorders, substance abuse disorders, and is often applied in the field of education as a method for helping learners improve their understanding of topic information, synthesize; evaluation; and apply information and concepts being learned. [17]

CBT has been proven effective with jail inmate populations and has shown to improve inmate behavior, improve adherence to programming and rules, reduce incidents of violence, improve community reentry outcomes, and reduce recidivism.[18]

Findings: CBT is well endorsed in the literature as an evidence-based best practice for use in jail settings as proposed.

Motivational Interviewing (MI) Concept

Motivational Interviewing began as a client-centered, goal-focused approach to psychotherapy and counseling in the 1990s. Its primary object to increase a person's intrinsic motivation for behavior change by exploring and resolving ambivalence about change. Primary aims of MI focus on increasing a person's desire to change (for the better) and to strengthen their commitment to positive change.

Since its development, MI has proven effective in various settings and with various clientele:

- Health Care – improves medical outcomes
- Mental Health – improves mental health / psychiatric outcomes
- Education – improves learning outcomes / improves teacher effectiveness
- Organizations – improves leadership and staff performance
- Jails and Prisons – improves inmate behavior, treatment outcomes, reduces recidivism
- Other

MI should be considered as a "tool" to be used in the process of target inmate assessment, care and treatment planning, treatment, custody management, education, and reentry preparedness. It is not a treatment "therapy" per se. MI is an evidence-based best practices for maximizing the effectiveness of all proposed programs, their intended individual and collective outcomes.[19]

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[17] http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml
[18] http://static.nicic.gov/Library/021657.pdf
[19] https://s3.amazonaws.com/static.nicic.gov/Library/025556.pdf

Findings: Motivational Interviewing, as proposed, is affirmed in the literature as an evidence-based best practice for use in correctional settings.

Education Based Incarceration

The Los Angeles County Sheriff's Department operates one of the largest education-based [jail] incarceration programs in the United States. Working from its Six Principles of EBI, this program is positively transforming the culture of corrections and the lives of inmates. The Six Principles of EBI include:

I. *Assess and evaluate both educational and trade skills of inmates.*

II. *Develop a system of educating Los Angeles County jail inmates who inevitably will serve time in the California state prison system that begins and ends with a period of time in Los Angeles County jail facilities.*

III. *The development and implementation of an automated case management information system.*

IV. *Strengthen and systematize the partnership with the California Department of Corrections and Rehabilitation (CDCR).*

V. *Develop a comprehensive curriculum that activates a wide variety of learning programs that are both traditional and non---traditional.*

VI. *Transform, through science and training, the LASD Custody Operations Division, as well as the State of California's cultural thinking to approve, support, and participate in the principles and practice of Education Based Incarceration.*

EBI, as proposed, plays a particularly important role in the implementation and effectiveness of prosed mental health and substance abuse programs because of its CBT program underpinnings. EBI managed CBT courses include:[20]

Changing How We Think: *Students learn how our internal thoughts affect our feelings, not external things like people or events. By changing how we think, we can change how we feel and behave.*

Domestic Violence: *Helps students understand what constitutes an abusive relationship and how to develop the skills necessary to resolve conflicts constructively.*

How to Get a Job: *Teaches students the basics of conducting a job search, preparing a resume, and participating in a job interview.*

[20] http://shq.lasdnews.net/pages/tgen1.aspx?id=EBU

Education is a Way of Life: *Offers an overview of how to obtain a basic GED and enroll in college courses, as well as how to access resources available to students, including local libraries and other services in their communities.*

Substance Abuse Education: *This course covers the physiology and psychology of substance abuse, including the effects of drugs and alcohol on the mind and body, and strategies for quitting.*

Leadership Training: Offers the basics of individual and group leadership, including the importance of values, ethics, and attitudes.

Interpersonal Communication: Discusses the interpersonal communication process, including verbal and non---verbal language, conflict management, and causes of miscommunication.

Conflict Resolution: This course focuses on how to manage and resolve interpersonal conflicts, including managing our responses, achieving rapport, taking perspective, and managing emotions.

Anger Management: Helps students understand how to recognize and control emotions, resolve conflicts, and improve interpersonal relationships.

A 2013 evaluation of the Los Angeles County Sheriff's Department EBI program by Dr. James Austin made favorable conclusions about program efficacy and effectiveness:[21]

> *"The initial evaluation of the EBI and more specifically MERIT initiative is generally positive. Field observations of the program at the various facilities where it has been operational show that the program has fundamentally altered the culture and nature of imprisonment within the LASD. These positive observations are also supported by interviews with a representative sample of inmates who are participants in EBI who feel that important services are being provided that should help them prepare for their inevitable release from jail.*
>
> *The quantitative analysis shows that nearly 4,000 inmates are in the EBI program at any given time. These EBI participants are not some "cherry picked" subgroup of inmates, but contains people convicted of violent and non---violent crimes, long and minimal prior records, and extensive drug abuse histories. What does set them apart is a desire to make amends for their crimes and reduce the chances that they will return to jail.*
>
> *The quantitative analysis, field observations and interviews all point to the same central finding that EBI, and MERIT in particular, provides for a very safe place within a sprawling jail system that has had its full share of violence in the past."*

[21] http://www.jfa-associates.com/publications/jss/Evaluation%20of%20EBI_6-24-13.pdf

Findings: LASD EBI is an effective jail-based inmate education program utilizing evidence-based best practices (i.e. cognitive behavioral treatment concepts). Although our research found no empirical studies about LASD-EBI, the Austin Report, combined with its evidence-based foundations, and the professional experience of these Consultants, endorse EBI as an important component of CCTF proposed programming array.

Medication Assisted Treatment (MAT)

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. Medication assisted treatment (MAT) is clinically driven with a focus on individualized patient care.[22]

The integrated programs being proposed also recognize the importance in expanding MAT applications to the non-co-occurring mentally ill CCTF target population. Despite the fact the psychotropic medication is a standard treatment in treated mental illness, MAT provides an added framework from which to integrate mental health and substance abuse treatment services by adopting a "medication assisted recovery" philosophy. [23] [24]

Findings: Medication Assisted Treatment/Medication Assisted Recovery concept is well grounded in the literature as an evidence-based best practice the treatment of inmates with mental illness, substance abuse and co-occurring disorders.

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[22] http://www.dpt.samhsa.gov/patients/mat.aspx

[23] http://www.dpt.samhsa.gov/comor/Co-occuring.aspx

[24] http://www.rsat-tta.com/Files/Trainings/FinalMAT

PROPOSED CCTF BEHAVIORAL HEALTH PROGRAMS

Mental Health Treatment Program – (as proposed by the LAC Department of Mental Health)

The Consolidated Correctional Treatment Facility (CCTF) provides an integrated medical/mental health/substance abuse treatment center as a component of the Jail Plan being developed at the direction of the Los Angeles County Board of Supervisors. The CCTF Mental Health Treatment Program (MHTP) will incorporate best practices in jail mental health care, including optimal facility and integrated program design, curricula and staffing within a safe and secure correctional environment.

A. Overview

Approach

The MHTP will utilize a multidisciplinary team approach to create a therapeutic environment that provides the most effective mental health programming with a focus on group interventions, integration of mental health, substance abuse and medical care, and inclusion of community providers through in-reach activities that foster development of a healthy community to support clients while incarcerated and in their neighborhoods upon release to the community. Emphasis in the MHTP will be on expanded daily programming, with the primary strategies being evidence-based group therapies, integrated care planning and case management beginning at the point of admission to the MHTP to develop and implement realistic plans for housing, benefits/income, mental health care and other necessary services and supports upon release. Best practices in psychopharmacology and medical stabilization in partnership with Los Angeles Sheriff's Department (LASD) pharmacy and Medical Services Bureau (MSB) in addition to the Department of Public Health (DPH) will also be features of the MHTP. In addition, the Department of Mental Health (DMH) will continue to collaborate with LASD and other stakeholders to develop pre- and post-booking jail diversion programs for individuals whose low-level offenses appear to be the result of or associated with their mental illness.

Goals

The goals of the MHTP are to provide a therapeutic environment and individualized services in the clinically least restrictive level of care that stabilize clients' mental illness, engage them in treatment, teach skills and behaviors that optimize functioning in jail and upon return to the community, promote release readiness and community reintegration, and reduce criminal and psychiatric recidivism, in keeping with DMH's mission of "enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency". Emphasis will be placed on ensuring that community re-entry plans are carried out at the time of release. Additional treatment goals include diagnostic assessment, medication evaluation and prescribing with appropriate medical/laboratory

and radiologic studies, development of sufficient client insight to accept oral medications or monthly injections, and stabilization of acute symptomatology to allow safe transition to lower levels of care.

Staff Experience and Training

The MHTP will be staffed by approximately 385 individuals, including JMHS Administration and program management/support staff. Over half will be existing Jail Mental Health Services (JMHS) staff, including psychiatrists, psychologists, social workers, psychiatric nurses, LASD nursing staff, psychiatric technicians, service coordinators, case workers that function as group leaders and case manager/release planners, substance abuse counselors, recreation therapists, other ancillary staff, support and administrative staff. All staff will have met the training and experience requirements for their job classifications as set forth by the Los Angeles County Department of Human Resources. All staff will receive orientation to the new facility and the treatment program, including training in evidence-based group and individual interventions that will be the focus of treatment, as well as training in correctional and safety issues specific to the new facility, provided by LASD.

Ongoing training for MHTP staff will be through in-service trainings at the facility, trainings in evidence-based interventions developed by the DMH Training Bureau specifically for clinicians working in forensic settings, and all other trainings offered by the Training Bureau or other organizations. JMHS currently has staff trained in a number of evidence-based modalities, including Seeking Safety, Cognitive Behavioral Therapy (CBT), WRAP (Wellness Recovery Action Plan), Moral Reconation Therapy (MRT), and Motivational Interviewing. Follow-up mentoring is provided for some of the modalities and training opportunities are repeated annually.

Treatment Programs

The CCTF facility design provides four levels of care for the MHTP: inpatient crisis care, intensive care, outpatient high observation and outpatient step-down.

- Inpatient Crisis Care expands the capacity of the Mental Health Unit of the Correctional Treatment Center (MHU CTC), JMHS' current acute inpatient program, from 46 to 60 beds.
- Intensive Care, a new level of care, adds 200 sub-acute inpatient beds that meet CTC physical plant licensing requirements. Intensive Care is planned to provide flexibility to convert its beds and augment staffing to meet inpatient crisis care requirements should the need arise.
- Outpatient High Observation level of care will expand JMHS' current High Observation Housing (HOH) capacity of approximately 550 beds (400 men and 150 women) to a total of 840 beds. 80%of the beds will be in single cells and 20% in double cells.
- Outpatient step-down level of care will expand JMHS' current Service Area (SA)/Dormitory capacity of approximately 1,550 beds (150 women and 1,400 men) to a total of 2,235 beds. It

should be noted that currently utilization of modules for either HOH or SA level of care is adjusted from time to time to provide care appropriate to the varying needs of the mental health population.

All MHTP levels of care will provide assessment, treatment planning, group and individual interventions, and development and implementation of release plans.

It should be noted that two JMHS programs will not be located in the CCTF. Due to the role the JMHS Inmate Reception Center (IRC) program plays in the LASD booking process, this program will continue to be located in the IRCs for the men's and women's jails. In addition, the Jail Mental Evaluation Team (JMET) program, which provides outreach, crisis intervention and medication management in the general and special population areas of the men's jails will continue to be housed in the jails the program serves.

B. Assessments

JMHS currently utilizes a variety of standardized assessments that will be incorporated in the MHTP. Assessments are individual interventions, to be conducted in areas affording as much privacy as possible within a forensic setting.

Initial Assessment

During the LASD booking process, LASD personnel screen all incoming inmates for medical and mental health issues and refer those that screen positive for mental health issues for further assessment by JMHS clinicians located in the IRCs. All referred inmates are provided an initial assessment to determine whether they require mental health treatment while incarcerated, develop preliminary treatment and release plans, address medication continuity needs and make recommendations to Sheriff's Custody regarding level of care and housing placement. An initial assessment guide is utilized to document the reason for referral, psychiatric history, history of present illness, medical history, mental status examination, diagnosis, initial treatment plan with level of care recommendation, and preliminary release plan.

Full Evaluation

Following admission to an MHTP level of care, a full assessment is completed by the client's assigned clinician, supplementing/adding to the initial assessment done in the IRC and following a similar format. During this evaluation, the clinician also completes a release planning form that places the client in one of three release planning tiers and identifies needed resources based on individual circumstances. A psychiatric evaluation for all clients referred for psychotropic medication evaluation and prescribing is also completed. A multidisciplinary treatment plan is initiated as part of the full evaluation.

Suicide Risk Assessment

In accordance with the JMHS Suicide Prevention Policy and Procedures, all inmates evaluated in the IRC are screened for suicide risk, utilizing the Guidelines for Clinical Assessment of Suicide Risk, also known as the Suicide Risk Assessment Form (SRAF) that is included as a template in the medical record. Subsequent to IRC initial assessment, the SRAF is utilized whenever inmates/clients injure themselves, make threats to harm themselves or engage in other behaviors that indicate potential suicide intent. The SRAF addresses static, slow changing and dynamic risk factors, as well as protective factors, and is also utilized to determine when to remove a client from suicide precautions. Inmates/clients assessed as being at risk for suicide are either placed on Suicide Watch (S status) and admitted to Inpatient Crisis Care on an involuntary basis, or placed on Risk Precaution (RP status) and housed in the Outpatient High Observation level of care, where daily assessment as to suicidality is required. Absent custody safety and security limitations, RP clients will be housed in two-person cells.

Assessment Challenges

- Minimizing false negatives and positives during initial assessment and suicide risk assessment. Some inmates may either attempt to avoid identification (false negative) or to obtain what is perceived as more desirable housing or other secondary gains by incorrectly reporting or exaggerating history and symptoms (false positive)
- Assessing clients with co-occurring mental health and substance use disorders, including those undergoing substance withdrawal
- Severity of a client's mental illness that precludes thorough assessment
- Clients' inability and/or unwillingness to access available/offered services
- Safety issues

To address these challenges, ongoing in-service training on assessment and suicide prevention will be offered as the system evolves, and clinicians' access to information systems related to mental health treatment in the jail and in the community will be maximized to the extent possible.

C. Treatment Planning

JMHS currently utilizes a treatment plan template that provides standardized options plus a section to enter individualized problems, goals and interventions. This format will be modified to include measurable outcomes (behavioral changes); the specific group interventions agreed upon with each client; and release planning needs and planned interventions. There will be the expectation that every client is a participant in developing his/her treatment plan. Multidisciplinary treatment teams that include Custody, MSB and DPH personnel will meet regularly and be responsible for monitoring

progress and meeting with clients to modify treatment plans when indicated. Treatment planning activities require space for individual and treatment team interventions with clients, as well as for the regular team meetings.

D. Interventions

The MHTP's primary treatment approach will be evidence-based group interventions, organized into Tracks that are tailored to the acuity levels and usual lengths of stay for the various levels of care in which the groups are offered. Groups will be led by various disciplines, dependent upon the topic, including but not limited to psychiatrists, psychologists, social workers, psychiatric technicians, recreational and rehabilitation therapists, substance abuse counselors and medical case workers. Size and duration of the groups will vary in accordance with the group topic and the acuity level of the clients attending the group. Blocks of time will be reserved for group interventions for at least two hours in the mornings and two hours in the afternoons, six days per week. The following table summarizes the group offerings for the three Tracks.

Summary of Track Offerings

	Level of Acuity	Length of Stay	Therapeutic Intervention/Curriculum
Track 1	High (MHU CTC, HOH)	Short- Variable	a. Recreational Therapy b. Occupational Therapy c. Topic-specific, Brief Small Groups (substance abuse, medication management, financial benefits, adjustment to incarceration) d. Psycho-educational Groups e. Release/Re-entry Planning f. Community Meetings
Track 2	Medium (Outpatient Step-down/SA)	Short-Variable	a. Seeking Safety (core strategy) b. Motivational Interviewing c. Substance Use Interventions d. Wellness Recovery Action Plan (WRAP) e. Release/Re-entry Planning f. Community Meetings
Track 3	Medium (Outpatient Step-down/SA)	Long (AB 109 clients)	a. Seeking Safety (core strategy) b. Motivational Interviewing c. Substance Use Interventions d. WRAP e. CBT (Depression, Insomnia) f. Moral Reconation g. Release/Re-entry Planning h. Community Meetings

Cognitive Behavioral Therapy (CBT) is intended to assist people with becoming conscious of their thoughts and behaviors and then make positive changes to them. CBT addresses several problems linked to offenders' behavior, e. g., problem solving, critical reasoning, moral reasoning, self-control and impulse management. As such, CBT is the basis for the majority of evidence-based group interventions that will be utilized in the MHTP including the core strategy, Seeking Safety; MRT, Motivational Interviewing and WRAP. These interventions are provided in group settings and reinforced individually. In some instances, homework will be utilized as a way to measure motivation for change and reinforce concepts learned during group time.

Gender – Specific Programming

The MHTP will also provide gender-specific group interventions such as classes on family planning, pregnancy/pre-natal care (in collaboration with MSB OB/GYN clinic), child care and development, accessing community resources, and domestic violence.

Community In-reach

In order to facilitate engagement with mental health care and other providers in the community, address community readiness and build a health neighborhood within the jail and in the community, in-reach groups are also planned for the MHTP. In addition to mental health care providers, representatives from the Veterans Administration, faith-based organizations, homeless/housing services, and vocational/employment services will be invited to co-facilitate groups.

Individual Interventions and Multidisciplinary Team Meetings

Individual interventions will include, but not be limited to initial evaluations and treatment planning, individual treatment, medication evaluation and prescribing, crisis intervention, benefits re-establishment and release planning. Multidisciplinary team meetings will be scheduled regularly at frequencies determined by the various levels of care.

E. Release Planning

The MHTP will place a strong emphasis on release planning, utilizing JMHS' current release planning process that assigns clients to one of three tiers for release planning purposes:

- Tier 1 – clients that require intensive, comprehensive planning; includes clients requiring mental health conservatorships
- Tier 2 – clients that require moderate release planning assistance; includes clients requiring assistance with obtaining adult residential care, residential treatment, Full Service Partnership enrollment
- Tier 3 – clients that require minimal assistance; have viable release plans for housing, mental health treatment and income/benefits

A release planning form is completed by the client's clinician or release planner during the evaluation and treatment planning process. The form is utilized to document the client's assignment to a release planning tier, the resources the client has in place, and the needed resources. The clinician or assigned release planner then works with the client to obtain needed resources, documenting all activities and plans in the release planning section of the medical record. Treating psychiatrists currently write release prescriptions for the medications the client is receiving at release; this will be done

electronically for the MHTP. Upon release, the client's clinician, or an IRC clinician if an after-hours release, is able to access the release plan and assist the client in implementing the plan. The MHTP will emphasize the importance of successful community re-entry by ensuring that an assigned clinician or release planner functions as case manager for release planning purposes throughout a client's incarceration. DMH also plans to place a psychiatrist, three release planners and two drivers in the Sheriff's IRC Release Center to ensure that needed resources are in place at the time of release and that clients are assisted in accessing them.

F. Treatment Programs – Levels of Care

Inpatient Crisis Care

The MHU CTC, licensed as part of the jail's Correctional Treatment Center, provides the MHTP's highest level of care, psychiatric inpatient crisis care. The MHU CTC is Lanterman-Petris-Short (LPS) designated in accordance with Welfare and Institutions Code, Section 5150 et. seq. to provide involuntary treatment to clients/patients that are dangerous to self or others and/or gravely disabled due to a mental disorder. The MHU CTC will have two nursing units with single cells for 30 patients per unit.

Focus of treatment will be on Track 1 group interventions that will be offered during two hours in the morning and two in the afternoon, six days per week. Rehabilitative and recreation therapists will provide the core services for gradual engagement and socialization, initially one-to-one and then advancing to small groups (2-4) and regular groups (6-8). Topic-specific, psycho-educational and release planning groups will be facilitated by therapists (psychologists and social workers) for patients that have advanced to that level of group activity. There will be a higher percentage of individual interventions in the MHU CTC than in the lower levels of care. All patients receive an assessment upon arrival by nursing staff for acute/emergent needs, level of monitoring and need for any safety precautions. Patients are evaluated by a psychiatrist on arrival or no later than 24 hours after admission and screened by a CTC physician or licensed medical practitioner to exclude the presence of an untreated medical cause for disordered behavior and to identify any other medical illnesses that will require treatment while in the MHU CTC. Nursing staff provide daily care and patients are seen regularly by their therapists for diagnostic assessment, evaluation of LPS involuntary status, evaluation and initiation of multidisciplinary treatment plans, individualized treatment and release planning. Multidisciplinary treatment teams make daily rounds to discuss each patient and meet formally as a treatment team on a weekly basis. The goal is to have patients out of their cells and involved in individual or group interventions whenever possible.

Intensive Care

This 200-bed level of care is designed to be CTC licensable as sub-acute inpatient care, providing flexibility should there be a need in the future for more licensed beds. Housing will be organized in

50-bed pods. Current plans are to initially utilize 100 beds for inmates with co-occurring mental health and substance abuse disorders (COD), and 100 beds for inmates with cognitive or behavioral disorders. Group interventions will be offered during two hours in the morning and two in the afternoon or evening. Staff will also provide individual interventions, including but not limited to medication evaluation and prescribing, crisis intervention, and release planning. It is anticipated that the Cognitive Disorders program will provide an alternative for long-term MHU CTC patients with cognitive or behavioral issues that currently cannot be successfully managed at lower levels of care.

Outpatient High Observation Care

Outpatient High Observation, the most intensive level of outpatient mental health care, will house 840 clients in pods of 50 beds each. This level of care is for clients that require intensive observation and care including risk precautions, but do not require hospitalization. The treatment approach is to facilitate active participation in the least restrictive environment by providing as much out of cell treatment as possible in order to enable clients to transfer to lower levels of care within the jail and to link to community services and supports upon release. Treatment goals are to provide hope and recovery, thereby reducing criminal and psychiatric recidivism. Focus of treatment will be on Track 1 group interventions that will be offered for two hours in the morning and two in the afternoon, six days per week. These interventions are intended for clients with high level acuity and short and variable lengths of stay in the Outpatient High Observation. Due to the level of acuity, for the most part group capacity will be 5 to 10 clients, and group duration will vary from 30 to 60 minutes. Staff will also provide individual interventions, including but not limited to initial evaluations and treatment planning, medication evaluation and prescribing, crisis intervention, benefits re-establishment and release planning.

Among the Outpatient High Observation clients are those that are refusing psychiatric medication, including offenders that have been adjudicated incompetent to stand trial. JMHS provides competency restoration services for clients charged with misdemeanors through its Misdemeanor Incompetent to Stand Trial (MIST) program, including a medication administration program that provides for court authorized medications. JMHS is currently exploring legal avenues to also provide medication pursuant to a court order for felony incompetents that are pending transfer to a State hospital for competency restoration services. Specialized individual and group interventions will also be provided these clients with the goal of achieving voluntary compliance with court authorized medications.

JMHS has recently initiated a tele-psychiatry program that currently serves a limited number of inmates incarcerated at Pitchess Detention Center. Tele-psychiatry accommodations for the treating psychiatrists will be located in the CCTF, most likely in the High Observation area.

Outpatient Step-down

The Outpatient Step-down level of care will serve clients with a broad range of mental health diagnoses and functioning, whose mental health needs can be cared for in a less intensive and more open setting than the High Observation level of care, but preclude their tolerating general population housing. Treatment goals are stabilizing the mental illness; engaging clients in treatment for mental health and co-occurring substance use disorders; and immediately beginning to develop and/or solidify release plans for housing, mental health care, access to benefits, employment or education; and connecting or reconnecting with families and other community supports. The treatment strategy is to provide as much group treatment as logistically possible to alleviate symptoms, enhance functioning, prevent relapse and prepare clients to return to their communities and avoid jail or psychiatric recidivism. Groups will be available for at least two hours in the morning and two in the afternoon, six days per week. For the most part, group capacity will be 12 – 15 clients and group duration will be 45 to 60 minutes.

Track 2 and Track 3 group interventions will be provided, with Seeking Safety as the core group intervention. Track 2 interventions are intended for clients with medium level acuity and short and variable lengths of stay, while Track 3 interventions will be utilized for clients with longer lengths of stay - primarily clients incarcerated under the provisions of Assembly Bill 109, the Public Safety Realignment Act. Staff will also provide individual interventions, including but not limited to initial evaluations and treatment planning, medication evaluation and prescribing, crisis intervention, benefits re-establishment and release planning.

By providing a continuum of care, integrated with medical and substance abuse treatment and incorporating best practices in mental health care, the MHTP is designed to enable incarcerated individuals to achieve community re-integration, recovery and wellness.

Substance Abuse Treatment Program – (as proposed by the LAC Department of Public Health)

The County of Los Angeles (county), Department of Public Health - Substance Abuse Prevention and Control (DPH-SAPC) has the primary responsibility of administering contracts and program oversight of Substance Use Disorders (SUD) services throughout the county. DPH-SAPC directly operates the Antelope Valley Rehabilitation Center, a 300-bed residential treatment facility for both males and females. DPH-SAPC's mission is to reduce community and individual problems related to alcohol and drug abuse through evidence-based programs and policy advocacy.

The criminal justice system in Los Angeles County continues to be driven by problems associated with alcohol and/or other drugs. Serving a jurisdiction of 10.4 million people, 88 cities and approximately 140 unincorporated areas[1], this system is the largest and most complex in the nation. The Los Angeles County Sheriff's Department (LASD) manages the largest jail population with nearly 19,000 inmates housed in eight county jails. The average inmate population has increased due to a substantial number of Non-serious, Non-sexual, Non-violent (N3) offenders returned from state prisons to local jails to serve the remainder of their terms as mandated under Assembly Bill 109.

To address the needs of inmates, the Los Angeles County Jail Plan prepared by Vanir Construction Management Inc., proposes to replace one tower of Men's Central Jail with a Consolidated Correctional Treatment Facility (CCTF) that will provide integrated medical, mental health and SUD treatment services in one location. Providing integrated treatment services in-custody provides inmates the opportunity to address specific health needs in a controlled environment and can assist in reducing criminal recidivism and jail costs.

The U.S. Department of Health and Human Services-Substance Abuse and Mental Health Services Administration (SAMHSA) have long supported the concept that integrated behavioral health is a necessary component of treatment that can improve individual and overall public health[3]. Integrated treatment services are currently limited in the county jail system and as a result the health and wellness of inmates are not adequately met. Untreated mental health and SUD conditions impose high recidivism rates and place a burden on prisons and jails in addition to healthcare delivery systems when inmates are released into the community.

DPH-SAPC will oversee the SUD treatment program at the CCTF include 500 dedicated beds. Treatment services will incorporate Evidence-based Practices (EBPs) specific to inmates with SUD in three severity levels: 1) Level 1 – Clinically Managed Low Intensity; 2) Level 2 – Clinically Manage Medium Intensity; and 3) Level 3 – Clinically Managed High Intensity.

II. TARGET POPULATION

The target population is comprised of Los Angeles County jail inmates that have an extensive history of criminal activity and a severe SUD and are at high risk for recidivism. SUD treatment and recovery services are to be provided during in-custody jail sentences to adult inmates age 18 and older. Proper treatment services for this population will reduce costs associated with inmate incarceration. The target population may include elderly inmates, inmates with a history of trauma, inmates with disabilities, inmates with co-occurring disorders classified as low level mental health and high SUD, and inmates with long-term medical conditions (i.e., HIV/AIDS, Tuberculosis, and Hepatitis).

III. GENERAL ADMISSION CRITERIA

Admission to CCTF SUD treatment shall be limited to those inmates who meet the following criteria:

1) Post-plea convicted inmates serving county jail time, with a minimum of two year sentences

2) N3 offenders

3) Inmates with a low mental health diagnosis and high SUD Axis I diagnosis

4) Inmates determined suitable for SUD with at least a score of six or above on the Addiction Severity Index (Attachment I), and the American Society of Addiction Medicine (ASAM) placement criteria.

IV. STAFF EXPERIENCE CAPABILITIES AND COMPETENCIES

CAPABILITIES AND COMPETENCIES

DPH-SAPC maintains the primary responsibility for administering the county's complex range of alcohol and drug programs and meets county, state, and federal regulations through the promotion, development, and maintenance of a comprehensive network of programs that respond to community needs, public policy, and regulatory requirements. DPH-SAPC currently maintains over 400 active contracts with over 180 community-based treatment and support organizations, and successfully monitors compliance with contract requirements for all of these entities.

Program Staff: DPH-SAPC staff will direct and manage delivery of SUD treatment services at the CCTF. DPH-SAPC administrative and clinical personnel will direct and manage the overall program. The following is the level and classification of staff for this program:

Level of Staff

- 1 Center Program Manager
- 2 Assistants Center Program

- 1 Rehab Therapy Chief
- 1 Staff Analyst, Health
- 1 Research Analyst III
- 5 Supervising Rehabilitation Counselors
- 2 Secretary II
- 2 Staff Assistant II
- 2 Senior Typist Clerks
- 25 Substance Abuse Counselors
- 10 Assistant Substance Abuse Counselors
- 1 Recreation Therapist I
- 3 Recreation Therapist Aides
- 1 Licensed Clinical Social Worker Supervisor I
- 3 Licensed Clinical Social Workers

V. &PURPOSE, TOOLS – SCREENINGS AND ASSESSMENT, GOALS AND SAMPLE FORMAT

Screening: Proper screening is critical for identifying inmates who are struggling with a SUD. The screening process is designed not only to collect information on SUD needs, but also to begin the process of determining eligibility/suitability for SUD services and explore additional needs to facilitate prompt entry into appropriate treatment services. DPH-SAPC staff will conduct initial screenings to identify potential inmates for housing at the CCTF. Staff will utilize the following SAMHSA Tip 445 recommended screening instruments geared towards the criminal justice population:

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment is a comprehensive and integrated approach to the delivery of early intervention and treatment services for persons with SUD, as well as those who are at risk of developing these disorders. Inmates with low or moderate substance use risk will receive a brief intervention while in-custody, and those high substance use risk will be referred to a community-based treatment provider.

Simple Screening Instrument for Substance Abuse

Simple Screening Instrument for Substance Abuse (SSI-SA) is a routine screening for substance abuse will be used to initiate the process of assessment by identifying inmates SUD needs. The SSI-SA is a 16 item screening instrument that examines symptoms of both alcohol and/or drug dependence. SAMHSA recommends using this tool to identify the largest number of inmates who

need treatment. The screening tool is designed to be broad in its detection of inmates who have a potential SUD, and covers a range of drugs.

Clinical Assessment

Within 30 days from screening, inmates will be assessed for suitability into the CCTF SUD program. DPH-SAPC staff will clinically assess the severity of the SUD and determine the appropriate level of treatment. Through structured inmate interviews and validated assessment instruments, the goal is to obtain information on support systems, medical illnesses, risk needs, and criminogenic factors. The assessment process will identify inmates with severe, chronic substance abuse and mental health disorders and other psychosocial problems for participation in the proposed treatment services.

American Society of Addiction Medicine

The ASAM is a comprehensive guideline for placing individuals in substance abuse treatment. These placement criteria are widely used for individuals with SUD or co-occurring disorders. The criteria are developed to address the inmate's needs, challenges, and susceptibilities. The six dimensions are the following: 1) Acute Intoxication and/or Withdrawal Potential, explores the inmate's past and current substance use and withdrawal; 2) Biomedical Conditions and Complications, explores the inmate's health history and current physical health; 3) Emotional, Behavioral, or Cognitive Conditions and Complications, explores the inmate's cognitions, emotions, and mental health issues; 4) Readiness to Change, explores the inmates readiness to change; 5) Relapse, Continued Use, or Continued Problem Potential, explores the inmate's relapse history and continued substance use or problems; and 6) Recovery/Living Environment, explores the inmate's recovery or living situation, his/her social circle, environment and possessions. ASAM Criteria are objective and designed to remove the "guesswork" out of the placement process.

Addiction Severity Index

The Addiction Severity Index (ASI) is a semi-structured interview designed to address seven potential problem areas in substance abusing inmates: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. The ASI provides an overview of problems related to substance, rather than focusing on any single area. The ASI is a commonly used assessment instrument in the substance abuse treatment field. Staff may use the ASI in inpatient and outpatient substance abuse treatment settings to assess problem severity and need for treatment. The ASI has become the standard assessment instrument used in most substance abuse treatment program throughout the United States.

Criminogenic Needs Assessment

Criminogenic needs are aspects of an individual's situation that when altered, are associated with changes in criminal behavior. Criminogenic needs may be understood as contributing towards criminal behavior and if effectively addressed, should decrease level of risk. DPH-SAPC will use the criminogenic needs assessment to determine needs in areas as substance abuse, antisocial attitudes, personality traits, associates, employment, marital and family relationships and other theoretical issues that have been shown to be correlated with criminal conduct and amenability to change. The following criminogenic needs assessments tool will be utilized:

Global Appraisal of Individual Needs

The Global Appraisal of Individual Needs (GAIN) covers background, substance abuse, physical health, risk behaviors and disease prevention, mental/emotional health, environmental/living situation, legal, and vocational. GAIN addresses problems, services, attitudes, beliefs, and desire for services. GAIN also collects information on recent problems, breadth of symptoms, recent prevalence lifetime service utilization, recent utilization, and the frequency of utilization.

VI. EVIDENCE-BASED PRACTICE MODELS AND INTERVENTIONS

The SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) outlines nationally recognized EBP identified to meet the needs of the SUD population. These EBP's have been shown to provide positive outcomes including, but not limited to, increased treatment engagement, program retention, and behavior modification. In selecting appropriate treatment activities for inmates, the treatment team will review inmates in the context of their culture, ethnicity, socioeconomic status, gender, age, sexual orientation, spiritual orientation, and any physical or cognitive disabilities, and recommend the appropriate EBP's to meet the needs of the inmate.

The following descriptions were obtained from the NREPP website:

1. Interactive Journaling

Interactive Journaling is a goal-directed, client-centered model that aims to reduce substance abuse and substance-related behaviors, such as recidivism, by guiding adults and youth with substance use disorders through a process of written self-reflection. The model is based on structured and expressive writing techniques, principles of motivational interviewing, cognitive-behavioral interventions, and the integration of the trans-theoretical model of behavior change. The approach helps participants modify their behavior as they progress through the stages of change that underlie the trans-theoretical model: 1) pre-contemplation (not intending to begin the change in behavior in the next 6 months); 2)

contemplation (intending to begin the change in behavior in the next 6 months); 3) preparation (intending to begin the change in behavior in the next 30 days); 4) action (practicing the behavior for less than 6 months); and 5) maintenance (practicing the behavior for at least 6 months).

2. Matrix Model

The Matrix Model is an intensive outpatient treatment approach for stimulant 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. Patients 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 therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. The program includes education for family members affected by the addiction.

3. Motivational Interviewing

Motivational Interviewing (MI) is a goal-oriented, inmate-centered counseling style for facilitating behavior change by helping inmate to resolve ambivalence across a range of problematic behaviors. MI uses an empathic and strategic approach in which the therapist provides feedback that is intended to strengthen and consolidate the inmate's commitment to change and promote a sense of self-efficacy. MI aims to elicit intrinsic motivation to change substance abuse and other behaviors by evoking the inmate's own motivation and commitment to change, responding in a way that minimizes defensiveness or resistance.

4. Moral Reconation Therapy

Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal inmates by increasing moral reasoning. The cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of three to six months.

5. **Seeking Safety**

Seeking Safety is a present-focused treatment for inmates with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female inmate, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psycho-education and has five key principles: 1) safety as the overarching goal (helping inmate attain safety in their relationships, thinking, behavior, and emotions); 2) integrated treatment (working on both post-traumatic stress disorder (PTSD) and substance abuse at the same time); 3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; 4) four content areas: cognitive, behavioral, interpersonal, and case management; and 5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

6. **Twelve-Step Facilitation Therapy**

Twelve Step Facilitation Therapy (TSF) is a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse, alcoholism, and other drug abuse and addiction problems. TSF is implemented with individual inmates over 12 to 15 sessions. The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These principles include acknowledging that willpower alone cannot achieve sustained sobriety, that surrender to the group conscience must replace self-centeredness, and that long-term recovery consists of a process of spiritual renewal. Therapy focuses on two general goals: 1) acceptance of the need for abstinence from alcohol and other drug use and 2) surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. The TSF counselor assesses the inmate s alcohol or drug use, advocates abstinence, explains the basic 12-step concepts, and actively supports and facilitates initial involvement and ongoing participation in AA. The counselor also discusses specific readings from the AA/NA literature with the inmate, aids the inmate in using AA/NA resources in crisis times, and presents more advanced concepts such as moral inventories.

In addition to the EBP's outlined above, the program will use specific cognitive behavioral approaches that have demonstrated effectiveness with clients having long criminal justice histories and long-term SUD dependence. The following EBP's have been identified as appropriate for the criminal justice population:

1. **Aggression Replacement Training**

   Aggression Replacement Training® (ART®) is the work of Barry Glick and Arnold Goldstein. ART® responds to characteristics frequently observed in juvenile delinquent population, namely, high levels of inappropriate acting out behaviors combined with deficient prosocial skills.

Such youth are proficient fighters, bullies, and intimidators, but generally are acting out rejection and anger. The 10-week core ART® curriculum has three components: Skill streaming, Anger Control Training, and Moral Education.

2. **Thinking 4 Change**

Thinking for a Change is an innovative, evidence-based cognitive behavioral curriculum from the National Institute of Corrections (NIC) that has broadly influenced the correctional field and the way correctional facilitators work with offenders and inmates. The program can be delivered to inmates by trained facilitators. Studies have shown that, when implemented with integrity, it can reduce recidivism among inmates.

VII. IN-CUSTODY SUBSTANCE USE DISORDER PROGRAMMING -PURPOSE AND METHODOLOGY

DPH-SAPC will implement in-custody SUD treatment services encompassing treatment delivery. The program will be staffed by SUD treatment and mental health personnel who will provide a planned regimen of care in a 24-hour setting. The following are designated program levels:

Level 1 – Clinically Managed Low Intensity – Is directed towards applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the community, educational setting, and family life. Inmates in Level 1 may be in treatment is for those with less severe substance use problems and with greater social support and resources. Those who benefit from this level of treatment have some stability in their lives such as housing and employment.

Level 2 – Clinically Managed Medium Intensity – Provides a higher treatment level than traditional Low Intensity treatment in a structured, recovery environment. It is combined with clinical services to support recovery from SUD. The inmate's SUD is so significant, and level of impairment is so great, where outpatient, and or relapse prevention strategies are not feasible or effective. The functional deficits seen in Level 2 are primarily cognitive and can be either temporary or permanent. When assessment indicates that the subject inmate is no longer cognitively impaired he/she can be transferred to more intensive or less intensive levels of care.

Level 3 – Clinically Managed High Intensity – Is designed for treating inmates who have significant social and psychological needs and require a safe environment for stabilization, intensive treatment, and an intensive recovery. The goals of Level 3 treatment are to treat SUD and antisocial behavior, and effect a global change in inmates' lifestyles, attitudes, and values. Appropriate inmates for this level have substance –related disorders, criminal activity, psychological disorders, impaired functioning, and/or disassociation with

mainstream values.[9] These inmates may involve serious and persistent Axis I Disorders, e.g., schizophrenia, bipolar disorder, and major depression, or Axis II personality disorders.

VIII. BEHAVIORAL CHANGE PLANS - INTAKE AND DISCHARGE TREATMENT PLANNING

Treatment is in a 24-hour setting where recovery services and/or specialized recovery services are made available to inmates who have a diagnosable SUD. Program inmates are to be involved in no less than six (6) hours of planned treatment and recovery activities, in addition to set aside time for outdoor activities per day under the supervision of trained staff (Attachment II-sample daily schedule). A framework will be provided that prioritizes treatment services for inmates based on the length of stay. The following represents the intake and discharge planning process:

Individualized Treatment Plans - Based on the SAMHSA's Treatment Improvement Protocol (TIP) 44, *Substance Abuse Treatment for Adults in the Criminal Justice system,* treatment planning is a collaborative process that requires an inmate and his or her service team to work together to complete a comprehensive assessment, consider assessment information, set individual goals, and specify the means by which treatment can help the inmate achieve those goals. This client-centered approach to treatment will ensure that SUD treatment addresses each inmate s issues related to age, race, ethnicity, culture, language, disability, literacy, and gender (Attachment III-Sample treatment plan).

Comprehensive Case Management **-** Based on SAMHSA's TIP 27, *Comprehensive Case Management for Substance Abuse Treatment,* effective case management will address not only the inmate's SUD needs, but also the health and social services needs to fully enhance the treatment continuum. Case management and coordination is not only based on individual needs, but also specific populations. TIP 27 discusses case management in the criminal justice population as an opportunity to merge two different systems, treatment and criminal justice, into a comprehensive strategy to reduce drug use and criminal activity.

Care Coordination **-** The care coordination will include the operations of the criminal justice and treatment system to work collaboratively based on the agreement of the inmate and the program protocols that define how each will manage the inmate. A coordinated effort will include a multi-disciplinary response that will take advantage of the wide range of treatment and rehabilitation options. The care coordination will include an assessment of the inmates' strengths, weaknesses, needs and the ability to remain crime and drug free, monitoring and reporting progress, and providing inmates with legal, social service, and medical systems in response to their needs.

Treatment Discharge **-** The inmate will receive a comprehensive treatment and discharge plan that will describe what treatment the inmate requires, both in and out of jail. The treatment plan will include how the inmate will be connected with treatment and services in

the community upon release. The discharge plan will be given to the inmate and will explain their health and service needs are and how the inmate can access services after release. The discharge planning process occurs while the inmate is still incarcerated, and prepares the re-entry into the community. The discharge plan will `include an estimated discharge date, programs that the inmate has completed in prison, and medical records, and attempt to line up a post-release residence, medical and mental health care providers, and other community-based services for the inmate (Attachment IV-Sample discharge plan). The following outlines specific SUD treatment services to be provided:

Level 1 – Clinically Managed Low Intensity

Maximum duration of treatment is 60 days: services to be provided include, but not limited to:

1. Intake, orientation, and evaluation using evidenced-based SUD assessment tool, e.g., Addiction Severity Index
2. Minimum of six (6) hours of planned treatment and recovery activities per day under the supervision of trained staff
3. Individual, and group counseling sessions, including alcohol and other drug education, at a maximum of five (5) sessions per week
4. Participation in self-help meetings, at three (3)/week
5. Individualized treatment planning as appropriate (e.g., perinatal and special needs).
6. Random, observed drug testing, as clinically justified

Level 2 – Clinically Managed Medium Intensity

Maximum duration of treatment is 90 days: services to be provided include, but not limited to:

1. Intake, orientation, and evaluation using SUD and Criminogenic Assessment tools
2. Minimum of six (6) hours of planned treatment and recovery activities per day under the supervision of trained staff
3. Participation in self-help meetings at five (5) per week
4. Individualized treatment planning as appropriate (e.g., perinatal and special needs)
5. Random, observed drug testing, as clinically justified

Level 3 – Clinically Managed High Intensity

Maximum duration of treatment is 90 days: services to be provided include, but are not limited to:

1. Intake, assessment, and treatment plan development
2. Minimum of six (6) hours of planned treatment/recovery services per day

3. Participation in five (5) self-help meetings per week
4. Random, observed drug testing, as clinically justified
5. Intervention services
6. Two hours case management per month
7. Relapse prevention
8. Skills development

Mental health treatment is integrated into Level 3 treatment. Specific services to be provided to the COD population:

1. Comprehensive assessment
2. Individual psychotherapy at least 1 time a week
3. Monitor and manage psychotropic medication
4. Provide short-term therapeutic interventions
5. Customize intensive treatment plan
6. Develop specific recovery goals
7. Case Conferences and Discharge planning
8. Case management
9. Group therapy 3 times a week
10. Psychiatry

The implementation of the SUD treatment component at the CCTF will build on existing rehabilitation efforts of LASD. Currently LASD operates Education Based Incarceration (EBI) programs throughout all eight county jails. The goal of EBI is to evaluate and assess educational and trade skills of all inmates, provide an educational system for inmates to further enhance these skills to reduce the likelihood of recidivism upon release from incarceration. EBI offers the Maximizing Education Reaching Individual Transformation program which includes a variety of programs including: adult basic education, behavior modification programs, life skills, computer skills and job preparedness.

IX. COMMUNITY RE-ENTRY PLAN

Treatment engagement while in custody can promote successful re-entry to the greater community upon release. For inmates completing their sentences and transitioning out of an in-custody setting, the coordination and collaboration between DPH-SAPC and contracted community-based organizations will build a stronger transitional support system. DPH-SAPC's Community Assessment Services Center (CASC) will assess and refer inmates to needed services within the Community Recovery and Reintegration Center immediately after release by linking them to appropriate community-based treatment. Available SUD treatment services include the following:

1. **Alcohol and Drug Free Living Center (Sober Living)**

Alcohol and Drug Free Living Centers (ADFLCs) are housing facilities where participants recovering from alcohol and drug problems reside. ADFLCs are living environments where the presence of or use of alcohol and drugs, other than prescribed drugs, is prohibited. ADFLCs provide an opportunity for residents who have re-entered or are preparing to re-enter the labor force to pursue their own personal plan for recovery in an alcohol and drug free atmosphere, removed from normal social pressures and temptations to drink alcoholic beverages and abuse drugs. No direct treatment services are provided. However, residents of ADFLCs participate in an offsite treatment program. The residents often function as a mutually self-supportive group, reinforcing each other's efforts to remain alcohol and drug-free, and may attend 12-step groups and other related activities outside the facility. Residents share in the responsibilities of house maintenance, food purchase and preparation, and development of house rules.

2. **Medication Assisted Treatment/Narcotic Treatment Program**

Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorder. MAT is clinically driven with a focus on individualized patient care. Program participants (including, but not limited to, homeless persons) must be 16 years or older deemed eligible for medication assisted treatment. Those who are between the ages of 16 and 18 require consent of parents or guardians. The minor must sign a consent form whereby he/she agrees that the treatment agency may contact his/her parent(s), caregiver, or guardian regarding the minor's history and that the agency may disclose to the parent(s), caregiver, or guardians that he/she is participating in a treatment program and is being referred for medication-assisted treatment.

3. **Outpatient Counseling Services**

Outpatient Counseling services are those alcohol and drug treatment and recovery services which are provided in a drug-free, non-drinking environment, directed towards alleviating and/or preventing alcohol and drug problems among individuals, or participants, pregnant and parenting women and their children, families, specific population groups, or the general community, which does not require residency at a provider s facility as part of the treatment and recovery process. Services include crisis intervention, individual/group/family counseling, urinalysis testing, case management, and referrals for ancillary services along with coordinated medical and mental health services. Services may also include referral of a participant for medical detoxification services, residential and recovery house services, methadone treatment program services, psychiatric services, or other treatment services deemed appropriate by Contractor.

4. **Outpatient Narcotic Treatment Program Detoxification Services**

Outpatient narcotic treatment program detoxification services are those substance use disorder treatment services which provide for the administering or furnishing of methadone, as a substitute narcotic drug, in decreasing dosage levels for a period not exceeding 21 days, in order to allow a patient who is dependent on heroin or other morphine-like drugs to withdraw from the use of such addicting drugs such outpatient detoxification treatment services shall be conducted in conjunction with an organized and coordinated program to aid the patient in altering his/her drug dependent life style, and to eventually eliminate dependency on drugs.

5. **Narcotic Treatment Program Services**

Narcotic treatment program services are drug treatment services which provides for the administration of methadone and/or levoalphacetylmethadol (LAAM), at relatively stable dosage levels for a period in excess of twenty-one (21) days, as an oral substitute narcotic drug accompanied by an ancillary social and medical services for individuals (including, but not limited to, homeless persons) eighteen (18) years or older who have a history of two (2) or more years of dependence on heroin or other morphine-like drugs, and two (2) or more failures in alternative treatment programs.

6. **Residential Medical Detoxification Services**

Residential Medical Detoxification services are services directed towards the care and treatment of persons including, but not limited to, homeless persons suffering from the toxic effects of narcotics and/or dangerous drugs. Once a participant is admitted for detoxification, medical staff should perform a comprehensive assessment to determine the level of prior and recent use and to determine the level of substance abuse and dependence. These services shall be conducted within a facility licensed and approved by the State of California, Department of Health Care Services in accordance with current federal and State standards for such facility (ies).

7. **Residential Treatment Services**

Residential Treatment is a twenty-four (24) hour residential program where recovery services, and/or specialized recovery services are made available to persons who have alcohol and/or drug problems. Program participants are to be involved in no less than six (6) hours of planned treatment and recovery activities per day under the supervision of trained staff. Specialized recovery services may include therapeutic intervention by professional staff such as Licensed Clinical Social Workers and Marriage and Family Therapists. The alcohol and drug residential services program is an accessible resource to the community for information about alcohol and drug related issues, referrals to appropriate alcohol and drug services, and opportunities for volunteer activity.

X. GENDER-SPECIFIC TREATMENT

Gender-specific treatment either in prison or in a community setting should have a positive impact on the recovery process. Although men make up the majority of inmates, gender-specific treatment takes into account the fact that men and women have vastly different physical and emotional responses to SUD and require treatment to meet the specific needs of their gender.

Additionally, research on gender-specific treatment has explored how gender affects the different stages of the treatment processes including the following: 1) initiation to treatment; 2) treatment engagement; 3) continuation in treatment; and 4) completion of mandated treatment program services. Gender-specific treatment (i.e., in-custody treatment) should establish appropriate relapse prevention strategies and prepare inmates for later stages of recovery.

Male Specific Treatment

Treatment concerns with male inmates often center on: 1) fathering; 2) violence, often against loved ones; 3) child custody; 4) lack of job training skills to maintain a crime-free lifestyle; 5) risky sexual behavior; 6) suicide; 7) depression; 8) trauma; 9) other health problems, including cancer and HIV and 10) Sexually Transmitted Diseases (STD).

A main challenge to the male inmate population is to understand that these males have difficulty establishing healthy relationships which can hinder treatment engagement if not properly addressed. Effective treatment should engage males in learning interpersonal skills that will not only aid in the therapeutic process, but also assist in developing positive relationship skills. Treatment programming specific to the male population may result in lower recidivism rates, encourage sobriety and ultimately promote better public health.

Female Specific Treatment

Treatment concerns with female inmates often center on: 1) pregnancy; 2) immediate risks for self-harm, suicide, and violence; 3) past and present mental disorders, including Post-Traumatic Stress Disorder (PTSD) and other anxiety disorders, mood disorders, and eating disorders; 4) past and present history of violence and trauma, including sexual victimization and interpersonal violence and 5) health screenings, including HIV/AIDS, hepatitis, tuberculosis, and STDs.

Women face many difficulties in accessing SUD treatment services and also require specific needs while in treatment. According to SAMSHA 34 percent of women needing SUD treatment could not cover treatment costs due to inadequate or nonexistent health insurance. Barriers to accessing treatment include low economic status, need to fulfill the role of primary caretaker for minor children, a greater frequency of trauma and the social stigma of SUD.

XI. & CONFIDENTIALITY /COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996:

Health Insurance Portability and Accountability Act (HIPAA) requires a covered entity to protect Patient Health Information (PHI) from unauthorized disclosure for any purpose not permitted in the HIPAA Privacy rule. DPH-SAPC is a covered entity and is bound by HIPAA to protect client health records and client privacy. In addition, treatment services conducted in a correctional institution shall be considered a covered entity and required to follow the HIPAA rules pertaining to disclosures of PHI.

XII. EVALUATION

Evaluation is a critical component of SUD treatment in the criminal justice system. Evaluation will be used for program monitoring and for ongoing decision making by program staff, administrators, and policy makers. An evaluation design would be established upon implementation of the SUD treatment program at CCTF, and identify appropriate benchmarks and target performance outcomes. Evaluating the program will provide accountability, and identify strengths and weaknesses in the program. Evaluation will examine the following:

1)&**Implementation** - The implementation phase of the program will identify problems and accomplishments during the early phase of the program to assist with the feedback to the clinical and administrative staff.

2)&**Process** - The process phase of the program will identify the assessment and the overall effects of the program on the inmates while they are in treatment. Components of the process evaluation will include the type and amount of services provided, attendance and participation in group treatment, the number of inmates who are screened, admitted, reviewed, and discharged.

3)&**Outcome -** The outcome phase of the program will involve quantitative research on the long-term treatment outcomes of the inmates that includes follow-up data such as drug relapse and recidivism. Follow up data will be collected from criminal justice and substance abuse department records or from face to face interviews with those who participated in the program.

BRIEF COMMENT RE: 2008 CRIPA MEMORANDUM OF AGREEMENT

The Los Angeles County Jail system operates under a 2008 Memorandum of Agreement (MOA) with the United States Department of Justice Civil Rights Division. Under this Agreement, Los Angeles County has made many improvements to inmate conditions of confinement and operations that directly comply with the following Provisions of the MOA:

A. **Intake Health Screening** (timeliness, privacy of interview, qualified screener, immediate care)
B. **Mental Health Evaluation** (timeliness, treatment planning, qualified personnel)
C. **Mental Health Referral of General Population** (routine rounds, monitor for decompensation of inmates, confidentiality of request for services)
D. **Treatment** (mental health treatment provided to all inmates, medication bridging and continuity, timely and comprehensive individualized treatment plan, 24/7 crisis intervention services, access to licensed care, SMI housing and structure programming and recreation, rights preclusion requirements, prohibition of supervisory trustees)
E. **Medication Administration** (full range of medications, properly prescribed and monitored, documentation by trained mental health professionals)
F. **Environmental Conditions** (sanitary and humane housing of mentally ill inmates, provide and maintain adequate mental health housing for all levels of care)
G. **Suicide Prevention** (crisis intervention services, timely safety housing, qualified monitoring and evaluation, first-aid training for correctional staff, housing conditions don't exacerbate suicidal condition, inmate in sight of staff)
H. **Medical Records and Communication** (good documentation, EMR and system integration, mental health record MIS)
I.& **Staffing and Training** (sufficient mental health staffing levels, mandatory psychiatrist-to-inmate on medication, qualified treatment services, 24/7 psychiatrist availability, bilingual mental health clinicians, adequate clerical; administrative; supervisory staffing levels, proper training of all staff, mandatory MH training for correctional staff)
J.& **Quality Assurance** (implement and document CQI program for mental health, CQI specifies procedures for mortality / morbidity / inmate self-harm / critical incidents)
K. **Abuse and Mistreatment** (prohibits any abuse of mentally ill inmates, allegations promptly investigated, justified staff disciplinary action, use of physical restraints consistent with community standards)

Although Los Angeles County has made significant positive progress with regard to MOA compliance, additional changes are needed before the MOA can be terminated. Based on our examination of the MOA and staff discussions, the most significant barriers to MOA termination appear to be the need for 1) adequate jail capacity/housing for the inmate target population, and 2) specifically targeted and higher level behavioral health programming for this population. The CCTF and proposed programs appear to meet both of these needs. Therefore, based on this assessment, we are convinced that the CCTF and proposed programs will play a significant role in moving the MOA toward timely and final termination.

RECOMMENDATIONS

- Create multi-disciplinary teams consisting of medical, mental health, substance abuse, and custody to provide a comprehensive set of services based on each detainee's individual and unique risks and needs.
- Immediately begin developing and designing metrics based on desired programmatic, treatment, and custody outcomes. This will provide a basis for determining which proposed programs are most likely to produce outcomes having the greatest impact on global risk and needs. In the process, expect that the metrics themselves will likely cycle through several revisions before the proposed CCTF is activated. It is possible that differing metrics should be used for different populations.
- Further stratification of the CCTF target population should be performed to better understand needs and risk volumes i.e. co-morbidities, co-occurring disorders, acuity, etc. and any other factors that allow for a clear understanding with regard to matching programs with outcomes.
- Programs being proposed include core concepts that have been proven effective for both health care and custody outcomes. Examples include Cognitive Behavioral Treatment and Motivational Interviewing. All respective disciplines who are members of the inter-disciplinary team must be trained regarding the content of their work including the metrics. Additionally, this training should be delivered in a multidisciplinary context.
- In an effort to design the most effective reentry programming likely to impact recidivism, programming should be closely tethered to the criminogenic and psychosocial needs of detainees. Additionally, program stakeholders are encouraged to study successful reentry programs used by other jail systems.
- Comprehensive policies, procedures, and protocols will need to be developed, tested, and refined well before activation of the proposed CCFT.
- Proposed programming should be closely aligned with CCTF physical design to help ensure that program delivery outcomes and custody supervision outcomes emphasize efficient allocation of staff resources.
- Complete a comprehensive staffing analysis for all positions (administrative, support, custody, clinical, etc.) being proposed for CCTF program management and delivery. Refine structural design to maximize staffing efficiencies and levels. For example, shared administrative support staff and spaces (i.e. office staff) could reduce staff levels while increasing multi-disciplinary integration. This concept is similar to co-locating program management staff (custody, mental health, substance abuse) that was proposed by participants during the site visit.

EXPANDED ANNOTATED BIBLIOGRAPHY

Evidence-Based & Best Practices in Criminal Justice Programming

The Early Years of Evidence-Based Assessment

Martinson, Robert. "What Works? Questions and Answers about Prison Reform." *The Public Interest* 35 (1974): 22-54.

The findings of a 3-year project, Effectiveness of Correctional Treatment, which reviewed the effectiveness of 231 offender rehabilitation programs that had been evaluated during the prior 30 years are presented. Based on his analysis of what was the most extensive offender treatment database that existed at that time, Martinson concluded that "With few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism. Studies that have been done since our survey was completed do not present any major grounds for altering that original conclusion". http://www.nationalaffairs.com/public interest/detail/what-worksquestions-andanswers-about-prison-reform

Martinson, Robert. "New Findings, New Views: A Note of Caution Regarding Sentencing Reform." *Hofstra Law Review* 7, no. 2 (1979): 243-258.

The current system of sentencing in the United States must be reformed. Not only are individual offenders treated disparately, but classes of offenders are treated disparately as well. Yet any reform must be approached with caution. The reprocessing rate is low and while some programs are beneficial under certain conditions, others can be distinctly harmful. In fact, some recent reforms show evidence of increasing the reprocessing rate, rather than decreasing it. Thus great care must be taken when introducing alternatives to our standard procedures--probation, imprisonment, and parole supervision. Those treatments that are helpful must be carefully discerned and increased; those that are harmful or impotent eliminated. [From Conclusion]

Palmer, Ted. *Journal of Research in Crime Delinquency* 12, no. 2 (1975): 133-152.

This paper presents the author's opinion on the article "What Works?--Questions and Answers About Prison Reform" by Robert Martinson. As part of his review, Martinson thus concurred with several findings regarding the beneficial effects of intensive supervision and individual psychotherapy for at least some types of offenders. In accounting for these positive results he suggested such possible variables as level of therapist skill and, to a lesser extent, nature of the treatment setting. In part, the answer is that Martinson was not especially concerned with the subject of individual variables in the first place and with the specific tendencies with which they were associated, for instance, within the area of individual counseling for male offenders in residence, Martinson reported three instances of positive or partially positive outcome and six instances of no experimental/control (E/C) difference; and within the area of group counseling for males and females in residence, he noted four instances of positive outcome and four of no E/C difference. These data suggest that as with methods of treatment themselves, most change agents are not likely to be either successful or unsuccessful on an across-the-board basis. It seems, instead, as if we are dealing with yet another interaction.

Palmer, Ted, Patricia Van Voorhis, Faye Taxman, and Doris Mackenzie. Insights from Ted Palmer: Experimental Criminology in a Different Era." *Journal of Experimental Criminology* 8, no. 2 (2012): 103-115.

Ted Palmer discussed the favorable and productive research climate at the California Youth Authority and the California Department of Corrections during the 1960s and 1970s. Research departments in both agencies had strong backing from the Governor and the state legislature. The research divisions were staffed by renowned social scientists who were able to work independently and free from political influence mostly because the state was growing rapidly and needed evidence to support the increasing number of state investments. Robert Martinson's 1974 study asserting that "nothing worked" in correctional treatment effectively dismantled treatment programming in California. Ted Palmer s response to Martinson involved an independent review of the same studies. The Palmer review reached the conclusion that programs meeting certain characteristics did in fact reduce recidivism. Ted experienced a number of attacks from Martinson and explained that it was essential to just keep to the science of the work, avoiding personal attacks. Palmer later expanded this inquiry into a book. Ted Palmer gave special credit to recent researchers, Canadian scholars especially, for meta-analyses and other studies that effectively showed that some types of correctional rehabilitation programs effectively reduced recidivism. Palmer recounted that he believed the most valuable findings of the classic experimental study, the Community Treatment Project, concerned the guidance for differential approaches and relationship styles for youth. He noted the importance of treating three conditions: internal conflicts, deficits in social skills, and external pressures. Palmer observed that contemporary treatment approaches tend to ignore internal, psychological problems and conflicts. He offered several recommendations regarding future research priorities. The field needs larger studies with longer follow-up periods that allow for a more thorough examination of optimal program conditions.

Principles 1 3. Assess Risk and Needs AND Target Interventions: Risk, Need, Responsivity (RNR), Dosage

Ameen, Christine A., Jennifer Loeffler-Cobia, and Meghan Guevara. *Evidence-Based Practice Skills Assessment for Criminal Justice Organizations, Version 1.0*. Washington, DC: National Institute of Corrections, 2010.

The Evidence-Based Practice Skills Assessment (EBPSA) is a self-report measurement tool designed to gauge the extent to which correctional staff demonstrate the skills necessary to successfully implement Evidence-based Practices (EBP)" (p. 5). Sections of this document include: introduction; reliability; EBPSA administration and scoring; indented utilization and scoring; and future development. This can be used in conjunction with the "Supervisors Leadership Academy: Cultivating an Evidence-Based Organization" curriculum guide and lesson plans and participant workbook. http://nicic.gov/Downloads/PDF/Library/024397.pdf

Andrews, Don A., and James Bonta. *The Psychology of Criminal Conduct* (5th ed.). Cincinnati, OH: Anderson Publishing Company. New Providence, NJ: Matthew Bender Company, Inc., 2010.

The authors bring the "person" back into criminology by focusing on understanding individual differences in criminal conduct and recognizing the importance of personal,

interpersonal, and community factors. What results is a truly interdisciplinary general personality and social psychology of criminal behavior that is open to a wide variety of factors that relate to individual differences - a perspective with both theoretical and practical significance in North America and Great Britain. The book is now organized into four parts: (1) The Theoretical Context and Knowledge Base to the Psychology of Criminal Conduct, (2) The Major Risk/Need Factors of Criminal Conduct, (3) Applications, and (4) Summary and Conclusions. Chapters include helpful Resource Notes that explain important concepts. A selection of technical notes, separated from the general text, allows the advanced student to explore complex research without distracting readers from the main points. [Publication Abstract]

Andrews, Don A., James Bonta, and Steven Wormith. "The Recent Past and Near Future of Risk and/or Need Assessment." *Crime and Delinquency* 52, no. 1 (2006): 7-27.

The history of risk assessment in criminal justice has been written on several occasions. In this article, the authors assess progress since Andrews, Bonta, and Hoge's statement of the human service principles of risk-need-responsivity (RNR) and professional discretion. The review is conducted in the context of the advent of the fourth generation (4G) of offender assessment. To begin, the authors note that theoretical, empirical, and applied progress within the psychology of criminal conduct (PCC) has been nothing less than revolutionary. Second, this article takes a brief look at clinical judgment (1G) with a nod to structured clinical judgment, notes a new energy in 2G actuarial instruments, and a renewed appreciation of the assessment of change (3G). Third, the challenge faced by forensic mental health approaches from general correctional instruments, even within mental health samples, is reviewed. Fourth, the widely known principles of effective service for offenders are supplemented by additional principles derived from meta-analytic evidence. Finally, this article closes with a discussion of some negative evaluations of RNR and the challenges that feminist, critical criminological perspectives, and humanistic perspectives present to the future of risk and/or need assessment. http://www.pretrial.org/Setting%20Bail%20Documents/The%20Recent%20Past%20and%20Near%20Future%20of%20Risk%20andor%20Need%20Assessment%202006.pdf

Andrews, Don A., James Bonta, and Stephen J. Wormith. "The Risk-Need-Responsivity (RNR) Model: Does Adding the Good Lives Model Contribute to Effective Crime Prevention?" *Criminal Justice and Behavior* 36, no. 7 (2011):735-755.

Recently, the good lives model (GLM) has been promoted as an alternative and enhancement to RNR [risk-need-responsivity]. GLM sets itself apart from RNR by its positive, strengths-based, and restorative model of rehabilitation. In addition, GLM hypothesizes that enhancing personal fulfillment will lead naturally to reductions in criminogenic needs, whereas RNR posits the reverse direction. In this article the authors respond to GLM's criticisms of RNR and conclude that little substance is added by GLM that is not already included in RNR, although proponents of RNR may learn from the popular appeal that GLM, with its positive, strength-based focus, has garnered from clinicians over the past decade" (p. 735). Sections of this article include: summarizing and contrasting the RNR and GLM models; the expanded RNR model; a summary of the major statements of GLM; pathways to reducing criminal behavior; what RNR really says; motivating offenders by concentrating on modifying dynamic risk factors; RNR and the role of "narrative identity" and agency in the change process; RNR's view of

human nature; therapeutic alliance and the role of non-criminogenic needs; RNR as a psychometric model; respect of individual differences; RNR as an integrated theory; why the appeal of the Good Lives model; and summary and conclusions. http://nicic.gov/Library/026244

Andrews, Don A., Ian Zinger, Robert D. Hoge, James Bonta, Paul Gendreau, and Terry Cullen. "Does Correctional Treatment Work: A Clinically Relevant and Psychologically Informed Meta-Analysis." *Criminology* 28, no. 3 (1990): 369-404.

Careful reading of the literature on the psychology of criminal conduct and of prior reviews of studies of treatment effects suggests that neither criminal sanctioning without provision of rehabilitative service nor servicing without reference to clinical principles of rehabilitation will succeed in reducing recidivism. What works, in our view, is the delivery of appropriate correctional service, and appropriate service reflects three psychological principles: (1) delivery of service to higher risk cases, (2) targeting of criminogenic needs, and (3) use of styles and modes of treatment (e.g., cognitive and behavioral) that are matched with client need and learning styles. These principles were applied to studies of juvenile and adult correctional treatment, which yielded 154 phi coefficients that summarized the magnitude and direction of the impact of treatment on recidivism. The effect of appropriate correctional service (mean phi .30) was significantly ($p < .05$) greater than that of unspecified correctional service (.13), and both were more effective than inappropriate service (-.06) and non- service criminal sanctioning (-. 07). Service was effective within juvenile and adult corrections, in studies published before and after 1980, in randomized and non-randomized designs, and in diversionary, community, and residential programs (albeit, attenuated in residential settings). Clinical sensitivity and a psychologically informed perspective on crime may assist in the renewed service, research, and conceptual efforts that are strongly indicated by our review. [Abstract from Author]

Aos, Steve, Stephanie Lee, Elizabeth Drake, Annie Pennucci, Tali Klima, Marna Miller, Laurie Anderson, Jim Mayfield, and Mason Burley. *Return on Investment: Evidence-Based Options to Improve Statewide Outcomes—July 2011 Update*. Olympia: Washington State Institute for Public Policy, 2011.

An overview is presented of findings regarding "a comprehensive list of programs and policies that improve ... outcomes for children and adults in Washington and result in more cost-efficient use of public resources" (p. 1). Sections comprising this report are: summary; background; the four-step research approach that assesses what works, calculates costs and benefits and ranks options, measures the risks associated with the analysis, and estimates the impact of various option combinations on statewide outcomes. Also included are two Technical Appendixes that provide in-depth results.

Aos, Steve, Marna Miller, and Elizabeth Drake. *Evidence-based Adult Corrections Programs: What Works and What Does Not*. Olympia: Washington State Institute for Public Policy, 2006.

A "systematic review of the evidence on what works (and what does not) to reduce crime" is presented (p.1) Sections comprising this report are: summary; Washington's Offender Accountability Act; the evidence-based review -- the basic question; research methods; findings; estimated percentage change in recidivism rates and the number of studies on which the estimate is based; and findings by type of program (e.g., drug-involved offenders, jail diversion for offenders with mental illness and co-occurring disorders,

general offender population treatment, domestic-violence offenders, sex offenders, intermediate sanctions, work and education programs for general offenders, and programs requiring further study). The top three programs which resulted in the most reduction in recidivism rates are cognitive-behavioral treatment for sex offenders in the community (-31.2%), intensive supervision treatment-oriented intermediate sanctions (-21.9%), and cognitive-behavioral treatment for sex offenders in prison (-14.9%). http://www.wsipp.wa.gov/rptfiles/06-01-1201.pdf

Aos, Steve, Marna Miller, and Elizabeth Drake. *"Evidence-based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates."* Olympia: Washington State Institute for Public Policy, 2006.

Under current long-term forecasts, Washington State faces the need to construct several new prisons in the next two decades. Since new prisons are costly, the 2005 Washington Legislature directed the Washington State Institute for Public Policy to project whether there are "evidence-based" options that can (a) reduce the future need for prison beds, (b) save money for state and local taxpayers, and (c) contribute to lower crime rates. This report describes our findings and discusses how we conducted the analysis. We review evidence-based adult corrections, juvenile corrections, and prevention options and analyze the effects of alternative portfolios of these investments. http://www.wsipp.wa.gov/pub.asp?docid=06-10-1201

Blandford, Alex M., and Fred C. Osher. *A Checklist for Implementing Evidence-Based Practices and Programs (EBPs) for Justice-Involved Adults with Behavioral Health Disorders.* Delmar, NY: SAMSHA's GAINS Center for Behavioral Health and Justice Transformation, 2012.

The prevalence of serious mental illness (SMI) among persons in the criminal justice system is between three and six times the rate for individuals with SMI in the general U.S. population. A recent study of over 20,000 adults in five local jails found that 14.5 percent of male inmates and 31 percent of female inmates met criteria for a SMI. If these same estimates are applied to the almost 13 million jail admissions reported in 2010, the study findings suggest that more than two million bookings of a person with SMI occur annually. Studies suggest that the co-occurrence of mental health and substance use disorders (COD) is common. In jails, of the approximately 17 percent with SMI, an estimated 72 percent had a co-occurring substance use disorder. http://gainscenter.samhsa.gov/cms-assets/documents/73659-994452.Ebpchecklistfinal.pdf

Bogue, Bradford M., *et al*. *Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention*. Washington, DC: National Institute of Corrections, 2004.

Principles of effective evidence-based intervention are presented. Topics discussed include: evidence-based practice (EBP); term clarification; eight principles for effective interventions -- assess actuarial risk/needs, enhance intrinsic motivation, target interventions, skill train with directed practice, increase positive reinforcement, engage ongoing support in natural communities, measure relevant processes/practices, and provide measurement feedback; components of correctional interventions; implementing EBP principles; applying the principles at the case, agency, and system levels; seven

recommended strategies for implementing effective interventions; and levels of research evidence. http://nicic.gov/Library/019342

Bonta, James, Guy Bourgon, Tanya Rugge, Terri-Lynne Scott, Annie K. Yessine, Leticia Gutierrez, and Jobina Li. *The Strategic Training Initiative in Community Supervision: Risk-Need-Responsivity in the Real World*. Ottawa: Public Safety Canada, 2010.

The application of the risk-need-responsivity (RNR) model of offender rehabilitation to one-on-one supervision of offenders placed under probation is examined. This RNR-based training program is called the Strategic Training Initiative in Community Supervision (STICS). Sections of this report include: abstract; the RNR model of offender rehabilitation; the present study; method; results for the success of random assignment, length and content of session discussions, quality of probation officers' skills and intervention techniques, recidivism, and clinical support; and discussion. "The results showed that the trained probation officers evidenced more of the RNR-based skills and that their clients had a lower recidivism rate" (p. ii). http://nicic.gov/Library/025079

Bonta, James, and Tanya Rugge. *Case Management in Manitoba Probation.* Ottawa: Public Safety and Emergency Preparedness Canada, 2004.

The majority of offenders in Canada are supervised in the community by probation services. The research literature suggests that supervision is most effective when offender needs are appropriately identified and addressed. Although much has been written on the effectiveness of offender rehabilitation programs, there is relatively little research on how probation officers can influence change in their clients.

In this study, probation officers from the province of Manitoba agreed to audiotape supervision sessions with their probationers. In addition, data was collected from files, interviews, and research questionnaires. Analyses of the data focused on how intake offender assessments were related to case management plans and how these plans were implemented in community supervision.

The results showed that the development of intervention plans was based more on what the court mandated then what the offender assessment indicated. As a result, addressing the offender's needs in supervision was not as common as we expected. Probation officers did engage in behaviours that have been associated with positive behavioural change but more could be expected.

In general, the study provides a snapshot of present practices in community supervision and points to areas of improvement. With training and support, probation officers can become more effective agents of change.

Bonta, James, Tanya Rugge, Terri-Lynne Scott, Guy Bourgon, and Annie K. Yessine. "Exploring theBlack Box of Community Supervision." *Journal of Offender Rehabilitation* 47, no. 3 (2008): 248-270.

The utilization of the principles of Risk, Need, and Responsivity (RNR) in community supervision is examined. Sections include probation in the U.S. and Canada; its effectiveness and what is known about reducing offender recidivism; method, findings regarding case management and the risk principle, formulating a case management plan, addressing criminogenic needs during supervision, and influencing offenders in interpersonal relationships; discussion; and conclusion. "For the most part, probation officers spent too much time on the enforcement aspect of supervision (i.e., complying with

the conditions of probation) and not enough time on the service delivery role of supervision" (p. 248). Overall, community supervision does not seem to reduce recidivism. http://cms.oregon.egov.com/doc/omr/cc/docs/pdf/black box.pdf

Bourgon, Guy, James Bonta, Tanya Rugge, Scott Terri-Lynne, Annie K. Yessine. "The Role of Program Design, Implementation, and Evaluation in Evidence-Based "Real World" Community Supervision." *Federal Probation* 74, no. 1 (2010).

The use of Strategy in Training Initiative in Community Supervision (STICS), a comprehensive model for community supervision, is discussed. Those individuals involved with community corrections and its increased effectiveness should read this article. It will explain how to transfer evidence-based practice into "real world" community supervision. Topics covered include: the emergence of the Risk-Need-Responsivity (RNR) model; the Strategic Training Initiative in Community Supervision—program design, implementation, and evaluation issues; and steps to bringing "what works" to the real world. http://nicic.gov/Library/025686

Bourgon, Guy, Leticia Gutierrez, and Jennifer Ashton. *From Case Management to Change Agent: The Evolution Of What Works' Community Supervision.* [This article was originally published in the *Irish Probation Journal*, October 8 (2011): 28-48.] Ottawa: Public Safety Canada, 2011.

Traditionally, the role of a community supervision officer has in large-part been that of a case manager. However, knowledge in the area of "What Works" in offender rehabilitation has stimulated efforts to revolutionize what it means to supervise clients in the community; that is, moving from a case-management approach to what we call a "change-agent" approach. In this article, we define what cognitive-behaviourism looks like in a criminal justice context and how it can be used to maximize the impact of community supervision. Through the amalgamation of cognitive-behavioural techniques and risk/need information, we propose the use of a theoretically and empirically-based framework (i.e., the STICS Action Plan) to assist community supervision officers in planning, prioritizing and effectively achieving change with their clients. http://www.publicsafety.gc.ca/res/cor/rep/2012-01-cmca-eng.aspx

Burrell, D. William. *Community Corrections Management: Issues and Strategies*. Kingston, NJ: Civic Research Institute, Inc., 2012.

Partial Table of Contents. *Part 4: "What Works" and Evidence-Based Practices* includes eight chapters on EBP: *Why* What Works *Isn't Working in Community Corrections; Implementing Evidence-Based Practices in Community Corrections—Helpful Lessons; Implementation—the Achilles Heel of Evidence-Based Practices; "What Works" for the Line Probation/Parole Officer; Cognitive Behavioral Tactics—The Next Phase for Evidence-Based Practices; Lessons from Drug Courts; Risk and Community Corrections; Managing Caseloads: The Challenge of Low-Risk Offenders.*

Carey, Mark. *EBP Step-By-Step Planning Guide: Six Phases toward Implementation of Evidence-Based Practices for Risk Reduction*. White Bear Lake, MN: The Carey Group, 2011.

The implementation of evidence-base practice (EBP) in community corrections is clearly explained. These six phases are: prepare for implementation; build a foundation for risk reduction; begin stakeholder collaboration; master the core correctional competencies;

implement continuous quality improvement processes; and develop infrastructural supports for sustainability. http://nicic.gov/Library/025563

Carey Group. *Checklist: Building and Sustaining an EBP Organization.* White Bear Lake, MN: The Carey Group, 2011.

A checklist for evaluating the ability of an organization to incorporate evidence-based practice (EBP) into its operations is provided. Sections of this document are: instructions; cultural alignment and readiness; assessments; effective staff-offender interactions; continuum of programming; quality assurance/performance data; organizational supports; and prioritizing action planning. http://nicic.gov/Library/025564

Center for Effective Public Policy. *A Framework for Evidence-Based Decision Making in Local Criminal Justice Systems. 3rd ed.* Washington, DC: National Institute of Corrections, 2010.

This report is essential reading for individuals wanting to achieve "measurable reductions of pretrial misconduct and post-conviction reoffending" (p.6). Eight sections follow an introduction (a new paradigm for the justice system): underlying premises; the key decision points, decision makers, and stakeholders in the criminal justice system; examining justice system decision making through the lens of harm reduction; the principles underlying the framework; applying evidence-based principles to practice; key challenges to implementing this framework; collaboration—a key ingredient of an evidence-based system; and building evidence-based agencies.

Center for Effective Public Policy. *Coaching Packet 2010.* Silver Spring, MD: Center for Effective Public Policy; Washington, DC: Urban Institute; White Bear Lake, MN: The Carey Group.

"Each of these Coaching Packets provides an overview of a key topic related to successful offender reentry, concrete strategies and key steps for enhancing practice in this area, and a self-assessment tool" that jurisdictions can use to evaluate their strengths and challenges in the particular topic area discussed. Coaching Packet Series 1: Creating a Blueprint for an Effective Offender Reentry System includes "A Framework for Offender Reentry," "Establishing a Rational Planning Process," and "Engaging in Collaborative Partnerships to Support Reentry." Coaching Packet Series 2: Delivering Evidence-Based Services has "Implementing Evidence-Based Practices," "Effective Case Management," "Shaping Offender Behavior," "Engaging Offenders' Families in Reentry," "Building Offenders Community Assets Through Mentoring," and "Reentry Considerations for Women Offenders." Coaching Packet Series 3: Ensuring Meaningful Outcomes contains "Measuring the Impact of Reentry Efforts" and Continuous Quality Improvement."http://cepp.com/documents/Center-for-Effective-Public-Policy-Coaching-Packets.pdf

Clawson, Elyse, and Meghan Guevara. *Putting the Pieces Together: Practical Strategies for Implementing Evidence-Based Practices.* Boston, MA: Crime and Justice Institute; Washington, DC: National Institute of Corrections, 2010.

Those new to the implementation of evidence-based practices (EBPs) will find this publication to be a great guide to the process. This manual is designed to be used "both as a checklist of key management concepts and as a reminder of important organizational issues that need to be addressed to achieve positive public safety outcomes in an evidence-based environment" (p. vii). There are six chapters contained in this publication: creating

evidence-based community corrections systems; getting started; organizational assessment—to know where you are going, you need to know where you are; strategic planning—choosing your destination; mapping the route—developing a workplan; and ongoing quality improvement. http://nicic.gov/Library/024394

Cullen, Francis T., Paula Smith, Christopher T. Lowenkamp, and Edward J. Latessa. "Nothing Works Revisited: Deconstructing Farabee's Rethinking Rehabilitation." *Victims and Offenders* 4 (2009):101–123.

In *Rethinking Rehabilitation*, Farabee claims that offender treatment is a failed enterprise and instead proposes a correctional approach that emphasizes deterrence through intensive supervision, electronic monitoring, and indeterminate parole sentences. We argue that this neo-Martinson attack on rehabilitation, which has the potential to shape public policy discourse, needs to be deconstructed. Although Farabee's critique has merits—especially about the limited effectiveness of many current prison programs—his analysis ignores research both favorable to offender treatment and unfavorable to his proposed policy agenda. In this context, his advice to choose a correctional future that is punitive and devoid of rehabilitation would be a mistake. [Publication Abstract] http://www.uc.edu/content/dam/uc/ccjr/docs/articles/nothing works revisted.pdf

Dowden, Craig, and Don A. Andrews. "The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice." *International Journal of Offender Therapy and Comparative Criminology* 48, no. 2 (2004): 203–214.

The purpose of this investigation is to conduct a meta-analytic review of the correctional treatment literature to examine whether adherence to these CCPs [core correctional practices] is associated with enhanced [rehabilitation] program effectiveness as evidenced by reduced recidivism' (p. 206). Core correctional practices involve the effective use of authority, appropriate modeling and reinforcement, teaching concrete problem-solving, effective use of community resources, and quality of interpersonal relationships. Programs utilizing CCPs had significant levels of reduced recidivism versus programs that did not.

Domurad, Frank. *Getting Corrections Professionals to Take Their EBP Medicine.* White Bear Lake, MN: The Carey Group, 2010.

The need to observe evidence-based practice (EBP) and ways to implement it into operations are explained. Topics discussed include: medical cost of not taking medicine; taking medicine and patient attitude; patient attitude and intervention; danger of attitudes; a model of cognitive performance; habits of thought; stress; the error of our ways the individual, the system, root causes, inside the black box, washing hands, and the jerk manager; and correcting the error of our ways; and a five-step plan—off the jerk manager, reinvent tasks, rebuild learning, exploit hypocrisy, and get the dumb stuff out of the way.

English, Kim, Diane Pasini-Hill, and David Bonaiuto. *Evidence-Based Practices Implementation for Capacity (EPIC).* Denver: Colorado Department of Public Safety, Office of Research and Statistics, 2012.

This is a great article regarding the statewide implementation of evidence-based correctional practice. The Evidence-Based Practices Implementation for Capacity (EPIC) is a collaborative effort of five agencies in Colorado that "seeks to change the way correctional agencies conduct daily business by changing the ways that correctional staff

interact with offenders" (p. 2). Mental Health First Aid training is one EPIC intervention aimed at detecting and helping people with mental health problems. Motivational Interviewing (MI) is another EPIC intervention and is described quite well. This article covers MI and corrections in the 21st century, the MI training and coaching process, stages of change, and the identification and addressing of criminogenic needs. Sections of this resource include: implementation science; selected interventions; and EPIC accomplishments so far—1900 professionals trained for Mental Health First Aid and nearly 300 for MI, and an increase in offender "change talk" with declines in the use of multiple sequential questions (questions which lead to offender defensiveness). http://nicic.gov/Library/026000

Fahey, Jennifer A. *Using Research to Promote Public Safety: A Prosecutor s Primer on Evidence-Based Practice.* Washington, DC: National Institute of Corrections; Boston: Crime and Justice Institute, 2008.

This paper "focus[es] primarily on those [evidence-based] intervention principles most likely to be encountered by the prosecution" (p.2). Sections following an executive summary are: introduction; prosecutorial duty; innovative research; evidence-based principles in prosecutorial practice and leadership; the need for systemic change; and conclusion. http://nicic.gov/Library/023361

Gendreau, Paul, Tracy Little, and Claire Goggin. "A Meta-Analysis of Adult Offender Recidivism: What Works!" *Criminology* 34, no. 4 (1996): 575–607.

Criteria for including the studies included collection of offender data prior to the recording of the criterion measures, a minimum follow-up period of 6 months, the recording of the outcome measure when the offender was 18 years old or older, and other factors. The predictors were grouped into eight predictor domains. The studies generated 1,141 correlations with recidivism. The strongest predictor domains were criminogenic needs, criminal history/history of antisocial behavior, social achievement, age/gender/race, and family factors. Weaker predictors included intellectual functioning, personal distress factors, and socioeconomic status in the family of origin. Dynamic predictor domains such as antisocial personality and drug abuse performed at least as well as the static domains such as age and criminal history. The most useful actuarial measure was the Level of Service Inventory (LSI-R) from Andrews and Bonta in 1995. Findings clarified which predictor domains and actuarial measures of risk will be the most useful to practitioners and policymakers.

Guevara, Meghan, and Solomon Enver. *Implementing Evidence-Based Policy and Practice in Community Corrections* 2nd ed. Washington, DC: National Institute of Corrections; Boston, MA: Crime Justice Institute. 2009.

A "guide for [community corrections] agencies to transform themselves into evidence-based organizations" is provided (p.xv). Six chapters follow an executive summary: what evidence-based practice is; the integrated model; the principles of effective intervention; implementing evidence-based principles; leading organizational change and development; and collaboration for systemic change. The appendixes include: research support gradient; the search conference; and key concepts in organizational development. http://nicic.gov/Library/024107

Harris, Patricia M. "What Community Supervision Officers Need to Know about Actuarial Risk Assessment and Clinical Judgment." *Federal Probation* 70, no. 2 (2006).

Three factors are identified as interfering with the greater use of standardized actuarial risk assessment instruments by community supervision officers: (1) a lack of training about how actuarial assessment tools function; (2) shortcomings in risk communication and understanding; and (3) a failure to affirm the importance of coupling actuarial risk assessments with clinical judgment. The author reviews research on clinical judgments versus actuarial predictions of offender risk, which reveals that unstructured clinical judgments are often inferior to predictions made by actuarial assessments while structured clinical judgments can fare just as well as some actuarial tools. However, the author points out that even the most trained and experienced professionals make predictions that perform no better than chance when they fail to use empirically derived actuarial assessment tools. The author contends that the best approach to offender risk assessment is to combine clinical judgment and skill with standardized actuarial risk assessment tools Research is also presented that illustrates that how risk is reported by actuarial tools influences the user's understanding and acceptance of the assessment results. For example, when risk scores are presented as a frequency rather than as a probability, users tended to view offender risk as higher. Future research should focus on identifying the factors that most influence an officers' likelihood of accepting and acting on risk assessment results. http://www.uscourts.gov/fedprob/September 2006/assessment.html

Lawrence, Alison, and Lyons Donna. *Principles of Effective State Sentencing and Corrections Policy.* National Conference of State Legislatures. Denver, CO: Sentencing and Corrections Work Group, 2011.

Seven principles and related points regarding sentencing and corrections policymaking are presented. The intent of these principles "is to provide broad, balanced guidance to state lawmakers as they review and enact policies and make budgetary decisions that will affect community safety, management of criminal offenders, and allocation of corrections resources" (p. 1). The report also shows the principles at work in determining criminal sentences, managing offenders in the community, treating drug offenders, using data and evidences, and preventing crime and reducing recidivism.
http://nicic.gov/Library/025237

Lerch, Jennifer, Jill Viglione, Ernest Eley, Susan James-Andrews, and Faye S. Taxman. "Organizational Readiness in Corrections." *Federal Probation* 75, no. 1 (2011).

"This article examines the impact of a continuous on-site training model to advance the implementation of evidence-based practices in correctional settings" (p. 5). Information from this article can be used in the development and implementation of your own agency's efforts to utilize evidence-based practices. Sections include: organizational readiness for change; resistance to change in corrections; implementing change; the Prison-Based Work Release Center (PWRC) experience with adopting evidence-based practices; findings; and conclusions.
http://nicic.gov/Library/025600
http://www.uscourts.gov/uscourts/FederalCourts/PPS/Fedprob/2011-06/02 organizational.html

Lowenkamp, Christopher T., Jennifer Pealer, Paula Smith, and Edward J. Latessa. "Adhering to the Risk and Need Principles: Does it Matter for Supervision-Based Programs?" *Federal Probation* 70, no. 3 (2007): 3-8.

The study found evidence of a link between program characteristics and its effectiveness in reducing recidivism. All of the programs were supervision-based and adhered to some degree to the principles of matching program features to the risk and need characteristics of the offender. These intensive supervision programs were more successful for the higher risk offenders. When at least 75 percent of the population supervised was classified as high risk, there was a 5-percent decrease in recidivism. This compared with a slight increase in recidivism for programs that served more low-risk offenders. Programs that required higher risk offenders to be in the programs for a longer period had a 4-percent reduction in recidivism. Those programs that had a "one-size-fits-all" approach had no effect on recidivism. Programs that had more referrals for higher risk offenders reduced recidivism by 7 percent. Programs that did not have more referrals for this population had a marginal reduction in recidivism. Programs in which 75 percent or more of the referrals were for treatment programming had an 11-percent reduction in returns to prison. Programs in which more than 25 percent of their referrals were nontreatment increased recidivism by 3 percent. Based on these findings, it is evident that programs tailored to prominent risks and needs of offenders achieved significant reductions in recidivism. The study examined 66 community-based jail and prison diversion programs in Ohio. Offenders served by these programs were compared to offenders who were processed as usual in jail, municipal probation, or prisons. A total of 5,781 prison diversion cases were compared to an equal number of parolees. A total of 707 comparison cases were used as a matched sample for the jail diversion programs.
http://www.uscourts.gov/fedprob/December 2006/adhering.html

Motiuk, Laurence, L., and Ralph C. Serin (Eds.), *Compendium 2000 on Effective Correctional Programming.* Ottawa: Correctional Service Canada, 2007.

Compendium 2000 on Effective Correctional Programming provides a comprehensive and critical appraisal of the empirical literature in the field of corrections and behaviour change. More importantly, it provides new knowledge on program effectiveness, an overview of existing programs in Canadian correctional jurisdictions, and guidelines for evaluating operations and policy in the area of correctional programs. http://www.csc-scc.gc.ca/text/rsrch/compendium/2000/index-eng.shtml

Mullins, Tracy G., and Christine Toner. *Implementing the Family Support Approach for Community Supervision*. Lexington, KY: American Probation and Parole Association; New York: Family Justice, 2008.

Implementation of the Family Support Approach for Community Supervision is explained. This publication includes the following sections: introduction and overview; guiding principles for putting this system into practice; tools and techniques for putting this approach into practice; practical application of guiding principles; administrative support; and "The Oklahoma Family Justice Project: Improving Community Supervision Outcomes One Family at a Time" by Justin Jones and Carol Shapiro.
http://nicic.gov/Library/023511

National Institute of Corrections. *A Framework for Evidence-Based Decision Making in Local CriminalJustice Systems*. Philadelphia: Center for Effective Public Policy; Washington, DC: Pretrial Justice Institute; Denver, CO: Justice Management Institute; Silver Springs, MD: The Carey Group, 2010.

This report is essential reading for individuals wanting to achieve "measurable reductions of pretrial misconduct and post-conviction reoffending" (p.6). Eight sections follow an introduction (a new paradigm for the justice system): underlying premises; the key decision points, decision makers, and stakeholders in the criminal justice system; examining justice system decision making through the lens of harm reduction; the principles underlying the framework; applying evidence-based principles to practice; key challenges to implementing this framework; collaboration—a key ingredient of an evidence-based system; and building evidence-based agencies.
http://nicic.gov/Library/024372

National Institute of Corrections. *Topics in Community Corrections: Applying Evidence-Based Practices in Pretrial Services*. Washington DC: National Institute of Corrections, 2008.

Foreword by Ken Rose; "A Framework for Implementing Evidence-Based Practices in Pretrial Services" by John Clark; "Advancing Evidence-Based Practices in the Pretrial Field" by Katie Green, Pat Smith, and Kristina Bryant; "Improving Pretrial Assessment and Supervision in Colorado" by Michael R. Jones and Sue Ferrere; "Pretrial Defendants: Are They Getting Too Much of a Good Thing?" by Barbara M. Hankey; "Charge Specialty and Re-victimization of Defendants Charged with Domestic Violence Offenses" by Spurgeon Kennedy; and "Pretrial Rearrests Among Domestic Violence Defendants in New York City" by Richard R. Peterson.
http://nicic.gov/Library/022904

National Institute of Corrections. *Topics in Community Corrections: Promising Strategies inTransition from Prison*. Washington DC: National Institute of Corrections, 2007.

Issue contents: "Foreword" by Kermit Humphries; "An Overview of NIC's Transition from Prison to the Community Initiative" by Peggy B. Burke; "Rising to the Challenge of Applying Evidence-Based Practices Across the Spectrum of a State Parole Board" by Sherry Tate and Catherine C. McVey; "Collaboration and Partnership in the Community: Advancing the Michigan Prisoner ReEntry Initiative" by Le'Ann Duran; "Providing Tools for Risk Reduction Case Management in Parole and Community Corrections" by Keven Pellant and Margie Phelps; "Improving Parole Outcomes with Performance Leadership and Data: Doing What Works" by Danny Hunter, George Braucht, and John Prevost; "Working Together to Improve Reentry: Bridging Budgets and Programs, Public and Private, Prison and the Community" by Ginger Martin; "Ensuring Successful Offender Reentry: Umatilla/Morrow County "Reach-In" Services" by Mark Royal; "Creating Better Transitions at Indiana's Plainfield Reentry Educational Facility" by Michael Lloyd; "Gender-Responsive Reentry in Rhode Island: A Long and Winding Road" by Bree Derrick; and "Missouri Makes Its Move Toward a New Reentry Philosophy" by Julie Boehm. http://static.nicic.gov/Library/022777.pdf

Nink, Carl, and Steve MacDonald. *Programs that Help Offenders Stay Out of Prison*. Centerville, UT: MTC Institute, 2009.

This report is required reading for any agency seeking to develop effective education and/or substance abuse programming. Sections of this publication include: introduction; current conditions—the prison population is growing despite decrease in crime; effective correctional programming; education provides opportunities; education impacts recidivism; effective educational program principles; substance abuse programs save tax dollars; effective substance abuse treatment program principles; evidence-based substance abuse treatment practices; cost to benefit; and conclusion. http://nicic.gov/Library/024304

Petersilia, Joan. *"*Community Corrections: Probation, Parole, and Prisoner Reentry.*"* In *Crime and Public Policy*, edited by James Q. Wilson and Joan Petersilia: 499-531. New York: Oxford University Press, 2011.

Crime in the United States has fluctuated considerably over the past thirty years, as have the policy approaches to deal with it. During this time criminologists and other scholars have helped to shed light on the role of incarceration, prevention, drugs, guns, policing, and numerous other aspects to crime control. Yet the latest research is rarely heard in public discussions and is often missing from the desks of policymakers. This book accessibly summarizes the latest scientific information on the causes of crime and evidence about what does and does not work to control it.

Pettway, Coretta. *Best Practices Tool-Kit: Community Corrections and Evidence-Based Practices.* London, OH: Ohio Department of Rehabilitation and Correction, Institute on Correctional Best Practices; Institute for Excellence in Justice; Ohio State University, Criminal Justice Research Center, 2008.

The utilization of evidence-based practice (EBP) in community corrections is explained. This document is comprised of these sections: definition of EBP; background on community corrections; principles of effective intervention; implementing EBP; and promising programs. An annotated selection of suggested readings is also provided. http://nicic.gov/Library/022973

Pew Charitable Trusts. S*tate of Recidivism: The Revolving Door of America's Prisons.* Washington, DC: Pew Center on the States, Public Safety Performance Project, 2011.

Anyone concerned with keeping ex-offenders out of prison or jail, be they correctional professionals or concerned community members, should read this publication. "This report seeks to elevate the public discussion about recidivism, prompting policy makers and the public to dig more deeply into the factors that impact rates of return to prison, and into effective strategies for reducing them" (p. 1). Sections following an executive summary are: introduction—recidivism as a performance measure, overview of the study, and what a recidivism rate is; a closer look at recidivism rates—new figures show steady national recidivism rate, states vary widely, and how recidivism rates have changed; unpacking the numbers—how sentencing impacts recidivism rate, how community corrections policy impacts recidivism rate, and examples of how three states dealt with recidivism; and improving public safety and cutting correctional costs—strategies for successfully reducing recidivism, resources for developing effective reentry and supervision strategies, and a promising start. http://nicic.gov/Library/024981.

Przybylski, Roger. *What Works: Effective Recidivism Reduction and Risk-Focused Prevention Programs, A Compendium of Evidence-Based Options for Preventing New and Persistent Criminal Behavior.* Lakewood, CO: RKC Group, 2008.

This report, prepared for Colorado Division of Criminal Justice, identifies and describes interventions that are effective in reducing recidivism and preventing crime. The primary audience is the Colorado Commission on Criminal and Juvenile Justice, and the primary goal of this compendium is to assist the Commission in carrying out its mission and statutory duties. These duties include investigating evidence- based recidivism reduction initiatives and cost effective crime prevention programs.
http://nicic.gov/Library/022943

Rengifo, Andres F., and Christine S. Scott-Hayward. *Assessing the Effectiveness of Intermediate Sanctions in Multnomah County, Oregon.* New York: Vera Institute of Justice, 2008.

In the 1990s the Department of Community Justice (DCJ) in Multnomah County, Oregon, initiated a series of evidence-based reforms intended to shift resources and change its supervision approach. This study by the Vera Institute of Justice is one of a number of studies the DCJ has solicited to look at particular questions about its system. It provides an overview of the patterns and practices of adult probation and post-prison supervision, based on Vera's quantitative and qualitative analysis of the use of intermediate sanctions in response to violations of probation conditions.
http://www.vera.org/download?file=1790/Final%2BMultnomah%2BReport.pdf

Rubin, Mark, William Ethridge, and Michael Rocque. *Implementing Evidence-Based Principles in Community Corrections: A Case Study of Successes and Challenges in Maine.* Washington, DC: National Institute of Corrections; Portland, ME: University of Southern Maine. Muskie School of Public Service, 2011.

The integration of evidence-based principles, organizational development, and collaboration is investigated. Sections of this report are: introduction; background; literature review; methodology; document review; key informant interviews; interviews with probation officers (observations of current climate); quantitative analysis of intermediate measures; and findings. "The research on evidence-based principles in Maine ... suggests that this concurrent model may not be a realistic strategy given its insistence on an integrated focus on evidence-based principles, organizational development, and collaboration" (p. 30).
http://nicic.gov/Library/025242

Serin, Ralph, Renee Gobeil, Laura J. Hanby, and Caleb D. Lloyd. "Evidence-Based Practice in Corrections: Entry Points for Improvement in Case-Based Decisions." *Corrections Today* 74 (2012), 81-83: 86.

Since 2003, the Criminal Justice Decision-Making Laboratory at Carleton University has pursued a program of research intended to inform decisions regarding individual offenders. Existing evidence shows the DRAOR holds promise as a new dynamic risk scale that can inform case planning and improve case-based decisions. [...] this research highlights the importance of considering more proximal and protective factors in the management of risk of community supervised offenders. [Publication Abstract]

Smith, Paula, Paul Gendreau, and Kirstin Swartz. "Validating the Principles of Effective Intervention: A Systematic Review of the Contributions of Meta-Analysis in the Field of Corrections." *Victims and Offenders* 4, no. 2 (2009): 148–169.

Responding to the "nothing works" movement in corrections, researchers in the field of corrections have employed meta-analytic techniques since the mid-1980s to cumulate knowledge on the effectiveness of offender rehabilitation programs. The purpose of this article is to summarize the contributions of these quantitative reviews in the field of corrections with special emphasis on the validation of the principles of effective intervention in particular. Meta-analysis has facilitated the identification of "what works" within correctional treatment, including the specific criteria for optimizing effectiveness along clinically and psychologically relevant dimensions. [Publication Abstract]

Taxman, Faye S., Eric S. Shepardson, and James M. Byrne. *Tools of the Trade: A Guide to Incorporating Science into Practice.* Washington, DC: National Institute of Corrections, and Maryland Department of Public Safety, 2004.

The community supervision field is a key component to public safety in the United States, and worldwide, albeit it is typically undervalued and underfunded. Over the last decade, research has contributed to building knowledge about effective practice in supervision. The American Probation and Parole Association (APPA) is committed to advancing the field of supervision. We have been working within the association and with individual agencies to learn more about how to apply research-based findings into practices. The Tools of the Trade presents the research literature to the field in a way that translates research into practice. As a strategy, it is an on-site training tool. Each chapter is devoted to helping line staff understand core concepts with key exercises devoted to applying the core concepts. The manual is designed to allow supervisors, mid-level managers, and field staff be a key to the change process by providing the key information and a guided tool to thinking about operations. The manual assists supervision agencies to embrace new concepts by providing the framework to help staff and managers apply a series of guiding principles to create a formula for advancing supervision. It is an important addition to the field. [Note from APPA, Carl Wicklund, Executive Director] http://www.gmuace.org/documents/tools/tools-of-the-trade.pdf

Trotter, Chris. "The Impact of Different Supervision Practices in Community Corrections." *Australian and New Zealand Journal of Criminology* 29 (1996): 1-18.

Can community corrections programs or probation reduce the incidence of recidivism among offenders under supervision? This question continues to be controversial. Some of the more recent research indicates however, that recidivism is likely to be reduced by as much as fifty percent if certain supervision practices are adopted. This research has found, among other things, that supervision characterised by a pro-social approach, the use of problem solving and the use of empathy is related to lower recidivism. This study looks at these factors in community based corrections in Victoria. It finds that where supervisors make use of these supervision principles, client recidivism rates, as measured by breach rates and re-offending rates one year and four years after the start of supervision, are twenty five to fifty percent lower. The study also finds that the pro-social approach seems to have more impact than the use of problem solving or empathy.

Trotter, Chris. *Working with Involuntary Clients* 2nd ed. Crow's Nest, New South Wales: Allen Unwin, 2006.

Many social workers are employed in positions where they deal with involuntary clients. These positions are demanding, and require a specific set of skills. The new edition of this successful book provides an accessible and practical guide for managing difficult and sensitive relationships and communicating with reluctant clients.

The author directly links theory to real-life by adopting a jargon-free and accessible guide to working in partnership with involuntary clients. Written in a lively and engaging style, the book is richly illustrated with case examples drawn from a variety of service-user groups, thus ensuring its relevance across the whole curriculum.

The author s integrated and systematic approach promotes prosocial values; emphasizes clarifying roles; and deals with issues of authority and goal-setting. Fully revised and updated throughout, the book also includes discussions of key themes such as evidence-based practice, risk assessment, legislation and multidisciplinary working. These changes bring the text up-to-date with current issues in social work education and practice.

Welsh, Brandon C., and David P. Farrington (Eds.). *Preventing Crime: What Works for Children, Offenders, Victims, and Places.* New York: Springer Science, 2007.

The main aim of this book is to advance knowledge on what works to prevent crime. Two chapters look at what works in intervening in the lives of children who are at risk for delinquency and later criminal offending. Five chapters examine what works in preventing offenders from committing further offenses in the community; three chapters address what works for victims of crime. Three chapters describe what works in preventing crime in high-risk areas for crime.

Winterfield, Laura, Mark Coggeshall, and Adele V. Harrell. *Development of an Empirically-Based Risk Assessment Instrument*. Washington, DC: The Urban Institute, 2003.

The development of an assessment instrument for assisting in the recommendation of pretrial release conditions is explained. Five chapters comprise this report: overview; research questions and methods; instrument construction; instrument performance; and summary and recommendations. http://www.urban.org/publications/410892.html

Principle 2. Enhance Motivation to Change

Bartholemes, Norma G., Donald F. Dansereau, and D. Dwayne Simpson. *Getting Motivated to Change:*
A Collection of Materials for Leading Motivation Groups with Substance Abuse Clients in Criminal Justice Settings. Fort Worth: Texas Christian University, Institute of Behavioral Research, 2006.

This manual includes a series of "topic-focused modular applications" designed particularly for counselors and group facilitators working in substance abuse treatment programs. The collection of applications contains focused, easily accessible, and brief adaptive strategies for engaging clients in discussions and activities on motivation. http://www.ibr.tcu.edu/pubs/trtmanual/GettingMotivated.html

Doran, Neal, Melinda Hohman, and Igor Koutsenok. "Linking Basic and Advanced Motivational Interviewing Training Outcomes for Juvenile Correctional Staff in California." *Journal of Psychoactive Drugs* 43, no. S1 (2011): 19-26.

Motivational interviewing (MI) is an evidence-based communication method that can be effective in engaging incarcerated juveniles in substance abuse programming and other treatment services. However, MI can be difficult to learn and often requires several training exposures for skill change. Few studies have examined MI training outcomes over time. This study reports outcomes for 222 juvenile corrections workers trained in MI in a three-day introductory and two-day advanced training. MI skills were measured via video-administered pre- and post-tests and with a written questionnaire. Combined results from a linear mixed model found that overall MI skills were positively associated with staff education level, and negatively associated with age and time between trainings. Those who attended their second training within nine months of the first training were more likely to score in the proficiency range. Motivation to use MI, belief in its efficacy with youth, job classification, and sex were not related to skill attainment.

Motivational Interviewing with a Criminal Justice Focus: An Annotated Bibliography. Aurora, CO: National Institute of Corrections Information Center, 2013.

This annotated bibliography contains the written resources pertaining specifically to the criminal justice field. In addition, certain documents considered seminal to the training, implementation, evaluation, coaching, and quality assurance of MI skills are included. http://static.nicic.gov/Library/025355.pdf

Miller, William R. and Stephen Rollnick. *Motivational Interviewing, Third Edition: Helping People Change.* New York: The Guilford Press, 2013.

This bestselling work for professionals and students is the authoritative presentation of motivational interviewing (MI), the powerful approach to facilitating change. The book elucidates the four processes of MI--engaging, focusing, evoking, and planning--and vividly demonstrates what they look like in action. A wealth of vignettes and interview examples illustrate the "dos and don'ts" of successful implementation in diverse contexts. Highly accessible, the book is infused with respect and compassion for clients. The companion Web page provides additional helpful resources, including reflection questions, an extended bibliography, and annotated case material. New to This Edition:

* Reflects major advances in understanding and teaching MI.
* Fully restructured around the new four-process model.
* Additional case examples and counseling situations.
* Reviews the growing evidence base and covers ways to assess MI fidelity. [From Amazon]

Program Profile: Prize-Based Incentive Contingency Management for Substance Abusers. CrimeSolutions.gov, 2012.

"Prize-based Incentives Contingency Management for Substance Abusers is a version of contingency management (CM) that provides adult substance abusers in community-based treatment with an opportunity to win prizes if they remain drug free ... CM interventions attempt to increase positive behavior in substance abusers by offering vouchers that are redeemable for retail goods and services but are contingent on behavior change. Prize-based CM reinforces positive abstinent behavior in substance-abusing clients in treatment by providing them an opportunity to win various prizes when they provide negative urine and breath samples or complete treatment-related activities" (p. 1). This profile reviews the evaluation outcomes from two studies regarding the efficacy of this program. Both

studies showed that the time individuals abstained from drug use was greatly increased by participation in the CM program. The program is therefore deemed effective due to the evidence.
http://nicic.gov/Library/025808

Principle 4. Skill Train with Directed Practice (CBT)

Bourgon, Guy, and Leticia Guitierrez. "The General Responsivity Principle in Community Supervision: The Importance of Probation Officers Using Cognitive Intervention Techniques and Its Influence on Recidivism." *Journal of Crime Justice* 35, no. 2 (2012): 149-156.

The present study examines the General Responsivity Principle of the Risk–Need–Responsivity model of offender assessment and treatment which holds that employing cognitive social learning methods to influence the behavior of offenders is the most effective approach to reduce recidivism. In this study, the prevalence rates of probation officers discussing procriminal attitudes and their use of cognitive intervention strategies during one-on-one supervision sessions with their clients was assessed and the impact of these discussions and strategies on reoffending was examined. Audio-recorded supervision sessions from officers engaging in routine practice as well as from officers who were trained in the Strategic Training Initiative in Community Supervision (STICS) model were rated. Results indicated that without this training, officers infrequently (i.e., approximately 5% of the recorded sessions) discussed procriminal attitudes/cognitions and rarely used cognitive intervention techniques with their clients (i.e., approximately 1% of sessions). Officers who were STICS trained showed significant improvement in talking about attitudes and using cognitive intervention techniques (i.e., 39 and 42% of sessions, respectively). Cox regression survival analysis found the use of cognitive intervention techniques was significantly related to lower rates of reoffending. These findings support the General Responsivity Principle within the context of one-on-one community supervision.

Bush, Jack, Barry Glick, and Juliana Taymans. *Thinking for a Change: Integrated Cognitive Behavior Change Program.* Washington, DC: National Institute of Corrections, 2011.

Thinking for a Change (T4C) is the innovative, evidence-based cognitive behavioral curriculum from the National Institute of Corrections (NIC) that has broadly influenced the correctional field and the way correctional facilitators work with offenders and inmates. The program can be delivered to correctional clients by facilitators who have been trained to do so. Studies have shown that, when implemented with integrity, it can reduce recidivism among offenders. Lessons comprising this manual are: introduction; social skill-active listening; social skill—asking questions; social skill-giving feedback; social skill-knowing your feelings; cognitive self-change—thinking controls our behavior; cognitive self-change step 1—pay attention to our thinking; cognitive self-change step 2—recognizing risk; cognitive self-change step 3—use new thinking; thinking check-in; social skill—understanding the feelings of others; social skill—making a complaint; social skill—apologizing; social skill—responding to anger; social skill—negotiating; introduction to problem solving; problem solving skill 1—stop and think; problem solving skill 2—state the problem; problem solving skill 3—set a goal and gather information; problem solving practice skills 1-3; problem solving skill 4—think of choices and consequences; problem solving skill 5—make a plan; problem solving skill 6—do and evaluate; problem solving

application; next steps; cognitive self-change—aftercare skill practice; social skill—aftercare skill practice; and problem solving—aftercare skill practice. This set of two DVDs include: one data DVD containing the manual, PowerPoint presentations, "Thinking for a Change: Sustaining Program Integrity after Implementation" videoconference held April 28, 2004 (playing time of 159 minutes), "Thinking for a Change 3.0" satellite/internet broadcast held May 11, 2011 (playing time of 158 minutes), and video vignettes (playing time of 20 minutes).
http://nicic.gov/Library/025057

Latessa, Edward, Francis T. Cullen, and Paul Gendreau. "Beyond Professional Quackery: Professionalism and the Possibility of Effective Treatment." *Federal Probation*, 66, no. 2 (2002): 43– 49.

"Correctional quackery" is the use of treatment interventions that are based on neither existing knowledge of the causes of crime nor existing knowledge of what programs have been shown to change offender behavior. Advances in the corrections field depend on the conscious rejection of quackery in favor of an evidence-based corrections. This will involve overcoming four failures that are common in correctional treatment. These are the failure to use research in designing programs, the failure to follow appropriate assessment and classification practices, the failure to use effective treatment models, and the failure to evaluate what is being done. In combating correctional quackery, there are eight principles of effective correctional intervention. First, there must be an organizational culture based in well-defined goals, ethical principles, and a history of responding efficiently to issues that have an impact on treatment facilities. Second, programs must be based on empirically defined needs and be consistent with organizational values. Third, the program director and treatment staff must be professionally trained and have previous experience in working in offender treatment programs. Fourth, offender risk must be assessed by psychometric instruments of proven predictive validity. Fifth, programs must target for change a wide variety of criminogenic needs by using empirically valid behavioral/social learning/cognitive behavioral therapies that are directed to higher risk offenders. Sixth, program therapists should use anti-criminal modeling, effective reinforcement and disapproval, problem-solving techniques, structured learning procedures for skill-building, effective use of authority, cognitive self-change, relationship practices, and motivational interviewing. Finally, there must be interagency communication to serve the provision of high-quality services in the community and the routine performance of program audits, consumer satisfaction surveys, process evaluations, and follow-ups of recidivism rates. [Abstract from https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=197813]
http://www.uc.edu/content/dam/uc/ccjr/docs/articles/EffectiveTreatment.pdf

Lipsey Mark W., Nana A. Landenberger, and Sandra J. Wilson. *Effects of Cognitive-Behavioral Programs for Criminal Offenders.* Campbell Systematic Reviews 6, 2007.

Background for the Review: Cognitive-behavioral therapy (CBT) is among the more promising rehabilitative treatments for criminal offenders. Reviews of the comparative effectiveness of different treatment approaches have generally ranked it in the top tier with regard to effects on recidivism (e.g., Andrews et al., 1990; Lipsey & Wilson, 1998). It has a well-developed theoretical basis that explicitly targets "criminal thinking" as a contributing factor to deviant behavior (Beck, 1999; Walters, 1990; Yochelson Samenow, 1976). And, it can be adapted to a range of juvenile and adult offenders,

delivered in institutional or community settings by mental health specialists or paraprofessionals, and administered as part of a multifaceted program or as a stand-alone intervention. Meta-analysis has consistently indicated that CBT, on average, has significant positive effects on recidivism. However, there is also significant variation across studies in the size of those treatment effects. Identification of the moderator variables that describe the study characteristics associated with larger and smaller effects can further develop our understanding of the effectiveness of CBT with offenders. Of particular importance is the role such moderator analysis can play in ascertaining which variants of CBT are most effective. The objective of this systematic review is to examine the relationships of selected moderator variables to the effects of CBT on the recidivism of general offender populations.http://campbellcollaboration.org/lib/project/29/www.campbellcollaboration.org/lib/download/143/

Lipsey, Mark W. "The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview." *Victims and Offenders* 4, no. 2 (2009): 124-147.

Previous meta-analyses have identified many effective interventions for reducing the recidivism of juvenile offenders and various program factors that are associated with the best outcomes. Most of that work has been focused on only one intervention area and thus has limited scope. Notable exceptions are two relatively comprehensive meta-analyses that have identified a small number of factors or principles that appear to characterize the most effective programs. This paper presents a new analysis of data from one of those meta-analyses designed to test a broader range of intervention factors in a manner that allows identification of both the general principles and the distinct intervention types associated with the greatest reductions in recidivism. Only three factors emerged as major correlates of program effectiveness: a "therapeutic" intervention philosophy, serving high risk offenders, and quality of implementation. With other variables statistically controlled, relatively few differences were found in the effectiveness of different types of therapeutic interventions.

Milkman, Harvey, and Kenneth Wanberg. *Cognitive-Behavioral Treatment: A Review and Discussion for Corrections Professionals.* Washington, DC: National Institute of Corrections, 2007.

Detailed information regarding the use and benefits of cognitive-behavioral therapy (CBT) in prisons and jails is provided. Chapters comprising this guide address: the increasing need for effective treatment services; what cognitive-behavioral therapy is; prominent CBT programs for offenders; measuring the effectiveness of rehabilitation programs; evaluating specific CBT curricula; and "real world" program applications. http://nicic.gov/Library/021657

Pearson, Frank S., Douglas S. Lipton, Charles M. Cleland, and Dorline S. Yee. "The Effects of Behavioral/Cognitive-Behavioral Programs on Recidivism." *Crime Delinquency* 48, no. 3 (2002): 476-796.

The Correctional Drug Abuse Treatment Effectiveness (CDATE) project coded studies of treatment/intervention programs in prison, jail, probation, or parole settings reported from 1968 through 1996. Meta-analyses were conducted on the 69 primary research studies on the effectiveness of behavioral and cognitive-behavioral treatment in reducing recidivism for offenders. Results on this heterogeneous collection of studies show that this treatment is associated with reduced recidivism rates. However, this effect is mainly due to cognitive-behavioral interventions rather than to standard behavior modification approaches. The specific types of programs shown to be effective include cognitive-behavioral social skills development programs and cognitive skills (Reasoning and Rehabilitation) programs.

Wilson, David B., Leana Aleen Bouffard, and Doris L. MacKenzie. "Quantitative Review of Structured, Group-Oriented, Cognitive-Behavioral Programs for Offenders." *Criminal Justice and Behavior* 32, no. 2 (2005): 172–204.

Prior reviews and meta-analyses have supported the hypothesis that offender rehabilitation programs based on cognitive-behavioral principles reduce recidivism. This article quantitatively synthesizes the extant empirical evidence on the effectiveness of structured cognitive-behavioral programs delivered to groups of offenders. The evidence summarized supports the claim that these treatments are effective at reducing criminal behavior among convicted offenders. All higher quality studies reported positive effects favoring the cognitive-behavioral treatment program. Specifically, positive reductions in recidivism were observed for moral reconation therapy, reasoning and rehabilitation, and various cognitive-restructuring programs. The evidence suggests the effectiveness of cognitive skills and cognitive restructuring approaches as well as programs that emphasize moral teachings and reasoning.

Principle 5. Increase Positive Reinforcement
(See Incentives and Sanctions/Contingency Management)

Principle 6. Engage Ongoing Community Support

Brazzell, Diana, *et al*. *From the Classroom to the Community: Exploring the Role of Education during Incarceration and Reentry*. New York: City University of New York, John Jay College of Criminal Justice, Prison Reentry Institute, 2009.

This monograph examines the "current state of education during education and reentry and identifie[s] promising programmatic and policy directions" (p. 3). Parts contained in this publication include: introduction—education, reincarceration, and reentry; the current landscape of education during incarceration and reentry; research on the effectiveness of correctional education; education behind the walls—challenges and opportunities; from classroom to community—education and reentry.
http://nicic.gov/Library/024041

Hairston, Creasie Finney, *et al*. *Coming Home from Prison: Family Matters*. London, OH: Institute for Excellence in Justice, 2008.

Access to keynote remarks, comments, Q and A, presentations, and handouts from a seminar on the impact of families on community reentry are available at this website. "Families as sources of support, conflict and domestic violence, parent-child relationships,

and parole practices and expectations are among the topics covered" (p. 1). http://nicic.gov/Library/023182

Myers, Robert, Michael Villanueva, and Jane Ellen Smith. "The Community Reinforcement Approach: History and New Direction." *Journal of Cognitive Therapy* 19, no. 3 (2005): 247-260.

This article provides an overview of 2 closely linked treatment approaches for the substance abusing client: The Community Reinforcement Approach (CRA) and Community Reinforcement and Family Training (CRAFT). In 1973, Hunt and Azrin created CRA in an attempt to restructure an individual's "community" so that a sober lifestyle was more rewarding than one dominated by alcohol. One salient CRA premise was that an individual's substance abuse recovery was heavily influenced by his or her social and occupational environment. Sisson and Azrin (1986) later built upon this premise in their work with a new type of client; the loved one of an alcoholic individual who refused to enter treatment. This program was an early version of CRAFT, which is an intervention that works through a non-using individual to affect the behavior of a substance abuser. This article provides an empirical review of the evolution of these 2 interventions, including their application to illicit drug using clients. It also outlines the clinical procedures that comprise CRA and CRAFT, and considers future research directions. [Publication Abstract]

Nellis, Ashley, Richard Hooks Wayman, and Sara Schirmer. *Back on Track: Supporting Youth Reentry from Out-of-Home Placement to the Community.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2009.

"Public safety is compromised when youth leaving out-of-home placements are not afforded necessary supportive services upon reentering their communities and are therefore at great risk to recidivate into criminal behavior" (p. 5). This report provides guidance and recommendations for achieving successful reentry services and programs. Sections following an executive summary are: introduction; characteristics of reentry youth; collateral consequences associated with out-of-home placement; essential components of youth reentry services; effective outcomes for youth reentry; federal support for reentry in the child welfare system; principles for effective youth reentry; and recommendations for federal leadership in youth reentry. http://nicic.gov/Library/024165

Ready4Reentry Prisoner Reentry Toolkit for Faith-Based and Community Organizations. Washington, DC: Center for Faith-Based and Community Initiatives, 2008.

A promising practices guide for small to medium sized faith-based and community organizations interested in starting or bolstering reentry efforts. Nine sections are contained in this publication: launching a reentry organization; designing an effective program structure; forming successful partnerships; recruiting clients and volunteers; crafting intensive case management; removing barriers to employment through supportive services; implementing effectual employment preparation; succeeding at job placement; mentoring adult ex-prisoners; monitoring program success; and conclusion. http://www.doleta.gov/PRI/PDF/Pritoolkit.pdf

Shanahan, Ryan, and Sandra Villalobos Agudelo. *Close to Home: Building on Family Support for People Leaving Jail*. New York: Vera Institute of Justice, Family Justice Program, 2011.

Most research and programming about incarcerated people and their family support systems focus on prison settings. Because jail is substantially different from prison—most notably, time served there is usually shorter—it is not clear that policies and practices that work in prisons can be applied successfully in jails. This report describes the Family Justice Program's Close to Home project, which implemented the Relational Inquiry Tool (RIT)—a series of questions originally designed for and tested in prisons to stimulate incarcerated people's thinking about supportive family members as a resource—in three jails in Maryland and Wisconsin. The report also discusses the results from qualitative and quantitative research at the three facilities, aimed at gauging the attitudes of jail staff, incarcerated men and women, and family members toward the RIT. http://www.vera.org/content/close-home-building-family-support-people-leaving-jail

Straight-Up: (Expanding) Mentoring of Current and Formerly Incarcerated Adults: Key Components of Successful Relationship-Building to Support Positive Change. Blaine, WA: National Coalition of Community-Based Correctional and Community Re-Entry Service Organizations, 2011.

"This paper contributes to identifying the determinants and characteristics of successful mentoring in the corrections and re-entry context. This analysis has application for formal mentors as well as for other front-line correctional staff and volunteers who seek effective interaction skills when engaging with current and formerly incarcerated individuals" (p. 3). Findings cover: mentoring as a support for positive post-prison outcomes; the context for mentoring relationships within corrections and reentry; the role of the mentorship-style of leadership; what mentoring is; the degree to which mentoring is effective; who is most likely to benefit from mentoring; identifying and selecting individuals for mentor guidance; demographics and mentoring; the relationships between a mentor and offender; and how to mentor. http://www.nc4rso.org/Straight%20Up%20Mentoring%20of%20Current%20and%20Formerly%20Incarcerated%20Individuals.pdf

Yoon, Jamie, and Jessica Nickel. *Reentry Partnerships: A Guide for States Faith-Based and Community Organizations.* Washington, DC: U.S. Bureau of Justice Assistance, 2008.

Recommendations are given on how states "can improve reentry, reduce recidivism, and build or improve collaborations with community-based service providers" (p. 3). Goals and recommendations explain how to: build and sustain comprehensive networks with faith-based and community organizations; simplify pathways to funding for reentry initiatives; tailor responses to the population that will be served by a reentry initiative; and how to ensure accountability for efficient use of funds and gather critical data. http://nicic.gov/Library/023485

Zhang, Sheldon X., Robert E.L Roberts, and Valerie J. Callahan. "Preventing Parolees from Returning to Prison through Community-Based Reintegration." *Crime and Delinquency* 52, no. 4 (2006): 551- 571.

In the late 1990s, California legislators funded a statewide, community-based correctional program intended to reduce parolee recidivism. Overseen by the California Department of Corrections, the Preventing Parolee Crime Program (PPCP) provided literacy training, employment services, housing assistance, and substance abuse treatment to tens of thousands of parolees. The study found that the PPCP produced modest reductions in

reincarcerations and parole absconding, creating the potential for substantial long-term cost savings for California taxpayers. Because the PPCP's positive effects were strongest for parolees who completed their services, future program designers and administrators should consider including mechanisms to improve parolee retention and service utilization. This study also points out the potential benefits of incorporating rigorous evaluation plans into the design and implementation of correctional rehabilitation programs.

Principles 7 8. Measure Relevant Processes & Practices AND Measurement Feedback

Bell, Robert M., et al. *Methodology for Evaluating Court-Based Mental Health Interventions in Maryland,* Baltimore: Maryland Judiciary Research Consortium, March 2010.

This report describes a methodology for process and outcome evaluations of court-based mental health interventions that reflects their complex, multi-organizational, and varied characteristics. The process evaluation methodology is designed to elicit how the intervention evolved, what organizations provide what services to whom, and how closely the participants and activities match what was intended. The outcome evaluation methodology is designed to establish the impact of the intervention on participants and on the mental health and criminal justice systems. This is the first of three reports addressing court-based mental health interventions produced by the Maryland Judiciary Research Consortium, a partnership between the Maryland Judiciary, Administrative Office of the Courts, and units of Maryland's public universities. The second report, Process Evaluation of the Harford County Mental Health Diversion Program, was also prepared by IGSR researchers. The third report, Evaluation of the Baltimore City Mental Health Court, was prepared by researchers at Morgan State University. http://www.igsr.umd.edu/appliedresearch/Pubs/Methodology%20for%20Evaluating%20CourtBased%20Mental%20Health%20Interventions.pdf

Bernstein, Gary A., David P. Farrington, and Alan W. Leschied. *Offender Rehabilitation Practice: Implementing and Evaluating Effective Programs.* New York: Wiley & Sons, 2001

Documented evidence suggests that community safety is best achieved through policies promoting human services rather than relying totally on prisons and that promoting intervention in an individual's own environment (known as ecological integrity') is closely associated with effective intervention. This is the first book to focus on the transfer of knowledge of worldwide effective offender rehabilitation programs. Prominent researchers and practitioners in the criminal justice field have contributed their extensive knowledge of what it takes to implement effective correctional practices with ecological integrity. [From Amazon.com]

Callahan, Kathe, and Kloby Kathryn. *Moving Toward Outcome-Oriented Performance Measurement Systems.* Washington, DC: *IBM Center for the Business of Government*, 2009.

The use of outcome-oriented performance measurement by community leaders is explained. Sections of this report include: introduction; three profiles in outcome-oriented performance measurement systems; the challenge of creating these systems; recommendations for creating these systems; conclusion; and an appendix comparing

government-sponsored and community indicator approaches. http://nicic.gov/Library/023642.

Dowden, Craig, and Ralph Serin. *Anger Management Programming for Offenders: The Impact of Program Performance Measures*. Ottawa: Correctional Service Canada/Research Branch, 2001. The present investigation is an extension of a previous controlled outcome evaluation of CSC's Anger and Emotions Management program (Dowden, Blanchette, Serin, 1999). Although the previous study explored the effectiveness of an institutional anger management program for federal male inmates, dropout and institutional incident data were not available at the time of the final report. The present study includes this additional information to explore three major research questions. The first issue was the impact of Anger Management programming on the frequency of institutional incidents... Another area of interest was the recidivism rates for the treatment, comparison and dropout groups. Finally, the incremental contribution of participation in an Anger Management program to the issue of recidivism prediction was explored through logistic regression analysis. The results revealed that successful completion of an Anger Management program was associated with reduced levels of reoffending once several significant predictors of post-release outcome were statistically controlled.
http://www.csc-scc.gc.ca/text/rsrch/reports/r106/r106 e.pdf

Geerken, Michael. *Performance Measurement for Justice Information System Projects*. San Marcos: Texas State University, Center for Society, Law and Justice; Washington, DC: U.S. Bureau of Justice Assistance, 2008.
The crafting of performance measures and those for criminal justice information sharing are discussed. "The guide helps managers, staff, and executives develop measures in two ways: by offering comments and advice on the process of developing measures, and by providing a catalog of workable examples for specific types of project" (p. 1). Nine chapters are contained in this publication: introduction—what performance measures are; which goals the project helps us achieve; how the project assists us in achieving our goals; what the best measures of the agency's goals are; how performance measures can best be implemented; introduction to performance measures for criminal justice information sharing; summary of performance measures; project type examples from the Automated Fingerprint Identification System (AFIS) to the Warrant Depository; and how to use this guide and final thoughts. An appendix explains the Chain of Results and Logic Model.
http://nicic.gov/Library/026137

Harrell, Adele, John Roman, Avinash Bhati, and Barbara Parthasarathy. *The Impact Evaluation of the Maryland Break the Cycle Initiative*. Washington, DC: The Urban Institute, 2003.
This evaluation examined the impact of Break the Cycle (BTC), an initiative designed to reduce drug use and crime among probationers and parolees in the state of Maryland. The BTC strategy uses intensive supervision to encourage offenders on supervision to abstain from using drugs and participate in drug treatment. BTC was adopted by the Division of Parole and Probation (DPP) for all offenders under DPP who were under supervision with a drug condition stipulated by a judge or the Parole Commission. Efforts to increase access to drug treatment took place in many DPP offices across the state and supervising agents

were encouraged to apply sanctions for violations of drug conditions. Six of Maryland's largest counties (Baltimore, Charles, Howard, Montgomery, Prince George's, and Washington) and Baltimore City received additional funds from the Maryland Legislature to support the implementation of BTC. These funds were used primarily for additional drug testing. In addition, these BTC areas developed an automated tracking system (HATS) to support the monitoring and treatment referral process for eligible probationers and parolees. http://www.urban.org/uploadedPDF/410807 MD BTC.pdf

Howe, Megan, and Lore Joplin. *Implementing Evidence-Based Practice in Community Corrections: Quality Assurance Manual*. Crime and Justice Institute. Washington, DC: National Institute of Corrections.

This manual provides a simple and straightforward approach to implementing evidence-based practice" (p. 3). This manual explains: quality assurance plan development; peer review; quality assurance indicators; customer satisfaction; program evaluation; and individual performance measurement. Samples of pertinent forms are also included. http://static.nicic.gov/Library/021258.pdf http://cjonline.uc.edu/field-of-criminal-justice/criminal-justice-research/does-correctional-program-quality-really-matter-the-impact-of-adhering-to-the-principles-of-effective-intervention-2006/

Performance Based Measurement System: What Really Counts in Corrections! [Broadcast held September 14, 2011, 130 min]. Washington, DC: National Institute of Corrections, 2011.

This program provides information about the nationwide automated Performance-Based Measures System (PBMS). PBMS is an accurate, consistent way to capture, record, report and share data between correctional agencies. It was created by the Association of State Correctional Administrators (ASCA). Participants will be able to describe the scope and development of PBMS regarding how specific needs gave rise to PBMS solutions; describe the key components of PBMS; examine the benefits of using the PBMS during an Evidenced Based Practice decision making process; and identify available resources that support implementation of PBM.
http://nicic.gov/Library/025292

Poulin, Mary, Stan Orchowsky, and Jason Trask. *Is This a Good Quality Outcome Evaluation Report? A Guide for Practitioners*. Washington, DC: Bureau of Justice Assistance; Center for Program Evaluation and Performance Measurement Justice Research and Statistics Association, 2011.

"This guide is designed to introduce and explain the key concepts in outcome evaluation research in order to help practitioners distinguish between good and poor quality evaluation reports" (p. 3). Topics covered include: what evaluation is; the role of evaluation design; how well the evaluation is carried out; sample size appropriateness; definitions of evaluation terms; cost-benefit analysis; meta-analyses and systematic reviews; assessing the report's quality; and "Is This a Good Quality Evaluation Report?" checklist. http://nicic.gov/Library/025537

Blueprints Programs

DeVore, Donald W. "Functional Family Therapy and Multisystemic Therapy: Doing More with Less." *Corrections Today* 73, no. 1 (2011): 20-23.

> While both Functional Family Therapy and Multisystemic Therapy (MST) have components that focus on the youth and adult caregivers to promote positive behavior, MST therapists try to enable the parent or adult caregiver to take the lead role in effecting change. [...] issues that impair the caregiver's ability to effectively parent the youth are addressed immediately.

Henggeler, Scott W., Gary B. Melton, Michael J. Brondino, David G. Scherer, and Jerome H. Hanley. "Multisystemic Therapy with Violent and Chronic Juvenile Offenders and Their Families: The Role of Treatment Fidelity in Successful Dissemination." *Journal of Consulting and Clinical Psychology* 65 (1997): 821-833.

> The effects of multisystemic therapy (MST) in treating violent and chronic juvenile offenders and their families in the absence of ongoing treatment fidelity checks were examined. Across 2 public sector mental health sites, 155 youths and their families were randomly assigned to MST versus usual juvenile justice services. Although MST improved adolescent symptomology at post-treatment and decreased incarceration by 47% at a 1.7- year follow-up, findings for decreased criminal activity were not as favorable as observed on other recent trials of MST. Analyses of parent, adolescent, and therapist reports of MST treatment adherence, however, indicated that outcomes were substantially better in cases where treatment adherence ratings were high. These results highlight the importance of maintaining treatment fidelity when disseminating complex family-based services to community settings.

Mihalic, Sharon F., and Katherine Irwin. *Blueprints for Violence Prevention: From Research to Real World Wettings – Factors Influencing the Successful Replication of Model Programs*. Boulder, CO: Center for the Study and Prevention of Violence, 2003.

> As science-based programs become more readily available to practitioners, the need for identifying and overcoming problems associated with the process of implementation becomes critical. A major goal of the Blueprints for Violence Prevention initiative has been to enhance the understanding of program implementation by studying the influence of human- and systems-level factors that challenge the successful implementation of programs. This article describes the results of a process evaluation focused on discovering common implementation obstacles faced by 42 sites implementing eight of the Blueprints programs. This evaluation revealed that most sites involved in the project faced many challenges when implementing in real-world settings. Using regression analyses to identify the most important of these factors, findings revealed that the quality of technical assistance, ideal program characteristics, consistent staffing, and community support were important influences on one or more measures of implementation success. http://www.colorado.edu/cspv/blueprints/articles/MihalicIrwin Article.pdf

Caseload Size

Armstrong, Gaylene, Doug Dretke, and Cassandra Atkin. *The Importance of a Low Span of Control in Effective Implementation of Evidence-based Probation and Parole Practices*. Huntsville, TX: Sam Houston State University/College of Criminal Justice, 2010.

This report explains why the current probation officer to supervisor ratio (7:1 span of control) should not be increased to a higher level due to significant impacts on the implementation and sustainability of evidence-based practices (EBPs) in the Community Based Correctional System in Iowa. Span of control is "the number of individuals, or resources, that a person can effectively supervise within a structured organizational, business of military setting" (p. i). Sections of this report following an executive summary are: the importance of a low span of control in effective implementation of EBPs for probation and parole; findings on the impact of this low span of control; probation officer competencies; application of theoretical span of control factors to an EBP probation and parole environment; and conclusions and considerations. http://nicic.gov/Downloads/PDF/Library/024881.pdf

DeMichele, Matthew T., Brian K. Payne, and Adam K. Matz. *Community Supervision Workload Considerations for Public Safety.* Lexington, KY: American Probation and Parole Association; Washington, DC: Bureau of Justice Assistance, 2011.

Two tools are described that will help the community corrections field become more efficient—a time study template and a workload matrix. "These tools, hopefully, will move the filed past the debate between caseload size and workload" (p. 2). This publication is divided into six parts: the misunderstood community corrections filed; more than evidence-based practices; framing the debate of workload versus caseload issues; the benefits of a time study template and a workload matrix for agencies, the benefits of time studies, workload studies, and eight barriers to completing tasks; methods-description of the APPA process; workload vs. caseload debate and time for a time study template; results; findings from the time studies in minutes per offenders/month; time study matrix with 17 matrix elements; and discussion. http://www.appa-net.org/eweb/docs/APPA/pubs/CSWCFPS.pdf

Jalbert, Sarah Kuck, *et al*. *A Multi-Site Evaluation of Reduced Probation Caseload Size in an Evidence-Based Practice Setting.* Washington, DC: National Institute of Justice, 2011.

Probation agencies striving for lower recidivism rates should look at this report. The reduction of probationer recidivism due to the combination of reduced caseloads and the implementation of evidence-based practice (EBP) is examined. These chapters follow an abstract and executive summary: introduction; background and literature review; research questions and study design; Oklahoma City; Polk County, Iowa; Colorado; and conclusions and policy implications. "The results showed that reducing probation officer caseloads can reduce criminal recidivism when delivered in a setting where probation officers apply EBP" (p. 1). http://www.ncjrs.gov/pdffiles1/nij/grants/234596.pdf

Evaluated Programs, including Core Correctional Practices (CCP)

See Also: Websites, below

Fry, Russ. *Why Evidence-Based Practices Matter (Or, Please Pass the Leeches).* 2008.

A collection of articles written by Russ Fry concerning corrections with an occasional focus on community corrections is presented. Articles included in this compilation are: "Why Evidence-Based Practices Are Important (Or, Please Pass the Leeches)"; "Thirty Percent Chances of Storms"; "What Does It Mean to Have a Disorder?"; "The High-End Risk Principle"; "Denial: A Cognitive-Behavioral Perspective"; "Three Pathways to Criminal Behavior"; Community Corrections' Core Mission"; "Dividing Treatment into Three Phases -- Treatment Readiness, Treatment, and Aftercare"; "Some Thoughts on Evidence-Based Therapeutic Programs"; "The Spirit of Motivational Interviewing"; "Radical Responsivity"; "Cognitive-Behavioral Therapies in Community Corrections: Getting to the Right Kind of Insight"; "EBP and Correctional Curriculums"; "What Does It Mean to Have a Problem?"; "The Accidental Criminal"; "Emotional Intelligence and Criminal Conduct"; "Universal Program Design for Criminogenic Problem Areas"; "A Cognitive-Behavioral Framework for Sanction Implementation"; and "Offender Empathy and Discovery/Experiential Based Facilitation." http://www.iowaica.com/sitebuildercontent/sitebuilderfiles/fryebook080604.pdf

Fabelo, Tony, and Angie Gunter. *Organizational Assessment of Travis County Community Supervision and Corrections Department (CSCD): Facing the Challenges to Successfully Implement the Travis Community Impact Supervision (TCIS) Model*, 2005.

The ability of the Travis County Community Supervision and Corrections Department to implement the Travis Community Impact Supervision model—"an evidence-based practices (EBP) organization and supervision model"—is assessed. This report is comprised of nine sections: Travis CSCD and the state probation system; trends and population profile; implementing the TCIS; organizational strengths; organizational challenges; recommendations; work plan; and appendix containing three preliminary maps showing distribution of supervised offenders. If certain conditions are met, "Travis CSCD may be a state and national incubator site of strategies showing how to realign a probation department to achieve better outcomes and improve public safety" (p. xv). http://www.jfa-associates.com/publications/ppope/Travis83105Fina l.pdf.

Hoffman, Nancy, Christine A. Ameen, and Jennifer Loeffler-Cobia. *Supervisors Leadership Academy: Cultivating an Evidence-Based Organization Collection,* 2010.

"The Supervisors Leadership Academy (SLA) is designed to prepare first line community corrections supervisors for their new role as change leaders" in an agency utilizing an evidence-based practice (EBP) approach (p. 1). Six sessions comprise this training program: the leadership journey--an overview of leadership; beginning the journey--preparing to change the organization's culture; engaging others--leadership skills; handling rough spots--potential obstacles; celebrating milestones--evaluations; and continuing the journey--ongoing growth and development. This zip file contains the curriculum guide and lesson plans and curriculum slides, and participant workbook. http://nicic.gov/Downloads/PDF/Library/024836.zip

Hoffman, Nancy, Elyse Clawson, Kristy Danford, and Meghan Guevara. *Supervisors Leadership Academy: Cultivating an Evidence-Based Organization: Curriculum Guide Lesson Plans [Lesson Plan]*. Washington, DC: National Institute of Corrections in partnership with Crime and Justice Institute, 2010.

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http://nicic.gov/Downloads/PDF/Library/024395.zip

Hoffman, Nancy, Elyse Clawson, Kristy Danford, and Meghan Guevara. *Supervisors Leadership Academy: Cultivating an Evidence-Based Organization: Participant Workbook*. Washington, DC: National Institute of Corrections in partnership with Crime and Justice Institute, 2010.

The Supervisors Leadership Academy (SLA) is designed to prepare first line community corrections supervisors for their new role as change leaders" in an agency utilizing an evidence-based practice approach. Six sessions comprise this training program: the leadership journey--an overview of leadership; beginning the journey--preparing to change the organization's culture; engaging others--leadership skills; handling rough spots--potential obstacles; celebrating milestones--evaluations; and continuing the journey--ongoing growth and development. Can be used in conjunction with curriculum guide and lesson plans.
http://nicic.gov/Downloads/PDF/Library/024396.pdf

Lowenkamp, Christopher T., Alexander M. Holsinger, Charles R. Robinson, and Melissa Alexander. "Diminishing or Durable Treatment Effects of STARR? A Research Note on 24-month Re-Arrest Rates." *Journal of Crime Justice* (in press).

In 2009 the Administrative Office of the US Courts developed and piloted a training program, Staff Training Aimed at Reducing Re-arrest (STARR) for probation and pretrial officers. The purpose of this program was to train officers in the use of core correctional practices in their one-on-one interactions with offenders. Two areas of interest were subsequently investigated by researchers. First, did the training impact officer behaviors and second did trained officers supervise offenders that had lower failure rates. The evaluation of this effort was published in 2012 and used a 12 month follow up for the measure of recidivism. The current study, a research note, extends the follow up period for recidivism to 24 months. While there is some decline in the overall treatment effects it appears that STARR training is associated with a reduction in recidivism for moderate risk offenders. Further, when coupled with training in MI, STARR seems to provide a promising reduction in recidivism with high-risk offenders. The limitations of the study and policy implications are discussed.

National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide*. Washington, DC: National Institutes of Health, 2007. This guide provides an overview of drug abuse treatment research, essential principles,

frequently asked questions, and resources for the criminal justice and treatment professionals working with individuals involved in the criminal justice system. http://www.samhsa.gov/co-occurring/topics/criminal-justice/drug-abuse-treatment-guide.aspx

National Research Council, Committee on Community Supervision and Desistance from Crime. *Parole, Desistance from Crime, and Community Integration*. Washington, DC: The National Academies Press, 2007.

Individuals should turn to this book if they want to know what is known "about various models of community supervision designed to reduce recidivism and promote desistance from crime" (p. ix). Sections following an executive summary include: dimensions of desistance; parole-current practices; services and practices for releases; criminal justice institutions and community resources; and conclusions, recommendations, and research agenda. It seems that recidivism is greatly reduced through the use of cognitive-treatment programs.

Robinson, Charles R., Christopher T. Lowenkamp, Alexander M. Holsinger, Scott VanBenschoten, Melissa Alexander, and J.C. Oleson. "A Random Study of Staff Training Aimed at Reducing Re-arrest (STARR): Using Core Correctional Practices in Probation Interactions." *Journal of Crime and Justice* (2012): 1-22.

The recent application of the risk–need–responsivity (RNR) model, in conjunction with core correctional practices, has offered promising results. In the present study, supervision officers were trained in core correctional skills and the RNR model. Supervision officers were randomly assigned to training groups and provided audio recordings of interactions with clients to assess their use of learned skills. The current study utilizes taped interactions between officers and offenders, individual-level offender data, and outcome/recidivism data to investigate the impact of the training regimen, which is the core focus of this paper. Trained probation officers demonstrated greater use of the skills taught during training and their clients had lower failure rates. These findings suggest that providing Staff Training Aimed at Reducing Re-arrest (STARR) training to community supervision officers can impact the officers' use of important correctional skills and improve client outcomes.

Scott, Wayne. *Effective Clinical Practices in Treating Clients in the Criminal Justice System*. Washington, DC: National Institute of Corrections, 2008

This monograph is "intended to strengthen and improve the dissemination of evidence-based rehabilitative technologies for offenders, within the multidisciplinary context of correctional treatment"(p.x). Sections of this document include: executive summary; effective clinical practices and the critical need for collaboration; what evidence-based practice (EBP) is; overarching principles of effective correctional treatment; common therapeutic factors—what works in treatment generally; specific evidence-based modalities for criminal justice clients; and conclusion—what have we lost. There are four appendixes: confidentiality in correctional treatment; the separate and complementary functions of corrections and treatment; coerced treatment; and quality assurance. http://nicic.gov/Downloads/PDF/Library/023362.pdf

Shelton, Deborah, Susan Sampl, Karen L. Kesten, Wanli Zang, and Robert L. Trestman. "Treatment of Impulsive Aggression in Correctional Settings." *Behavioral Sciences and the Law* 27 (2009):787-800.

This article reports the implementation of Dialectical Behavioral Therapy—Corrections Modified (DBT-CM) for difficult to manage, impulsive and/or aggressive correctional populations. Methods. Participants were English-speaking women (n1/418) and men (n1/445) of diverse cultural backgrounds between the ages of 16 and 59 years old retained in state-run prisons in Connecticut. Following consent, and a psychological assessment battery, twice-weekly DBT-CM groups were held over 16 weeks followed by random assignment to DBT coaching or case management condition, with sessions taking place individually for eight weeks. Data analysis. A mixed effects regression model was used to test the hypotheses: participants will show decreased aggression, impulsivity, and psychopathology, as well as improved coping, after completing the DBT-CM groups; and will show greater reduction in targeted behaviors than those receiving case management at the six month and 12 month follow-up assessment periods. Results. Significant reduction in targeted behavior was found from baseline to following the16 week DBT-CM skills treatment groups. Both case management and DBT coaching were significant at 12-month follow-up. A significant difference was found for adult men and women. Conclusions. The study supports the value of DBT-CM for management of aggressive behaviors in prison settings.

Taxman, Faye S. "No Illusions: Offender and Organizational Change in Maryland's Proactive Community Supervision Efforts." *Criminology Public Policy* 7, no. 2 (2008): 275-302.

Evidence-based supervision is the newest in a long line of efforts to advance community corrections. This new model adopts a risk-need-responsivity model where the agency uses a risk and need tool to identify appropriate treatment and control services and then assigns offenders to such services. Underscoring this new approach is the creation of a social learning environment that makes supervision officers active in facilitating offender change. The goal is to empower the offender. Maryland's Proactive Community Supervision (PCS) model was one of the first to implement this approach. Controlling for length of time on supervision and prior history, logistic regression results found that offenders who were supervised in this new style were less likely to be rearrested (30% for the PCS and 42% of the non-PCS sample; $p < 0.01$) and less likely to have a warrant issued for technical violations (34.7% of the PCS group and 40% for the non-PCS group; $p < 0.10$).

Wanberg, Kenneth, and Harvey Milkman. *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change: Pathways to Responsible Living. The Provider's Guide,* 2nd ed. Thousand Oaks, CA: Sage Publications, 2008.

The Strategies for Self-Improvement and Change (SSC) curriculum is designed to assist in the treatment of individuals with a combination of criminal activity and substance abuse. "Effective treatment of judicial clients must go beyond the more traditional therapeutic approaches of self-caring and responsibility to self and make caring about and responsibility to the community and society of equal importance. Thus, [the authors] see social responsibility therapy (SRT) as a core element in the treatment of judicial clients" (p. xvi). The Provider s Guide describes: the treatment platform—core strategies and conceptual

framework, the therapeutic relationship and motivational enhancement, treatment phases, cognitive-behavioral approach as the platform for change, and relapse and recidivism prevention; operational guidelines; assessment structure, process and instrumentation, methods and skills for effective program delivery, and provider knowledge and skills necessary in SSC delivery; and the treatment curriculum. Modules are organized according to treatment phases. Phase I, challenge to change—building knowledge and skills for responsible living, includes: orientation; how this program works; cognitive-behavioral approach to change and responsible living; alcohol and other drug (AOD) use patterns and outcomes; understanding and changing criminal thinking and behavior; sharing and listening, communication pathways to self-awareness and other-awareness; understanding and preventing relapse and recidivism; steps, stages, and skills for self-improvement and change; and closure; looking forward and making a commitment. Phase II, commitment to change—strengthening skills for self-improvement, change, and responsible living, includes: mental self-control; managing thoughts and emotions; social and relationship skills building; skills in social and community responsibility; and closure; looking forward and taking ownership. Phase III, ownership of change—lifestyle balance and healthy living, includes: relapse and recidivism prevention; strategies for a balanced lifestyle; strengthening ownership of change; skills for a healthy lifestyle; and closure; continuing your journey for responsible living.

Weibrecht, Kimberly A. *Evidence-Based Practices and Criminal Defense: Opportunities, Challenges, and Practical Considerations*. Washington, DC: National Institute of Corrections, 2008.

Guidance is provided to criminal defense attorneys concerning the use of evidence-based practices (EBP). Sections of this report include: executive summary; principles of EBP; the role of defense counsel as advocate in an EBP criminal justice system; and the role of defense counsel as policy-maker. http://static.nicic.gov/Library/023356.pdf

Wilson, David B., Doris L. MacKenzie, and Fawn Ngo Mitchell. *Effects of Correctional Boot Camps on Offending.* Campbell Systematic Reviews 2003:1.

Background: Correctional boot camps were first opened in United States adult correctional systems in 1983. Since that time they have rapidly grown, first within adult systems and later in juvenile corrections, primarily within the United States. In the typical boot camp, participants are required to follow a rigorous daily schedule of activities including drill and ceremony and physical training, similar to that of a military boot-camp. Punishment for misbehavior is immediate and swift and usually involves some type of physical activity like push-ups. Boot-camps differ substantially in the amount of focus given to the physical training and hard labor aspects of the program versus therapeutic programming such as academic education, drug treatment or cognitive skills. Objectives: To synthesize the extant empirical evidence on the effects of boot-camps and boot camp like programs on the criminal behavior (e.g., postrelease arrest, conviction, or re-institutionalization) of convicted adult and juvenile offenders. www.campbellcollaboration.org/lib/download/3/

Incentives and Sanctions / Contingency Management

Bartholemew, Norma G. *Contingency Management Strategies and Ideas.* Institute of Behavioral Research, Texas Christian University, 2005.

This manual includes a series of "topic-focused modular applications" designed particularly for counselors and group facilitators working in substance abuse treatment programs. The collection of applications contains focused, easily accessible, and brief adaptive strategies for using rewards and star charts to reinforce goal setting, early engagement, and retention in treatment settings. http://www.ibr.tcu.edu/pubs/trtmanual/CMStrategies.html

Brauer, Jonathan R. "Testing Social Learning Theory Using Reinforcement's Residue: A Multilevel Analysis of Self-Reported Theft and Marijuana Use in the National Youth Survey." *Criminology* 47, no. 3 (2009): 929-970.

Critics have expressed concerns regarding measurement strategies or analytic techniques often used in social learning research (Horan and Phillips, 2003; Krohn, 1999; Sampson, 1999; Tittle, 2004). In response to these concerns, this study tests the hypothesized causal relationships among reinforcement, general definitions, and self-reported crime (theft and marijuana use) using a multilevel modeling approach with longitudinal data from the first five waves of the National Youth Survey (NYS), as well as with indirect parent and friend reinforcement measures that incorporate both the assumed products of reinforcement (expected consequences of behavior) and the efficacy of reinforcement (expected influence of the reinforcement source). Within-subject analyses present a challenge to the theory as social learning variables do not exhibit co-variation significantly over time with criminal offending rates. Between subject analyses offer support for the theory as across-person differences in average parent and friend reinforcement are significantly related to offending rates, and these reinforcement–crime relationships are mediated partially or fully by learned definitions. Implications of these findings are discussed.

Carter, Madeline. *Responding to Parole and Probation Violations: A Handbook to Guide Local Policy Development.* Washington, DC: National Institute of Corrections, 2001.

The manner in which jurisdictions respond to parole and probation violations should be thoughtful and deliberate. Although each case requires individual decision-making, the response to a given violation should be consistent with policy developed by that jurisdiction. Agency violation policies should be built around such considerations as assessment of risk posed by the offender, case processing requirements, local resource availability, and outcomes desired by the agency for certain types of violations. Agency violation policies guide line staff in making supervisory decisions and assist decision-makers in reaching consistent and equitable dispositions. During the past decade, the National Institute of Corrections (NIC) helped 29 jurisdictions address violation issues by providing onsite technical assistance. Many other jurisdictions have expressed interest in receiving such support. Among the lessons learned is that goals, resources, and values differ from one place to another. It is vital that jurisdictions work through a process leading to informed policy options that meet their particular needs. This handbook is built around what we have learned about how agencies effectively address violations policy. Expanding on information and examples from the 29 jurisdictions, this document is designed to lead

agency policy teams through a series of activities to help them develop their own set of violation policies. http://static.nicic.gov/Library /016858.pdf

Gendreau, Paul, Shelley J. Listwan, and Joseph B. Kuhns. *Managing Prisons Effectively: The Potential of Contingency Management Programs*. Ottawa: Public Safety Canada, 2011.

There has been increasing interest in the prison management policy area to promote a course of action that holds inmates more accountable for their actions. It has been proposed that inmates need more structure and discipline and engage in activities that will demonstrate they truly earn privileges leading to early release. This study draws attention to a long forgotten prison treatment literature known as contingency management (e.g., token economies) which has the potential to meet the goals of an "accountability" management perspective. The contingency management (CM) literature was reviewed to assess its potency for improving inmates' performance (e.g., prison adjustment, educational/work skills) and to generate a list of principles nominated by experts in the area for managing CM programs effectively. First, it was found that CM programs produced large positive gains in the range of 60%-70% which surpassed the effectiveness of other types of interventions. Secondly, the list of principles tabulated for delivering CM program were categorized as to how to implement them and deliver the service (i.e., strategies for what to do, not to do and problematic issues). It was concluded that following the course of action recommended by experts for running CM programs with fidelity placed tremendous demands on all of the prison stakeholders. Unless a number of conditions were met, CM programs should be approached with a great deal of caution given the nature of prison settings.
http://www.publicsafety.gc.ca/res/cor/rep/2011-04-mpe-eng.aspx

Hawken, Angela, and Mark Kleiman. *Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii s HOPE.* A report to the National Institute of Justice, 2009.

HOPE (Hawaii's Opportunity Probation with Enforcement), a community supervision strategy, is evaluated. Results of this investigation are organized into the following areas: primary outcomes--drug testing; missed scheduled probation appointments; revocations; incarceration; process evaluation; and summary of surveys—probation officer training, job satisfaction, stakeholder groups' workload, and general perceptions. HOPE probationers have lower positive drug tests and missed appointments. https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf

Lowenkamp, Christopher T., Edward J. Latessa, and Paula Smith. "*Does Correctional Program Quality Really Matter? The Impact of Adhering To the Principles of Effective Interventions*." *Criminology and Public Policy* 5, no. 3 (2006): 575-594.

Research Summary: This study analyzed data on 3,237 offenders placed in 1 of 38 community-based residential programs as part of their parole or other post-release control. Offenders terminated from these programs were matched to, and compared with, a group of offenders (N = 3,237) under parole or other post-release control who were not placed in residential programming. Data on program characteristics and treatment integrity were obtained through staff surveys and interviews with program directors. This information on program characteristics was then related to the treatment effects associated with each program.

Policy Implications: Significant and substantial relationships between program characteristics and program effectiveness were noted. This research provides information that is relevant to the development of correctional programs, and it can be used by funding agencies when awarding contracts for services.

Higgins, Stephen T., and Kenneth Silverman. *Motivating Behavior Change Among Illicit-drug Abusers: Research on Contingency Management Interventions*. Washington, DC: American Psychological Association, 1999.

Overcoming drug addiction requires great personal motivation on the part of the addict: The drug abuser must want to break the habit before change may occur. Contingency management interventions represent one of the most effective ways to enhance motivation among substance abusers. This book describes the use of contingency management with individuals addicted to cocaine, heroine, and other illicit-drugs. Contingency management is a scientifically based process of providing incentives for abstaining from drug abuse. Techniques involved in this treatment include positive reinforcement for drug abstinence and punishment for returning to drug use, with the emphasis on positive reinforcement.

Marlowe, Douglas B. "Evidence-Based Policies and Practices for Drug-Involved Offenders." *The Prison Journal* 91, no. 3 (2011): 27S-47S.

Research on effective rehabilitation of drug-involved offenders has advanced considerably in recent years. Yet policies and practices remain rooted in sentiments from decades past when authorities did not know how to supervise drug offenders closely, apply effective behavioral consequences, or treat the disease of addiction. This article reviews evidence-based practices in sentencing, supervision, treatment, and reentry for drug-involved offenders, drawing on painful lessons from past failed policies. Recommendations are offered at each stage in the justice process for incorporating evidence-based principles into sentencing laws, correctional practices, and treatment interventions. [Author Abstract]

Marlowe, Douglas B., David S. Festinger, Karen L. Dogosh, Patricia L. Arabia, and Kimberly C. Kirby. "An Effectiveness Trial of Contingency Management in a Felony Preadjudication Drug Court." *Journal of Applied Behavioral Analysis* 41, no. 4 (2008): 565-577.

This study evaluated a contingency management (CM) program in a drug court. Gift certificates for compliance were delivered at 4- to 6-week intervals (total value $390.00). Participants in one condition earned gift certificates that escalated by $5.00 increments. Participants in a second condition began earning higher magnitude gift certificates, and the density of reinforcement was gradually decreased. No main effects of CM were detected, which appears to be attributable to a ceiling effect from the intensive contingencies already delivered in the drug court and the low density of reinforcement. Preplanned interaction analyses suggested that participants with more serious criminal backgrounds might have performed better in the CM conditions. This suggests that CM programs may be best suited for more incorrigible drug offenders. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2606594/

Palmer, Ted. *A Profile of Correctional Effectiveness and New Directions for Research*. Albany: State University of New York. 1994.

The first chapter describes the different ways that meta- analyses and literature reviews integrate information from numerous studies and how these methods provide insight into different, as well as overlapping, aspects of intervention. This examination summarizes 10 of the 32 meta-analyses and literature reviews, focusing on their findings and conclusions for correctional intervention overall. Two subsequent chapters present the results of the 32 analyses for each of 20 intervention approaches individually, and then describe the major trends regarding intervention that emerge from the collective findings. The second set of chapters propose a new direction for intervention research that would study a combination of features comprising given programs. The final chapters focus on technical and conceptual issues, such as success criteria and the nature of decisive factors. This book's review of 20 types of interventions identifies several types that are more likely to reduce recidivism. https://www.ncjrs.gov/App/Publications/abstract.aspx? ID=151762

Petersilia, Joan. "Employ Behavioral Contracting for 'Earned Discharge' Parole." *Criminology and Public Policy* 6, no. 4 (2007): 807–814.

Current parole contracts focus on specifying the requirements for parolees behavior while on parole and the punitive sanctions that will be applied if these requirements are violated. In order to foster long-term behavioral change, a balance of rewards and sanctions is necessary for pro-social behavioral change. For most parolees, discharge from parole is a major goal. Linking the shortening of the parole period with positive behavior can reduce reoffending and the violation of other parole requirements, such as remaining in treatment. The author has conducted dozens of interviews with parolees over the past several years, which have included asking them what might motivate them to enroll in rehabilitation programs and continue to attend. One of the consistently strong motivators is the prospect of being released from parole supervision. Parole terms should not only prohibit reoffending but also require participation in prescribed prosocial activities. Offenders who complete such activities as drug treatment or educational programs should be rewarded with a reduction in the length of their parole. The parole contract should include precise statements about how much time will be reduced from the parole term by successful participation in specified activities as well as for remaining arrest-free for indicated lengths of time. Every parolee should be on parole for at least 6 months, since recidivism studies consistently show that parolees at high risk of reoffending will do so quickly.
https://www.ncjrs.gov/App/Publications/abstract.aspx? ID_242585]
http://www.colorado.gov/ccjjdir/Resources/Resources/Ref/Parole_Petersillia.pdf

Pratt, Travis C., et al. "The Empirical Status of Social Learning Theory: A Meta-Analysis." *Justice Quarterly* 27, no. 6 (2010): 765-802.

Social learning theory has remained one of the core criminological paradigms over the last four decades. Although a large body of scholarship has emerged testing various propositions specified by the theory, the empirical status of the theory in its entirety is still unknown. Accordingly, in the present study, we subject this body of empirical literature to a meta-analysis to assess its empirical status. Results reveal considerable variation in the magnitude and stability of effect sizes for variables specified by social learning theory across different methodological specifications. In particular, relationships of crime/deviance to measures of differential association and definitions (or antisocial attitudes) are quite strong, yet those for differential reinforcement and modeling/imitation

are modest at best. Furthermore, effect sizes for differential association, definitions, and differential reinforcement all differed significantly according to variations in model specification and research designs across studies. The implications for the continued vitality of social learning in criminology are discussed.

Rudes, Danielle S., et al. "Adding Positive Reinforcement in Justice Settings: Acceptability and Feasibility." *Journal of Substance Abuse Treatment* 42, no. 3 (2012): 260-270.

Although contingency management (CM) approaches are among the most promising methods for initiating drug abstinence (S. T. Higgins, S. M. Alessi, & R. L. Dantona, 2002; S. T. Higgins, S. H. Heil, & J. P. Lussier, 2004), adoption and implementation of CM protocols into treatment programs are both challenging and infrequent. In criminal justice agencies, where roughly 70% of clients report substance abuse issues (F. S. Taxman, K. L. Cropsey, D. W. Young, H. Wexler, 2007), CM interventions are virtually nonexistent. The Justice Steps (JSTEPS) study uses a longitudinal, mixed-method design to examine the implementation of a CM-based protocol in five justice settings**.** This article presents qualitative data collected during Phase 1 of the JSTEPS project regarding the acceptability and feasibility of CM in these justice settings**.** The study finds a level of acceptability (find CM tolerable) and feasibility (find CM suitable) within justice agencies, but with some challenges. These challenges are reflected in the following: (a) incorporating too many desired target behaviors into CM models; (b) facing intraorganizational challenges when designing CM systems; and (c) emphasizing sanctions over rewards despite the evidence-base for positive reinforcers. These findings have implications for advancing the dissemination, adoption, and implementation of evidence-based treatments (and CM in particular) in criminal justice settings. [Author Abstract]

Wilson, David, Ojmarrh Mitchell, and Doris MacKenzie. "A Systematic Review of Drug Court Effects on Recidivism." *Journal of Experimental Criminology* 2, no. 4 (2006), 459–487.

Drug courts have been proposed as a solution to the increasing numbers of drug involved offenders entering our criminal justice system, and they have become widespread since their introduction in 1989. Evaluations of these programs have led to mixed results. Using meta-analytic methods, we systematically reviewed the extant evidence on the effectiveness of drug courts in reducing future criminal offending. Fifty studies representing 55 evaluations were identified, including both experimental and quasi-experimental comparison group designs. The overall findings tentatively suggest that drug offenders participating in a drug court are less likely to reoffend than similar offenders sentenced to traditional correctional options. The equivocation of this conclusion stems from the generally weak methodological nature of the research in this area, although higher quality studies also observed positive results. Furthermore, the evidence tentatively suggests that drug courts using a single model (pre- or post-plea) may be more effective than those not employing these methods. These courts have a clear incentive for completion of the drug court program.

Wodahl, Eric, J., Brett Garland, Scott E. Culhane, and William P. McCarty. "Utilizing Behavioral Interventions to Improve Supervision Outcomes in Community-Based Corrections." *Criminal Justice and Behavior* 38, no. 4 (2011) 386-405.

The number of offenders supervised in the community has grown significantly over the past few decades, whereas successful completions of probation and parole terms have been declining during the same time period. The current study examines the impact of rewards and sanctions on offenders in an Intensive Supervision Program (ISP). Data were collected on a random sample of 283 offenders who participated in an ISP between 2000 and 2003. Agency records, including supervision notes, violation reports, and other offender-related correspondence, were used to track offenders' sanction and reward histories during their participation in the program. Controlling for a number of variables, the study found that the use of both sanctions and rewards led to higher success rates. Administering rewards in proportionally higher numbers than sanctions produced the best results, especially when a ratio of four or more rewards for every sanction was achieved. Correctional administrators are encouraged to identify ideological obstacles that may impede the application of behavioral techniques and to carefully train and guide line staff in the use of sanctions and rewards. [Publication Abstract]

Juveniles

Barnoski, Robert. *Outcome Evaluation of Washington State's Research-based Programs for Juvenile Offenders*. Olympia: Publication Abstract State Institute for Public Policy, 2004. In 1997, the Washington State Legislature passed the Community Juvenile Accountability Act (CJAA). The primary goal of the CJAA is to reduce juvenile crime, cost effectively, by establishing "research-based" programs in the state's juvenile courts. The basic idea is straightforward: taxpayers are better off if their dollars fund programs that have been proven to be effective in achieving key policy outcomes, in this case reduced re-offending.

The CJAA funded the nation's first statewide experiment concerning research-based programs for juvenile justice. Because selected treatment programs had already been researched elsewhere in the United States, usually as small scale pilot projects, the question here was whether they work when applied statewide in a "real world" setting. This report indicates that the answer is yes—when the programs are competently delivered. [From Executive Summary] http://www.wsipp.wa.gov/rptfiles/04-01-1201.pdf

California Department of Correction and Rehabilitation. *Dialectical Behavior Therapy: Evidence for Implementation in Juvenile Correctional Settings,* 2011. Sacramento, CA: CDCR, Office of Research, Juvenile Justice Branch, 2011.

The provision of Dialectical Behavior Therapy (DBT) is obviously resource intensive and requires a broad base of support for the idea that people can change. Obtaining such resources and support is naturally more feasible in regard to juveniles than adults. The reason for this is the assumption, which is not unfounded, that juveniles are generally more amenable and deserving of treatment and a chance to change than are adults. http://www.cdcr.ca.gov/Reports Research/docs/DBT Evidence Draft 04 06 2011.pdf

Drake, Elizabeth, and Robert Barnoski. *Recidivism Findings for the Juvenile Rehabilitation Administrator's Dialectical Behavior Therapy Program: Final Report*. Olympia: Washington State Institute for Public Policy, 2006.

Recidivism of juvenile offenders who participate in the Dialectical Behavior Therapy (DBT) program is investigated. "DBT is a cognitive-behavioral treatment for individuals

with complex and difficult to treat mental disorders" (p. 1). Sections of this report are: summary of findings; background; constructing the study groups; recidivism findings; next steps; and technical appendix. While there are no statistically significant differences, the DBT group does have a lower recidivism rate.http://www.wsipp.wa.gov/rptfiles/06-07-1201.pdf

Howell, James C., and Mark W. Lipsey. "Research-Based Guidelines for Juvenile Justice Programs." *Justice Research and Policy* 14, no. 1 (2012): 17-34.

Juvenile justice systems make use of many programs intended to reduce the recidivism of the juvenile offenders with whom they interact. Not all such programs are effective and one of the more progressive reforms of recent years has been the movement toward programs validated by research evidence. Three ways to define evidence-based programs are described, with a focus on a relatively unfamiliar approach—evidence from meta-analysis of evaluation research that supports the effectiveness of many generic types of programs. In contrast to the prevailing model program approach, this approach makes use of evidence that supports the effectiveness of many of the homegrown and local programs that juvenile justice systems use. The findings of a large meta-analysis of hundreds of studies reveal that many of these more generic programs are as effective as comparable model programs. These findings have been operationalized into a rating scheme based on the characteristics of effective interventions that can be used by service providers and juvenile justice systems to assess their programs. Two recidivism studies provide promising indications of the validity of this scheme for identifying effective programs and guiding improvement for ineffective ones. The results of this work show that the large body of research on interventions with juvenile offenders can be used to create guidelines that extend the concept of evidence-based programs to the kinds of generic programs most commonly used in juvenile justice systems.

Luong, Duyen, and Stephen J. Wormith. "Applying Risk/Need Assessment to Probation Practice and its Impact on the Recidivism of Young Offenders." *Criminal Justice and Behavior* 38, no. 12 (2011): 1177-1199.

Evaluating the extent to which case management practices are guided by risk/need assessment is important because the impact of the assessment process will not be realized if the instrument is not applied as fully intended. This study investigated whether risk/need assessment is linked to the case management of young offenders and whether adherence to the principles of risk, need, and responsivity, as part of the case management plan, is related to recidivism. Data were collected on a sample of 192 young offenders. The Level of Service Inventory–Saskatchewan Youth Edition (LSI-SK) total score and seven of the eight subscale scores were positively correlated with recidivism. Generally, the LSI-SK was used to inform supervision intensity and interventions toward criminogenic needs. Moreover, adherence to the need principle was associated with reductions in recidivism. Implications for case management and direction for future research are discussed.

Marlowe, Douglas B. *Research Update on Juvenile Drug Treatment Courts.* Alexandria, VA: National Association of Drug Court Professionals, December 2010.

Research on Juvenile Drug Treatment Courts (JDTCs) has lagged considerably behind that of its adult counterparts. Although evidence is mounting that JDTCs can be effective at

reducing delinquency and substance abuse, the field is just beginning to identify the factors that distinguish effective from ineffective programs. http://www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Juvenile %20Drug%20Treatment%20Courts%20-%20NADCP 1.pdf

Pretrial Services

Cohen, Thomas H., and Brian A. Reaves. *Pretrial Release of Felony Defendants in State Courts*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2008.

Presents findings on the pretrial release phase of the criminal justice process using data collected from a representative sample of felony cases filed in the 75 largest U.S. counties in May during even-numbered years from 1990 to 2004. It includes trends on pretrial release rates and the types of release used. Pretrial release rates are compared by arrest offense, demographic characteristics, and criminal history. Characteristics of released and detained defendants are also presented. Rates of pretrial misconduct including failure to appear and re-arrest are presented by type of release, demographic characteristics, and criminal history. http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail &iid=834

Demuth, Stephen. "Racial and Ethnic Differences in Pretrial Release Decisions and Outcomes: A Comparison of Hispanic, Black, and White Felony Arrestees." *Criminology* 41, no. 3 (2003): 873– 907.

Regarding the effects of race and ethnicity on judicial decisions and defendant outcomes at earlier stages of the criminal case process prior to sentencing, knowledge is limited, limited to the treatment of different racial and ethnic groups in the criminal courts based on the impact of race at the sentencing stage. This study examined the effect of race and ethnicity on pretrial release among White, Black, and Hispanic defendant groups using individual-level data compiled, biennially by the State Court Processing Statistics (SCPS) program of the Bureau of Justice Statistics on the procession of a sample of formally charged felony defendants in the State courts of the Nation's 75 most populous counties in 1990, 1992, 1994, and 1996. The study conducted a multiple regression analysis examining the effects of race and ethnicity and other extralegal and legal factors on pretrial release decision-making and outcomes and examined the pretrial release as a process comprising several intermediate, contingent dimensions or states. The study also attempted to determine whether racial/ethnic differences in pretrial detention existed among violent, property, and drug offenses. Study findings show a general pattern of Hispanic disadvantage across all stages of the pretrial release process. Hispanic defendants were more likely to be denied bail, more likely to have to pay bail to gain release, required to pay higher amounts of bail, and more likely to be held on bail. This was consistent with a growing body of research that show Hispanic disadvantage throughout the criminal case process. The study suggests that Hispanics are more likely to encounter criminal stereotypes and are less likely to have the resources to avoid the imposition of negative labels. These findings indicate the continued importance of racial and ethnic stratification in United States society. https://www.ncjrs.gov/App/publications/Abstract.aspx?id =204620

Goldkamp, John S., and Michael D. White. "Restoring Accountability in Pretrial Release: The Philadelphia Pretrial Release Supervision Experiments." *Journal of Experimental Criminology* 2, no. 2 (2006): 143–181.

The report examines the pretrial release process in the context of jail overcrowding in Philadelphia, PA, and considers the unique challenges associated with reinventing pretrial release practices in anticipation of the end of years of court-imposed "emergency" crowding reduction measures. The supervision strategy behind the Philadelphia release guidelines was based on: (1) full use of the supervision option suggested under the guidelines; (2) notification of defendants of important court dates; (3) orientation of defendants to the criminal process and the requirements of conducted release by pretrial services staff; (4) case management of defendants on supervised release by pretrial services; and (5) enforcement of compliance among defendants under supervision. Investigation of the role of supervision in enhancing the effectiveness of pretrial release was conducted in five parts: two notification experiments, a supervision experiment, an enforcement experiment, and a predictive analysis of defendant non-compliance (no-shows at the first supervision stage). The report describes two principal conclusions from this research. The first relates to the weak impact of notification strategies in reducing defendant misconduct (Failure to Appear and re-arrest), while the second relates to the problems with achieving deterrence in conditions of supervision.

Goldkamp, John S., and E. Rely Vilcica. "Judicial Discretion and the Unfinished Agenda of American Bail Reform: Lessons from Philadelphia's Evidence-Based Judicial Strategy." In Sarat, Austin, Ed. Special Issue: New Perspectives on Crime and Criminal Justice." *Studies in Law, Politics, and Society* 47 (2009):115-157.

Following in the footsteps of critics of the 1920s and 1930s, Caleb Foote's 1954 study of the bail system in Philadelphia set the agenda for bail reform in the United States focusing on judicial discretion and the inequities of a predominantly financially based pretrial detention system. This article argues that the bail reform movement originating in the 1960s fell short of its objectives in its failure to engage judges in the business of reform. From Foote's study on, Philadelphia has played a role historically in studies of bail, detention, and reform. The article considers the experience of Philadelphia s judicial pretrial release guidelines innovation from the 1980s to the present and its implications as an important contemporary bail reform strategy in addressing the problems of bail, release, and detention practices. The implications of the judge-centered pretrial release guidelines strategy for addressing pretrial release problems in urban state court systems are discussed in light of the original aims and issues of early bail reform. [Abstract from Author]

Lowenkamp, Christopher T., Richard Lemke, and Edward Latessa. "The Development and Validation of a Pretrial Screening Tool." *Federal Probation* 72, no. 3 (2008): 2-9.

The last two decades have witnessed a sharp increase in the use of offender assessment instruments across every stage of the criminal justice system. The reasons for this increase in use are generally centered on the problems of overcrowding and shrinking monetary resources (Jones, 1996). These conditions are ubiquitous across every level of the criminal justice system, forcing correctional institutions at all levels to accommodate themselves to these expanding populations with diminishing resources. Correctional institutions (Beck, Karberg, and Harrison, 2002; Sabol and Couture, 2008), community

corrections agencies (Glaze and Bonczar, 2007), and jails (Sabol and Minton, 2008) have had significant increases in their respective populations over the last decade. While population growth has slowed for jail populations in the last eight years, it has not declined. Despite a continual growth in jail capacity over the last few years, estimates calculate that local jails operated at 96 percent capacity, which is significantly higher than years before (Sabol and Minton, 2008).

In the search for assistance, many agencies have employed classification techniques that develop typologies of an individual's level of risk. Researchers have summarized the numerous ways these typologies benefit the agencies that utilize them, including: minimizing the subjective personal bias that exists in decision making, improving the placement of individuals for treatment and public safety, aiding in protecting against legal scrutiny, and improving the allocation of resources (Andrews and Bonta, 2007; Andrews, 1995; Bonta, 1996; Jones, 1996; Latessa and Allen, 2003; Van Voorhis, Braswell and Lester, 2004). While a majority of these efforts are based on probation or prison populations, the underlying classification principles are not limited to these agencies and are also applicable to pretrial goals and decisions. **Error! Hyperlink reference not valid.** 2008/PretrialScreeningTool.html

Mamalian, Cynthia A. *State of the Science of Pretrial Risk Assessment*. Washington: U.S. Bureau of Justice Assistance and Pretrial Justice Institute, 2011.

"This publication is designed for a wide-ranging audience of criminal justice stakeholders who have questions about pretrial risk assessment and its value to the pretrial justice process." (p.3) Sections of this report are: introduction; setting the stage; critical issues related to pretrial release, detention, and risk assessment; challenges to implementing evidence-based risk assessment and threats to reliable administration; methodological challenges associated with prediction of risk; where to go next—recommendations for research and practice; and conclusion. http://nicic.gov/Library /024954

Measuring What Matters: Outcome and Performance Measures for the Pretrial Services Field. National Institute of Corrections. Washington, DC: Pretrial Executives Network, 2011.

"This monograph presents recommended outcome and performance measures and mission-critical data ... [that] will enable pretrial service agencies to gauge more accurately their programs' effectiveness in meeting agency and justice system goals" (p. v). Sections of this publication include introduction, outcome measures, performance measures, mission-critical data, setting targets, and examples of pretrial release program measures. http://nicic.gov/Library/025172

VanNostrand, Marie. *Legal and Evidence-Based Practices: Applications of Legal Principles, Laws, and Research to the Field of Pretrial Services.* Washington, DC: National Institute of Corrections; Crime and Justice Institute, 2007.

[T]here are critical legal principles applicable to defendants during pretrial stage. These principles, as applied to specific pretrial practices, serve as the legal foundation on which pretrial services programs must operate. A clear grasp of these legal tenets is necessary to build a framework for appropriate delivery of pretrial services. [From Introduction and Background.]http://www.dcjs.virginia.gov/corrections/documents/legalAndEvidence.pdf

VanNostrand, Marie, and Gena Keebler. *Pretrial Risk Assessment in the Federal Court for the Purpose of Expanding the Use of Alternatives to Detention*. Washington, DC: U.S. Department of Justice, Office of the Federal Detention Trustee, 2009.

The identification of "federal criminal defendants who are most suited for pretrial release without jeopardizing the integrity of the judicial process or the safety of the community, in particular release predicated on participation in an alternatives to detention program" is investigated. Sections following an executive summary include: introduction; population description; research objective one -- pretrial risk classification; research objective two -- risk levels, release and detention rates, and pretrial failure rates; research objective three -- alternatives to detention, risk levels, and pretrial failure; research objective four -- efficacy of the alternatives to detention program; research objective five -- current risk assessment practices; and research objective six -- best practices for pretrial risk assessment and recommendations. http://www.nicic.org/Library/023758

Jails & Prisons

Aos, Steve, Marna Miller, and Elizabeth Drake. *"Evidence-based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates." Victims and Offenders,* 4 (2009):170–196. *(See EBP / RNR)*

Bourgon, Guy, and Barbara Armstrong. "Transferring the Principles of Effective Treatment into a 'Real World' Prison Setting." *Criminal Justice and Behavior* 32, no. 1 (2005): 3–25.

The principles of risk, need, and responsivity have been empirically linked to the effectiveness of treatment to reduce reoffending, but the transference of these principles to the inside of prison walls is difficult. Results from a sample of 620 incarcerated male offenders—482 who received either a 5-week, 10-week, or 15-week prison-based treatment program and 138 untreated comparison offenders—found that treatment significantly reduced recidivism (odds ratio of .56; effect size *r* of .10) and that the amount of treatment (e.g., "dosage") played a significant role (odds ratios between .92 and .95 per week of treatment; adjusted effect size *r* of .01 and .02). These results indicate that prison-based treatment can be effective in reducing recidivism, that dosage plays a mediating role, and that there may be minimum levels of treatment required to reduce recidivism that is dependent on the level of an offender's risk and need.

Cullen, Francis T., Cheryl Lero Jonson, and Daniel S. Nagin. "Prisons Do Not Reduce Recidivism: The High Cost of Ignoring Science." *The Prison Journal* 91, no. 3 (2011): 48S-65S.

Using an evidence-based approach, we conclude that there is little evidence that prisons reduce recidivism and at least some evidence to suggest that they have a criminogenic effect. The policy implications of this finding are significant, for it means that beyond crime saved through incapacitation, the use of custodial sanctions may have the unanticipated consequence of making society less safe'(48S). Sections of this article following an abstract include: prisons as cost versus an experience; the failure of prisons; five illustrative studies; systematic review of evidence; and conclusion.

Drake, Elizabeth K., Robert Barnoski, and Steven Aos. *Increased Earned Release From Prison: Impacts of a 2003 Law on Recidivism and Crime Costs, Revised.* Olympia: Washington State Institute for Public Policy, 2009.

The effects of increasing earned release time (similar to "good time") from 33% to 50% of an inmate's total sentence are assessed. Sections after a summary include: background -- earned release time and eligibility criteria for 50% level; evaluation design; recidivism findings; incapacitation effects; and cost-benefit analysis. It appears the law increases property crimes, reduces felony recidivism, and results in cost savings. http://www.wsipp.wa.gov/rptfiles/09-04-1201.pdf

French, Sheila, and Paul Gendreau. *Safe and Humane Corrections through Effective Treatment.* Ottawa: Correctional Service of Canada, 2003.

A meta-analysis was conducted examining the effects of prison-based treatment programs on inmates' misconduct rates. A total of 70 studies generated 103 effect sizes in this regard. Behavioral treatment programs produced considerably larger effect size estimates (r .26) compared to non-behavioral programs (r = .10), educational/vocational programs (r .02), and an unspecified group of treatments (r .02). The same result applied when effect sizes were weighted (z+). Stronger research designs were associated with a larger reduction in misconducts in the case of r but not z+ values. Yet, treatment programs that targeted more criminogenic needs and were rated higher on therapeutic integrity, generated greater reduction in misconducts for both r and z+ estimates. Generalization effects were also found: the greater the misconduct treatment effect, the larger the reductions in recidivism (r = .44) reported for those prison programs that followed their offenders into the community. As a result, the reductions in prison misconduct carried over to the community. In conclusion, despite the fact that the studies in the database lacked a good deal of essential information, the results offer the strongest support for the policy recommendation that offering more and better treatment programs in prison is the preferred choice for maintaining safe and humane prison environments. http://www.csc-scc.gc.ca/text/rsrch/reports/r139/r139 e.pdf

Latessa, Edward J., Paula Smith, Myrinda Schweitzer, and Lori Lovins. *Evaluation of Selected Institutional Offender Treatment Programs for the Pennsylvania Department of Corrections*. University of Cincinnati, Center of Criminal Justice Research, 2009.

The effectiveness of intervention programs ran by the Pennsylvania Department of Corrections is evaluated. Sections comprising this report include: principles of effective intervention, programming and services, Thinking for a Change (T4C), Batterer's Intervention, Violence Prevention, Sex Offender program—outpatient and therapeutic community, delivery of treatment services, description of PA DOC assessment process, methods, results for overall strengths and areas for improvement and staff surveys. Overall, T4C is effective while the remaining programs need improvement. http://nicic.gov/Library/025449

Minnesota Department of Corrections. *The Effects of Prison Visitation on Offender Recidivism.* Rochester: Minnesota DOC, 2011.

The influence visitation has on the recidivism of visited prisoners is examined. Sections of this report include: research summary; introduction; prison visitation policies; reentry and

social support; prison visitation research; methodology; results for descriptive statistics, impact of visitation on time to first felony reconviction, impact of visitation on time to first revocation, and impact of inmate-visitor relationship on time to first reconviction; conclusion; and implications for correctional policy and practice. Visitation has a significant effect on recidivism. "Any visit reduced the risk of recidivism by 13 percent for felony reconvictions and 25 percent for technical violation revocations, which reflects the fact that visitation generally had a greater impact on revocations. The findings further showed that more frequent and recent visits were associated with a decreased risk of recidivism" (p. 27). http://nicic.gov/Library/026127

Nink, Carl, and Steve McDonald. "Programs that Help Offenders Stay Out of Prison." Centerville, UT: MTC Institute, 2009.

This report is required reading for any agency seeking to develop effective education and/or substance abuse programming. Sections of this publication include: introduction; current conditions—the prison population is growing despite decrease in crime; effective correctional programming; education provides opportunities; education impacts recidivism; effective educational program principles; substance abuse programs save tax dollars; effective substance abuse treatment program principles; evidence-based substance abuse treatment practices; cost to benefit; and conclusion. http://nicic.gov/Library/024304

Serin, Ralph C. *Evidence-Based Practice: Principles for Enhancing Correctional Results in Prisons*. Washington, DC: National Institute of Corrections; Boston: Crime and Justice Institute, 2005.

"The purpose of this paper is to introduce prison administrators and staff to an accumulated body of knowledge regarding correctional practice to enhance their management of their prisons" (p.1). Sections comprising this discussion paper are: introduction -- transition from prison to the community, effective correctional practice, overview of prison research findings for prison classification, and summary; an overview of prison classification and risk assessment – correctional programming, guidelines, staff, and impact; and prison realities -- organizational culture and priorities, staff recruitment and training, role of staff, additional considerations (such as gangs, drugs, threats, and extortion), excellence in prison practice, implications for correctional practice, anticipated goals and outcomes, integration with community corrections, and corporate accountability. Provided as appendixes are "Eight Evidence-Based Principles for Effective Practice: Linking to Prison-Based Corrections" and "Measuring Inmate Competencies." http://nicic.gov/Library/023360.

Sex Offenders

Hanson, Karl R., Guy Bourgon, Leslie Helmus, and Shannon Hodgson. *A Meta-Analysis of the Effectiveness of Treatment for Sexual Offenders: Risk, Need, and Responsivity*. Ottawa: Public Safety Canada, 2009.

This report examines "whether the principles associated with effective treatments for general offenders (Risk-Need-Responsivity: RNR) also apply to sexual offender treatment" (p. i). Sections following an abstract include: introduction; method; results according to the effects of treatment on recidivism, on adherence to RNR principles, and by year and adherence to RNR principles; and discussion about the implications for

treatment providers and for researchers. The largest reductions in recidivism are experienced by programs utilizing RNR. http://nicic.gov/Library/023701 http://www.uscourts.gov/viewer.aspx?doc=/uscourts/FederalCourts/PPS/Fedprob/2010-06/index.html

Hanson, Karl R., Guy Bourgon, Leslie Helmus, and Shannon Hodgson. "The Principles of Effective Correctional Treatment also Apply to Sexual Offenders: A Meta-Analysis." *Criminal Justice and Behavior* 36, no. 9 (2009): 865-891.

The effectiveness of treatment for sexual offenders remains controversial, even though it is widely agreed that certain forms of human service interventions reduce the recidivism rates of general offenders. The current review examined whether the principles associated with effective treatments for general offenders (risk-need-responsivity; RNR) also apply to sexual offender treatment. Based on a meta-analysis of 23 recidivism outcome studies meeting basic criteria for study quality, the unweighted sexual and general recidivism rates for the treated sexual offenders were lower than the rates observed for the comparison groups (10.9%, n = 3,121 vs. 19.2%, n = 3,625 for sexual recidivism; 31.8%, n = 1,979 vs. 48.3%, n = 2,822 for any recidivism). Programs that adhered to the RNR principles showed the largest reductions in sexual and general recidivism. Given the consistency of the current findings with the general offender rehabilitation literature, the authors believe that the RNR principles should be a major consideration in the design and implementation of treatment programs for sexual offenders.

McGrath, Robert J., Georgia F. Cumming, Michael P. Lasher. *SOTIPS: Sex Offender Treatment Intervention and Progress Scale.* Brandon, VT: Safer Society Foundation, 2012.

"The Sex Offender Treatment Intervention and Progress Scale (SOTIPS) is a statistically-derived dynamic measure designed to aid clinicians, correctional caseworkers, and probation and parole officers in assessing risk, treatment and supervision needs, and progress among adult males who have been convicted of one or more qualifying sexual offenses and committed at least one of these sexual offenses after their 18th birthday ... SOTIPS item scores are intended to reflect an individual's relative treatment and supervision needs on each risk factor. The SOTIPS total score is intended to provide an estimation of an individual's overall level of dynamic risk and need for supervision and treatment" (p. 1). Sections of this manual include: overview and administration; item descriptions and scoring criteria; and the SOTIPS scoring sheet. http://nicic.gov/Library/024981

Zgoba, Kristen M. Michael Miner, Raymond Knight, Elizabeth Letourneau, Jill Levenson, and David Thornton. *A Multi-State Recidivism Study Using Static-99 and Static 2002 Risk Scores and Tier Guidelines from the Adam Walsh Act.* Research Report Submitted to the National Institute of Justice, 2012.

The effectiveness of various sex offender classification instruments is investigated. This research is important in determining the best practices driving the success of sex offender management classification systems allowing you to utilize the best tool in your jurisdiction. Sections of this report include: abstract; executive summary; introduction; research design and methods; results regarding the respective abilities of nationally recommended Adam Walsh Act (AWA) classification tiers and actuarial risk assessment instruments to identify

high-risk sex offenders, the risk assessment efficacy of existing state classification schemes compared to the AWA tiers and risk assessment instruments, the distribution of risk assessment scores within and across AWA tier categories, and the role of adult offender age in risk and recidivism; and discussion regarding implications for policy and practice. "The findings indicate that the current AWA classification scheme is likely to result in a system that is less effective in protecting the public than the classification systems currently implemented in the states studied. Policy makers should strongly consider substantial revisions of the AWA classification system to better incorporate evidence-based models of sex offender risk assessment and management" (p. 1). http://nicic.gov/Library/026786

Specialized Assessment

Bechtel Kristin, and Bill Woodward. *Overview of Domestic Violence (DV) Risk Assessment Instruments Frequently Asked Questions.* Washington, DC: National Institute of Corrections, 2008.

Frequently asked questions about domestic violence (DV) risk assessment instruments are answered. Topics covered are: why risk assessment instruments are needed for DV offenders; instruments that can be used to assess DV offenders; what can be done if caseloads are too high to provide a full general/violent assessment of all DV offenders; why one should use a general third generation risk assessment tool before using a specific DV assessment instrument; how to know there are low risk DV offenders; why assessment matters even if all DV offenders are placed under the same treatment; how an assessment instrument is selected; the specific instruments that are available and commonly used in the U.S.; and which tools are available but have less current research in the DV literature. http://static.nicic.gov/Library/023364.pdf

Campbell, Mary Ann, Sheila French, and Paul Gendreau. "The Prediction of Violence in Adult Offenders: A Meta-Analytical Comparison of Instruments and Methods of Assessment." *Criminal Justice and Behavior* 36, no. 6 (2009): 567-590.

Using 88 studies from 1980 to 2006, a meta-analysis compares risk instruments and other psychological measures on their ability to predict general (primarily nonsexual) violence in adults. Little variation was found amongst the mean effect sizes of common actuarial or structured risk instruments (i.e., Historical, Clinical, and Risk Management Violence Risk Assessment Scheme; Level of Supervision Inventory–Revised; Violence Risk Assessment Guide; Statistical Information on Recidivism scale; and Psychopathy Checklist–Revised). Third-generation instruments, dynamic risk factors, and file review plus interview methods had the advantage in predicting violent recidivism. Second-generation instruments, static risk factors, and use of file review were the strongest predictors of institutional violence. Measures derived from criminological-related theories or research produced larger effect sizes than did those of less content relevance. Additional research on existing risk instruments is required to provide more precise point estimates, especially regarding the outcome of institutional violence.

DeMichele, Matthew, and Brian Payne. *Predicting Repeat DWI: Chronic Offending, Risk Assessment, and Community Supervision.* Lexington, KY: American Probation and Parole Association, 2010.

The risk-assessment tool includes items modified from previous scales as well as items found to be significant in this project's own research. It contains seven separate domains. The mental-health domain contains eight items that determine the nature of the relationship between mental health disorders and chronic offending. The socio-personal responsibility domain intends to reveal the level of personal and social responsibility of an individual. This measures one's general attachment to society and an internal locus of control. The risky substance abuse domain measures features related to a person's level of risky drug and alcohol use that may be related to chronic DWIs. The criminal-histories domain measures the offender's past involvement with the criminal justice system. The desire-for-change domain includes four questions related to an individual's desire to change his/her drinking patterns. The connection-between-internalized-locus-of-responsibilityand-DWI domain includes several items that measure how offenders assign responsibility in their decision-making process. The risky-driving domain measures specific characteristics related to driving in general to test general risky driver theories. The aforementioned domains provide a foundation from which increased understanding about habitual drunk driving will evolve. The research team plans to pilot test this draft risk-assessment tool in up to three locations, using convicted DWI offenders on community supervision. Currently, the team has received agreements from two agencies interested in participating in the pilot test. 8 tables, 3 figures, 64 references, and appended items drawn from other scales, and the draft risk-assessment tool. http://www.appa-net.org/eweb/docs/APPA/pubs/PRDWI-DRAFT.pdf

Dvoskin, Joel A., Jennifer L. Skeem, Raymond W. Novaco, and Kevin S. Douglas (Eds). *Using Social Science to Reduce Violent Offending.* Oxford University Press, 2011.

These essays describe methods for changing the behavior of offender groups who present particular challenges for justice system officials, including individuals with mental illnesses, sex offenders, and juveniles. They describe how to apply specific correctional interventions designed to equip offenders with the skills they will need to succeed in avoiding crime upon release. Authors also highlight methods for overcoming system inertia to implement these recommendations. (*Using Social Science to Reduce Violent Offending: A Briefing Paper for Public Policymakers* is available at: http://reducingviolence.com/storage/briefingpaper.pdf.)

Fazel, Seena, Jay P. Singh, Helen Doll, and Martin Grann. "Use of Risk Assessment Instruments to Predict Violence and Antisocial Behaviour in 73 Samples Involving 24,827 People: Systematic Review and Meta-Analysis." *British Medical Journal* 345:e4692 (2012): 1-12.

Objective: To investigate the predictive validity of tools commonly used to assess the risk of violence, sexual, and criminal behavior, using systematic review and tabular meta-analysis of replication studies following PRISMA guidelines. Risk assessments were conducted on 73 samples comprising 24,847 participants from 13 countries, of whom 5879 (23.7%) offended over an average of 49.6 months. When used to predict violent offending, risk assessment tools produced low to moderate positive predictive values (median 41%, interquartile range 27-60%) and higher negative predictive values (91%, 81-95%), and a corresponding median number needed to detain of 2 (2-4) and number safely discharged of 10 (4-18). Instruments designed to predict violent offending performed better than those aimed at predicting sexual or general crime.

Conclusions: Although risk assessment tools are widely used in clinical and criminal justice settings, their predictive accuracy varies depending on how they are used. They seem to identify low risk individuals with high levels of accuracy, but their use as sole determinants of detention, sentencing, and release is not supported by the current evidence. http://www.bmj.com/highwire/filestream/595479/fieldhighwirearticle pdf/0/bmj.e4692

Klima, Tali, and Roxanne Lieb. (2008). Risk Assessment Instruments to Predict Recidivism of Sex Offenders: Practices in Washington State. Olympia: Washington State Institute for Public Policy, Document No. 08-06-1101.

This paper reviews policies and practices regarding assessment of sex offenders for risk of re-offense among public agencies and private treatment providers in Washington State. Specifically, we reviewed the use of risk assessment instruments, which gauge the likelihood that individual sex offenders will reoffend. We found that a diverse set of instruments are employed by public and private entities in making decisions about sex offenders. These decisions include sentencing, facility assignment, treatment, release, public notification, and community supervision. As expected, there was greater variability in risk assessment practices among private treatment providers than public agencies. Three policies related to risk assessment were identified as topics of concern. One is the lack of appropriate instruments for juvenile sex offenders. The second is the validity of the primary instrument used to determine risk levels for registration purposes, the Washington State Sex Offender Risk Level Classification Tool (soon to be replaced). Third, some informants discussed the static nature of risk level assignment and suggested provisions to reassess offenders' levels during extended registration periods. http://www.wsipp.wa.gov/rptfiles/08-06-1101.pdf

KrÖner, Carolin, Cornelis Stadtland, Matthias Eidt, and Norbert Nedopil. "The Validity of the Violence Risk Appraisal Guide (VRAG) in Predicting Criminal Recidivism." *Criminal Behaviour and Mental Health* 17, no. 2 (2007): 89–100.

The Violence Risk Appraisal Guide (VRAG) is an actuarial risk assessment instrument, developed in Canada as an aid to estimating the probability of reoffending by mentally ill offenders.

Aim. To test the predictive validity of the VRAG with a German sample.

Method. The predictive validity of the VRAG was tested on a sample of 136 people charged with a criminal offence and under evaluation for criminal responsibility in the forensic psychiatry department at the University of Munich in 1994–95. The predicted outcome was tested by means of ROC analysis for correlation with the observed rate of recidivism between discharge after the 1994–95 assessment and the census date of 31 March 2003. Recidivism rate was calculated from the official records of the National Conviction Registry. The validity of the VRAG was replicated with a German sample. The VRAG yielded good predictive accuracy, despite differences in sample and outcome variables compared with its original sample.

McGrath, Robert J., Michael P. Lasher, and Georgia F. Cumming. *A Model of Static and Dynamic Sex Offender Risk Assessment.* Washington, DC: Department of Justice, 2011.

The purpose of the present study was to test models of combining static and dynamic risk measures that might predict sexual recidivism among adult male sex offenders better than

any one type of measure alone. Study participants were 759 adult male sex offenders under correctional supervision in Vermont who were enrolled in community sex offender treatment between 2001 and 2007. These offenders were assessed once using static measures (Static-99R, Static-2002R and VASOR) based on participants' history at the date of placement in the community. A 22-item dynamic risk measure Sex Offender Needs and Progress Scale (SOTNPS) was used multiple times to assess participants, shortly after their entry into community treatment and approximately every six months thereafter. Analyses of SOTNPS scores resulted in the development of a new 16-item dynamic risk measure, the Sex Offender Treatment Intervention and Progress Scale (SOTIPS). At fixed one- and three-year follow-up periods from participants' initial, second, and third dynamic risk assessments, the SOTIPS and Static-99R, the static risk measure selected for further analysis in the present study, each independently showed moderate ability to rank order risk for sexual, violent, and any criminal recidivism and return to prison. A logistic regression model that combined SOTIPS and Static-99R consistently predicted recidivism and outperformed either instrument alone when both instruments had similar predictive power. Participants who demonstrated treatment progress, as reflected by reductions in SOTIPS scores, showed lower rates of recidivism than those who did not. https://www.ncjrs.gov/pdffiles1/nij/grants/236217.pdf

Pullmann, Michael D. "Predictors of Criminal Charges for Youth in Public Mental Health During the Transition to Adulthood." *Journal of Child Family Studies* 19, no. 4 (2010): 483-491.

Dual involvement with the mental health system and justice system is relatively frequent for young adults with mental health problems, yet the research on factors predictive of dual involvement is incomplete. This study extends past research on predictors of criminal charges for people in the public mental health system in four ways. First, this study expands the longitudinal study period to include the time of transition to adulthood, from 16 to 25 years of age. Second, this study separately predicts specific types of criminal charges, including violent, property, drug, and nuisance charges. Third, this study examines whether residential treatment or inpatient hospitalization are predictive of criminal charges. Fourth, this study stratifies prediction by gender. Findings indicated high levels of dual involvement during this time period. In general, males and people diagnosed with substance use disorder or conduct disorder were more likely to have a criminal charge. Other predictors of specific criminal charges varied by gender. Residential treatment, inpatient hospitalization, and anxiety disorder were generally not related to criminal charges. Implications for cross-system collaboration and early intervention are discussed. [Abstract from Author] http://www.ncbi.nlm.nih.gov/pmc/articles /PMC2950104/

Skeem, Jennifer L., and John Monahan. "Current Directions in Violence Risk Assessment." *Current Directions in Psychological Science* 20 (2011): 38-42.

Over recent years, a variety of instruments that improve clinicians' ability to forecast the likelihood that an individual will behave violently have been published. Increasingly, these instruments are being applied in response to laws that require specialized risk assessments. In this article, we present a framework that goes beyond the "clinical" and "actuarial" dichotomy to describe a continuum of structured approaches to risk assessment. Despite differences among validated instruments, there is little evidence that one predicts violence

better than another. We believe that these group-based instruments are useful for assessing an individual's risk and that an instrument should be chosen based on an evaluation's purpose (i.e., risk assessment vs. risk reduction). The time is ripe to shift attention from predicting violence to understanding its causes and preventing its (re)occurrence. [Publication Abstract] http://riskreduction.soceco.uci.edu/pdfs/yasi/skeemMonahan2011.pdf

VanNostrand, Marie. *Assessing Risk among Pretrial Defendants in Virginia: The Virginia Pretrial Risk Assessment Instrument*. Richmond: Virginia Department of Criminal Justice Services, 2003. The development of this instrument is explained along with application instruction. Nine risk factors are utilized to classify a defendant according to five risk levels. This report is comprised of the following sections: executive summary; introduction; pretrial risk assessment; research methods; instrument development; instrument application; and future plans. http://www.napsa.org/publications/assessingriskva.pdf

Wong, Timothy. *Validation of the State of Hawaii LSI-R Proxy*. Honolulu: Hawaii State Department of Health, Interagency Council on Intermediate Sanctions, 2008.
The Proxy, developed by private consultants from [Justice] System Assessment and Training (J-SAT), is administered to all sentenced and a small number of pre-trial offenders. This includes offenders who are adjudicated through Hawaii's court system and placed under the supervision of the Department of Public Safety's Intake Service Center (PSD-ISC); Hawaii Paroling Authority (HPA); and Probation Services (Judiciary). The purpose of the Proxy is to identify offenders who are at minimal recidivism risk. By ICIS policy, offenders who score four or less on the Proxy are classified at the Administrative risk level (lowest level of risk). Offenders who score five or greater are at elevated risk, and consequently are administered an LSI-R, the primary risk assessment instrument used to identify criminogenic risks and needs. http://hawaii.gov/icis/documents/copy2ofcopyofSARADVSI%20Exploratory%20Study%20%28Oct%202008%29.pdf

Specialty Courts

Arming the Courts with Research: 10 Evidence-Based Sentencing Initiatives to Control Crime and Reduce Costs. Washington, DC: Pew Center on the States, Public Safety Performance Project, 2009.
The use of cost-effective evidence-based practices to reduce offender recidivism, crime rates, and costs is explained. Strategies covered are: establish recidivism reductions as an explicit sentencing goal; provide sufficient flexibility to consider recidivism reduction options; base sentencing decisions on risk/needs assessment; require community corrections programs to be evidence-based; integrate services and sanctions; ensure courts know about available sentencing options; encourage swift and certain responses to probation violations; use court hearings and incentives to motivate offender behavior change; and promote effective collaboration among criminal justice agencies. http://nicic.gov/Library/023777

Casey, Pamela M., Roger K. Warren, and Jennifer K. Elek. *Using Offender Risk and Needs Assessment Information at Sentencing Guidance for Courts from a National Working Group.* Washington, DC: National Center for State Courts, 2011.

During the last two decades, substantial research has demonstrated that the use of certain practices in criminal justice decision making can have a profound effect on reducing offender recidivism. One of these practices is the use of validated risk and needs assessment (RNA) instruments to inform the decision making process. Once used almost exclusively by probation and parole departments to help determine the best supervision and treatment strategies for offenders, the use of RNA information is expanding to help inform decisions at other points in the criminal justice system as well. The use of RNA information at sentencing is somewhat more complex than for other criminal justice decisions because the sentencing decision has multiple purposes— punishment, incapacitation, rehabilitation, specific deterrence, general deterrence, and restitution—only some of which are related to recidivism reduction. [From Introduction] http://www.ncsc.org/~/media/Files/PDF/Services%20and%20Experts/Areas%20of%20expertise/Sentencing%20Probation/RNA%20Guide%20Final.ashx

Huddleston, West, and Douglas B. Marlowe. *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts.* Programs in the United States. Washington, DC: National Drug Court Institute, 2011.

Specific to this volume and in addition to reporting on the aggregate number and types of operational Drug Courts and other Problem-Solving Court programs throughout the United States, a major section of this report is dedicated to recent research findings related to the most prevalent Drug Court models. Additionally, sections are dedicated to analyses of national survey data on Drug Court capacity; drug-of-choice trends among Drug Court participants in rural, suburban and urban areas; average graduation rates; participation costs; state Drug Court authorization legislation and funding appropriations; and international Drug Court activity. Finally, this year's report provides first-ever national demographic data on racial and ethnic minority representation among Drug Court participantshttp://www.ndci.org/sites/default/files/nadcp/PCP%20Report%20FINAL.PDF

Marlowe, Douglass B., David S. Festinger, Patricia A. Lee, Karen L. Dugosh, and Kathleen M. Benasutti. "Matching Judicial Supervision to Clients' Risk Status in Drug Court." *Crime and Delinquency* 52, no. 1 (2006): 52–76.

This article reports outcomes from a program of experimental research evaluating the risk principle in drug courts. Prior studies revealed that participants who were high risk and had (a) antisocial personality disorder or (b) a prior history of drug abuse treatment performed better in drug court when scheduled to attend biweekly judicial status hearings in court. In contrast, participants who were low risk performed equivalently regardless of the court hearings schedule. This study prospectively matches drug court clients to the optimal schedule of court hearings based on an assessment of their risk status and compares outcomes to clients randomly assigned to the standard hearings schedule. Results confirmed that participants who were high risk and matched to biweekly hearings had better during-treatment outcomes than participants assigned to status hearings as usual. These findings provide confirmation of the risk principle in drug courts and yield practical information for enhancing the efficacy and cost-efficiency of drug courts.

Marlowe, Douglas B. "Evidence-Based Sentencing for Drug Offenders: An Analysis of Prognostic Risks and Criminogenic Needs." *Chapman Journal of Criminal Justice* 1, no. 1 (2009): 167-201. A model of evidence-based sentencing is presented that attempts to match drug offenders to dispositions that optimally balance impacts on cost, public safety, and the welfare of the offender (p. 169).

This model may give your agency some ideas on what sentencing options work best for your offender population. Sections of this article are: introduction; dispositions for drug offenders' pre-trial diversion of administrative probation, probation without verdict, drug courts, intermediate punishment, and incarceration; evidence-based sentencing; assessment of risks and needs, risk of dangerousness, prognostic risks, and criminogenic needs; matching dispositions by risks and needs, high risk/high need, high risk/low need, low risk/high need, and low risk/low need; and conclusion. *http://www.ndcrc.org/content/evidence-based-sentencing-drug-offenders-analysis-prognostic-risks-and-criminogenic-needs*

Marlowe, Douglas B., David S. Festinger, Patrick L. Arabia, Karen L. Dugosh, Kathleen M. Benasutti, Jason R. Croft, and James M. McKay. "Adaptive Interventions in Drug Court: A Pilot Experiment." *Criminal Justice Review* 33 (2008): 343–360.

This pilot study (N = 30) experimentally examined the effects of an adaptive intervention in an adult misdemeanor drug court. The adaptive algorithm adjusted the frequency of judicial status hearings and clinical case-management sessions according to pre-specified criteria in response to participants' ongoing performance in the program. Results revealed the adaptive algorithm was acceptable to both clients and staff, feasible to implement with greater than 85% fidelity, and showed promise for eliciting clinically meaningful improvements in drug abstinence and graduation rates. Estimated effect sizes ranged from 0.40 to 0.60 across various dependent measures. Compared to drug court as-usual, participants in the adaptive condition were more likely to receive responses from the drug court team for inadequate performance in the program and received those responses after a substantially shorter period of time. This suggests the adaptive algorithm may have more readily focused the drug court team s attention on poorly-performing individuals, thus allowing the team to "nip problems in the bud" before they developed too fully. These preliminary data justify additional research evaluating the effects of the adaptive algorithm in a fully powered experimental trial.

Ojmarrh, Mitchell, David B. Wilson, Amy Eggers, and Doris L. MacKenzie. *Drug Courts' Effects on Criminal Offending for Juveniles and Adults.* Oslo, Norway: Campbell Collaboration, 2012.

"The objective of this review is to systematically review quasi-experimental and experimental randomized-control trial (RCT) evaluations of the effectiveness of drug courts in reducing recidivism, including drug courts for juvenile and DWI offenders. This systematic review critically assesses drug courts' effects on recidivism in the short- and long-term, the methodological soundness of the existing evidence, and the relationship between drug court features and effectiveness" (p. 6). Results are provided for: a description of eligible studies; overall mean effects by type of drug court; robustness of findings to methodological weaknesses; drug courts' long-term effects; features of the drug court; and additional sensitivity analysis. Overall, research shows that adult drug courts are effective in reducing recidivism, DWI drug courts moderately successful, and

juvenile drug courts having small impact. http://www.ndcrc.org/sites /default/files/mitchell drugcourts review.pdf http://nicic.gov/Library/026520

Pogarski, Greg. "Deterrence and Individual Differences among Convicted Offenders." *Journal of Quantitative Criminology* 23 no. 1 (2007), 59–74.

Conflicting evidence exists on how criminal propensity moderates deterrent effects, and there is little empirical evidence on this issue from relatively experienced offenders. This study tested how variation in criminal propensity (operationalized as "low self-control") moderates deterrent effects in a sample of convicted offenders in New Jersey's Intensive Supervision Program (ISP) in 1989 and 1990. Offenders' perceptions of the risks and consequences from violating ISP were associated with whether they successfully completed ISP. Moreover, lower self-control did not diminish, and if anything, enhanced these deterrent effects.

Warren, Roger. *Evidence-Based Practice to Reduce Recidivism: Implications for State Judiciaries*. Washington, DC: National Institute of Corrections, 2007.

The reduction of recidivism by state judiciaries utilizing six principles of evidence-based practice (EBP) is explained. Seven sections follow an executive summary: introduction; current state sentencing policies and their consequences; drug courts -- the state judiciary's successful experiment with EBP; the principles of EBP; local sentencing and corrections policy reforms; state sentencing and corrections policy reforms; and conclusion. "[C]arefully targeted rehabilitation and treatment programs can reduce offender recidivism by conservative estimates of 10-20%" (p. 72). Crime and Justice Institute. http://nicic.gov/Downloads/PDF/Library/023358.pdf

Supervision by Risk Level

Barnes, Jeffrey C., Lindsay Ahlman, Charlotte Gill, Lawrence W. Sherman, Ellen Kurtz, and Robert Malvestuto. "Low-intensity Community Supervision for Low-Risk Offenders: A Randomized, Controlled Trial." *Journal of Experiential Criminology* 6, no. 2 (2010): 159-189.

The Philadelphia Low-Intensity Community Supervision Experiment provides evidence on the effects of lowering the intensity of community supervision with low-risk offenders in an urban, US county community corrections agency. Using a random forests forecasting model for serious crime based on Berk et al. Journal of the Royal Statistical Society, Series A, 172(Part 1), 191–211, 2009, 1,559 low-risk offenders were identified and randomly assigned to either standard or reduced frequency of mandatory office visits. Treatment as assigned was substantially delivered at 4.5 probation visits per year versus 2.4, for as long as offenders remained on active probation or parole. In a one-year follow-up for all cases, outcomes examined were the prevalence, frequency, seriousness and time-to-failure of arrests for new crimes committed after random assignment was implemented. No significant differences (p .05) in outcomes were found between standard and low-intensity groups. Non-significant differences for offense seriousness favored the low-intensity group. We conclude that lower-intensity supervision at the tested level of dosage can allow fewer officers to supervise low risk offenders in the community without evidence of increased volume or seriousness of crime. [Publication Abstract]

Bonta, James, Suzanne Wallace-Capretta, and Jennifer Rooney. "A Quasi-experimental Evaluation of an Intensive Rehabilitation Supervision Program." *Criminal Justice Behavior* 27(2000): 213-329.

Over the past 20 years, an increased understanding has been developed of what interventions do and do not work with offenders. Treatment programs that attend to offender risk, needs, and responsivity factors have been associated with reduced recidivism. There is also a recognition that sanctions without a rehabilitative component are ineffective in reducing offender recidivism. This study evaluates a cognitive-behavioral treatment program delivered within the context of intensive community supervision via electronic monitoring (EM). Offenders receiving treatment while in an EM program were statistically matched on risk and needs factors to inmates who did not receive treatment services. The results showed that treatment was effective in reducing recidivism for higher risk offenders, confirming the risk principle of offender treatment. The importance of matching treatment intensity to offender risk level and ensuring that there is a treatment component in intensive supervision programs is reaffirmed.

Lowenkamp, Christopher T., Anthony W. Flores, Alexander M. Holsinger, Matthew D. Makarios, and Edward J. Latessa. "Intensive Supervision Programs: Does Program Philosophy and the Principles of Effective Intervention Matter?" *Journal of Criminal Justice* 38, no. 4 (2010): 368-375.

Although traditional intensive supervision programs that have aimed at increasing control and surveillance in the community have not been shown to reduce recidivism, prior research indicates that intensive supervision programs that are based on a human service philosophy and provide treatment to offenders offer more promise. The current research examined the effectiveness of fifty-eight intensive supervision programs and sought to determine whether program philosophy and treatment integrity are associated with reductions in recidivism. The results indicated that both program philosophy and treatment integrity vary independently of one another and are related to the ability of programs to produce meaningful effects on recidivism. [Publication Abstract] http://www.uc.edu/content/dam/uc/ccjr/docs/articles/AR-620N 20101130 161746.pdf

Lowenkamp, Christopher T., and Edward J. Latessa. "Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders." *Topics in Community Corrections, Annual Issue 2004: Assessment Issues for Managers.* Washington, DC: National Institute of Corrections, 2004.

"[W]hat the risk principle is, what it means for corrections, and why we see intensive treatment and supervision leading to no effect or increased recidivism for low-risk offenders" are discussed (p. 3). This article covers: risk as the probability of reoffending; meta-analyses involving the risk principle; differing treatment effects for high- and low-risk offenders; and why interventions are more successful with high-risk offenders. http://www.yourhonor.com/dwi/sentencing/RiskPrinciple.pdf

Paparozzi, Mario, and Paul Gendreau. "An Intensive Supervision Program that Worked: Service Delivery, Professional Orientation, and Organizational Supportiveness." *The Prison Journal* 85, no 4 (2005): 445-466.

This study examined the effect of treatment services, organizational supportiveness, and parole officer orientation on parolee recidivism. The sample consisted of 240 parolees enrolled in an intensive surveillance supervision program and 240 parolees undergoing traditional parole supervision. The participants were high-risk/high need parolees. Three measures of parolee recidivism were used: (a) technical parole violation, (b) new conviction, and (c) revocation. These measures were examined by level of treatment services, organizational supportiveness, and the law enforcement/ treatment orientation of intensive surveillance supervision program parole officers of which there were three classifications: (a) law enforcement, (b) balanced, and (c) social casework. The data support the view that intensive supervision programs that (a) provide more treatment to higher risk offenders, (b) employ parole officers with balanced law enforcement/social casework orientations, and (c) are implemented in supportive organizational environments may reduce recidivism from 10% to 30% depending on the comparisons being made. http://mariopaparozzi.com/uploads/isp that worked.pdf

Women Offenders

Andrews, Don A., and Craig Dowden. "A Meta-Analytic Investigation into Effective Correctional Intervention for Female Offenders." *Forum on Corrections Research* 11 (1999): 18-21.

Evidence from past meta-analytic reviews has suggested that the principles of human service, risk, need, and general responsivity are associated with reductions in recidivism for general offender populations. However, a recent study stated "the question of whether or not these findings (i.e., principles of effective correctional treatment) can be generalized to the female offender population still is very much in need of an answer" (p. 517). 2 The purpose of the present meta-analytic investigation 3 was to explore whether adherence to the principles of human service, risk, need, general responsivity, program integrity, and core correctional practice were important program considerations for female offenders. The results demonstrated that adherence to these principles significantly enhanced program effectiveness through higher mean reductions in recidivism. This paper concludes with a summary of effective correctional practices for female offenders and directions for future research. http://www.csc-scc.gc.ca/text /pblct/forum/e113/113e e.pdf

Calhoun, Stacy, Nena Messina, Jerome Cartier, and Stephanie Torres. "Implementing Gender-Responsive Treatment for Women in a Prison Setting: Client and Staff Perspectives." *Federal Probation* 74, no. 3 (2010).

Over the past two decades, the overall number of female prisoners in the United States has grown substantially. While the number of women in prison remains lower than the number of men, women are entering prisons at a faster rate than men. From 1995 to 2005, the total number of female prisoners increased 57 percent compared with a 34 percent increase in male prisoners (Harrison Beck, 2006). The increase of the number of women in the nation's prison population has largely been due to incarceration for drug-related offenses. Zero tolerance policies related to addiction have created a greater demand for substance abuse treatment for men and women within a prison setting. http://www.uscourts.gov/uscourts/FederalCourts/PPS/Fedprob/2010-12/implementing.html

Cobbina, Jennifer E. *From Prison to Home: Women's Pathways In and Out of Crime.* Washington, DC: Department of Justice, 2008.

Questions related to the reentry experiences of female prisoners are investigated. This dissertation includes an abstract and the following chapters: introduction; the study; women's pathways into crime; legal barriers and practical challenges to reentry; factors impacting reintegration success and failure; succumbing to the lure of criminal pursuit; the straight and narrow -- pathways out of crime; and conclusions and recommendations. https://www.ncjrs.gov/pdffiles1/nij/grants/226812.pdf

Gehring, Krista S., Patricia Van Voorhis, and Valerie R. Bell. *What Works for Female Probationers? An Evaluation of the Moving On Program.* University of Cincinnati, Division of Criminal Justice, 2009.

The effectiveness of the Moving On program is evaluated. Moving On is a gender-responsive, cognitive behavioral program for women probationers. Sections of this report include: program description; data and study design; sample; outcome measures; results for rearrests, convictions, incarcerations, and technical violations; effects of program completion on rearrests, convictions, incarcerations, and technical violations; and implications of the findings. "The findings from this study indicate the Moving On program would be a good fit for agencies looking for an evidence-based gender-responsive program (p. 12). http://nicic.gov/Library/025408

Hardyman, Patricia, and Patricia Van Voorhis. *Developing Gender-specific Classification Systems for Women Offenders.* Washington, DC: National Institute of Corrections, 2004.

A report which highlights the results of two cooperative agreements from the National Institute of Corrections (NIC) addressing the critical need for gender-specific objective classification systems is presented. Following an executive summary are six chapters: introduction; classification issues for women offenders--the literature; NIC Prisons Division—women's classification initiatives (e.g., National Assessment of Current Practices for Classifying Women Offenders and Working With Correctional Agencies to Improve Classification for Women Offenders); building blocks to effective classification of women offenders; addressing classification issues that require systemic change; and future steps. This report also has two appendixes: descriptions of seven states women's classification initiatives (Colorado, Florida, Hawaii, Idaho, Nebraska, West Virginia, and Wisconsin); and sample initial and reclassification instruments developed by Colorado and Idaho. http://nicic.gov/Library /018931

Lynch, Shannon M., Nicole M. Heath, Kathleen C. Mathews, and Galatia J. Cepeda. "Seeking Safety: An Intervention for Trauma-Exposed Incarcerated Women?" *Journal of Trauma Dissociation* 13, no. 1 (2012): 88-101.

Recent guidelines for incarcerated women's programming have called for interventions that address offenders' traumatic experiences, posttraumatic stress disorder (PTSD), and substance use in an integrated manner. Seeking Safety (SS) is an empirically supported cognitive behavioral manualized treatment for individuals with PTSD and substance use disorders. This study examined the effectiveness of SS with 59 incarcerated women who completed the intervention and 55 who were waitlisted. Participants in SS demonstrated greater symptom improvement in PTSD and depression as well as improved interpersonal

functioning and coping as compared to waitlisted offenders. These findings provide preliminary support for the use of this intervention with incarcerated women.

Messina, Nena, Christine E. Grella, Jerry Cartier, and Stephanie Torres. "A Randomized Experimental Study of Gender-Responsive Substance Abuse Treatment for Women in Prison". *Journal of Substance Abuse Treatment* 38, no. 2 (2010): 97–107.

This experimental pilot study compared post-release outcomes for 115 women who participated in prison-based substance abuse treatment. Women were randomized to a gender-responsive treatment (GRT) program using manualized curricula (Helping Women Recover and Beyond Trauma) or a standard prison-based therapeutic community. Data were collected from the participants at prison program entry and 6 and 12 months after release. Bivariate and multivariate analyses were conducted. Results indicate that both groups improved in psychological well-being; however, GRT participants had greater reductions in drug use, were more likely to remain in residential aftercare longer (2.6 vs. 1.8 months, $p < .05$), and were less likely to have been re-incarcerated within 12 months after parole (31% vs. 45%, respectively; a 67% reduction in odds for the experimental group, $p < .05$). Findings show the beneficial effects of treatment components oriented toward women s needs and support the integration of GRT in prison programs for women. http://www.stephaniecovington.com/pdfs /Messina%20March.pdf

Messina, Nena, Stacy Calhoun, and Umme Warda. "Gender-Responsive Drug Court Treatment: A Randomized Controlled Trial." *Criminal Justice and Behavior* 39, no. 12 (2012): 1539-155.

This pilot study compared outcomes for 94 women offenders in San Diego County, California, who participated in four drug court programs. Women were randomized to gender-responsive (GR) programs using Helping Women Recover and Beyond Trauma or standard mixed-gender treatment. Data were collected at program entry, during treatment, and approximately 22 months after treatment entry. Bivariate and multivariate analyses were conducted. Results showed that GR participants had better in-treatment performance, more positive perceptions related to their treatment experience, and trends indicating reductions in posttraumatic stress disorder (PTSD) symptomology. Both groups improved in their self-reported psychological well-being and reported reductions in drug use ($p < .06$) and arrest (a diagnosis of PTSD was the primary predictor of reductions in re-arrest, $p < .04$). Findings show some beneficial effects of adding treatment components oriented toward women's needs.

Smith, Paula, Francis T. Cullen, and Edward J. Latessa. "Can 14,737 Women Be Wrong? A Meta-Analysis of the LSI-R and Recidivism for Female Offenders." *Criminology Public Policy* 8, no, 1 (2009): 183-208.

Over the past two decades, researchers have been increasingly interested in measuring the risk of offender recidivism as a means of advancing public safety and of directing treatment interventions. In this context, one instrument widely used in assessing offenders is the Level of Service Inventory-Revised (LSI-R). Recently, however, the LSI-R has been criticized for being a male-specific assessment instrument that is a weak predictor of criminal behavior in females. Through the use of meta-analytic techniques, we assessed this assertion. A total of 27 effect sizes yielded an average r value of .35 ([confidence interval] CI .34 to .36) for the relationship of the LSI-R with recidivism for female offenders (N= 14,737). When

available, we also made within-sample comparisons based on gender. These comparisons produced effect sizes for males and females that were statistically similar. These results are consistent with those generated in previous research on the LSI-R. They call into question prevailing critiques that the LSI-R has predictive validity for male but not for female offenders. At this stage, it seems that corrections officials should be advised that the LSI-R remains an important instrument for assessing all offenders as a prelude to the delivery of treatment services, especially those based on the principles of effective intervention. Critics should be encouraged, however, to construct and validate through research additional gender-specific instruments that revise, if not rival, the LSI-R. [Abstract from Author]

Taxman, Faye S., and Steven Belenko. *Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment*. New York: Springer, 2012.

"This book addresses the connected issues of knowledge development and utilization in the context of adopting and implementing EBP, particularly addiction treatment programs, in community corrections agencies" (p. 3). Chapters include: identifying the evidence base for "What Works" in community corrections and addiction treatment; theories of organizational change and technology transfer; organizational change technology transfer process review of the literature; community corrections addiction treatment strategies to adopt, implement, and sustain effective practices; current state of EBP in the community corrections field; the idiosyncrasies of the corrections and treatment environments; making good choices, a multistage conceptual model for identifying and selecting evidence-based practices; evidence-based interagency implementation model; and evidence-based implementation agenda.

Van Voorhis, Patricia, Emily Salisbury, Emily Wright, and Ashley Bauman. *Achieving Accurate Pictures of Risk and Identifying Gender-Responsive Needs: Two New Assessments for Women Offenders.* Washington DC: U.S. Department of Justice, National Institute of Corrections, 2008.

The development of new risk/needs assessments specifically designed for female offenders is discussed. This report is comprised of the case for women s needs, development of new assessments, construction validation research, full instruments, implementation considerations, and obtaining the gender-responsive assessments. http://nicic.gov/Library/022844

Ziatic, Joseph M., Donna C. Wilkerson, and Shannon M. McAllister. "Pretrial Diversion: The Overlooked Pretrial Services Evidence-Based Practice." *Federal Probation* 74, no. 1 (2010).

Although Pretrial Diversion (PTD) was conceived in the late 1940s as a program for dealing with juvenile offenders, it was not implemented in the federal judiciary under its current form until the passage of the Pretrial Services Act of 1982. Originally, PTD was meant to be an alternative to prosecution for low-level criminal offenders who had identifiable rehabilitative needs (Ulrich 2002). Moreover, an expectation of this program was that participants lack a significant criminal history. Through identifying potential participants in this program and developing an individualized supervision plan aimed at addressing root causes of the individual's criminal activity, stakeholders attempted to prevent future involvement in criminal behavior. http://www.uscourts.gov/viewer.aspx?doc=/uscourts/FederalCourts/PPS/Fedprob/2010- 06/index.html

Training Materials / Presentations

Addiction, the Brain, and Evidence-based Treatment. Washington, DC: U.S. Department of Justice. [PowerPoint slides and transcript], 2012

"Dr. Chandler will discuss why punishment alone is an ineffective response to the problem of drug abuse in the criminal justice system ... Dr. Chandler will also highlight evidence-based principles of addiction treatment based on an integrated public health/public safety strategy." Topics discussed include: drugs of abuse and crime are linked; smoking in criminal justice; mental health disorders among incarcerated populations; key participants in the criminal justice system and intervention opportunities; what addiction is—a disease of the brain; reward circuits; dopamine; memory circuits; cocaine craving; treatments for relapse prevention—medications and behavioral; evidence-based principles of drug abuse treatment for criminal justice populations; what recovery looks like on average; assessing risks, needs, and progress; criminal justice CEST (Client Evaluation of Self and Treatment); and tailoring supervision to fit the needs of the individual is important. http://nicic.gov/Library/026291

Carey, Mark. *Evidence-Based Practices for Stakeholders*. Power Point Presentation, 2011.

Objectives: Understand how the application of research around risk reduction can lead to improved justice system objectives; Identify the top criminogenic needs; Describe the key risk reduction principles and why they are important to know; Identify the interventions that increase future crime and those that decrease crime; Show how other jurisdictions have been applying the principles effectively.

Corso, Deena, Nathan Lowe, and Geraldine Nagy. *Evidence-Based Practices of Community Supervision: Part 1, A Focus on Current Issues and Trends in Probation,* 2011.

This training session was developed by the American Probation and Parole Association, in partnership with the National Reentry Resource Center, and is made possible through funding by the Bureau of Justice Assistance, U.S. Department of Justice. http://www.nationalreentryresourcecenter.org/documents/0000/1217/11_10_11Final_EB_P Probation 11 10 11 Final.pdf

Bartruff, Jerry, Nathan Lowe, and Shawn Rogers. *Webinar: Evidence-Based Practices of Community Supervision: Part 2, What Works in Parole and the Prisoner Reentry Process.* New York: National Reentry Resource Center; Lexington, KY: American Probation and Parole Association, 2011

The goal of this webinar is to educate community corrections professionals on evidence-based practices (EBPs) of parole supervision, particularly with respect to the reentry of parolees leaving prison. Participants will be able to: understand the core elements of EBPs and parole supervision; discuss the pros and cons of EBPs implementation; recognize leadership qualities that are conducive to using a successful evidence-based approach; and identify at least two practices that they could implement to enhance parole supervision and reentry outcomes.
http://www.nationalreentryresourcecenter.org/documents/0000/1245/EvidenceBased Practices of Community Supervision- Part II What Works in Parole Supervision-20111213 1902-1.wmv

http://www.nationalreentryresourcecenter.org/documents/0000/1244/Final_EBP_Parole Reentry 12 13 11 LK.pdf

Latessa, Edward J. *Improving the Effectiveness of Correctional Programs through Research.* http://www.drc.ohio.gov/web/iej files/200802 Speaker Latessa.pdf

National Institute of Corrections. *Evidence-Based Practices for Supervisors.* Online Training. First-line supervisors are key players in implementing the changes required of organizations committed to evidence-based service delivery. The first-line supervisor must perform supervisory duties that support the new role of staff as they impact offender behavior in the community and institution. Often, these new roles for line staff and line officers are not clearly defined, resulting in unclear expectations for job performance. The role of the first-line supervisor is crucial to assisting staff in making this adjustment in their approach to offender supervision, including dynamic risk assessment, offender case management, linkage to appropriate interventions and quality assurance. http://nicic.gov/Training/NICWBT13

Stitzer, Maxine. *Contingency Management in Drug Courts: Research and Resources*. PowerPoint Presentation, 2011.
http://www.gmuace.org/documents/presentations/2011/NADCP%202011%20Stitzer.pdf

WEBSITES

Advancing Evidence-Based Practice. http://advancingebp.org
Our mission is to promote the development, adoption, and effective implementation of evidence-based programs for at-risk youth and families.

Blueprints for Violence Prevention. http://www.colorado.edu/cspv/blueprints/
Demand for effective violence, drug, and crime prevention programs continues to grow. Across the country, a raft of programs aimed at preventing violence and drug abuse is underway. All of these programs are well-intentioned. Yet very few of them have evidence demonstrating their effectiveness. Many are implemented with little consistency or quality control. How do we know what works? Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado, provide answers to that question. The Blueprints mission is to identify truly outstanding violence and drug prevention programs that meet a high scientific standard of effectiveness. In doing so, Blueprints serves as a resource for governments, foundations, businesses, and other organizations trying to make informed judgments about their investments in violence and drug prevention programs. Boulder, CO: University of Colorado, Center for the Study and Prevention of Violence, Institute of Behavioral Science.

Bureau of Justice Statistics, http://bjs.ojp.usdoj.gov
BJS mission: To collect, analyze, publish, and disseminate information on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government. These data are critical to federal, state, and local policymakers in combating crime and ensuring that justice is both efficient and evenhanded.

The Campbell Collaboration. What Helps? What Harms? Based on What Evidence? http://www.campbellcollaboration.org/

The Campbell Collaboration (C2) helps people make well-informed decisions by preparing, maintaining and disseminating systematic reviews in education, crime and justice, and social welfare.

Center for Criminal Justice Research, Division of Criminal Justice, University of Cincinnati, www.uc.edu/criminaljustice
http://www.uc.edu/ccjr/publications.html

The nationally-ranked School of Criminal Justice holds a number one ranking for research productivity, and recognition in U.S. News World Report as one of the top three doctoral programs in the nation. With a mission dedicated to research, teaching and service, the School supports these and related activities through the Center for Criminal Justice Research, which includes the Corrections Institute and the Policing Institute. Graduate students are provided opportunities to learn and conduct research, training, and technical assistance in a wide range of criminal justice settings.

Crimesolutions.gov. http://www.crimesolutions.gov/TopicDetails.aspx?ID=2

You should go to this website first if you are looking for "[r]esearch on program effectiveness reviewed and rated by Expert Reviewers [with] [e]asily understandable ratings based on whether a program achieves its goals." Programs in the corrections and reentry field are divided into all, community corrections, inmate programs and treatment, recidivism, and reentry and release. In addition to corrections and reentry, the other broad topical areas are courts, crime and crime prevention, drugs and substance abuse, juveniles, law enforcement, technology and forensics, and victims and victimization.

Court Statistics Project: http://www.courtstatistics.org/

The Court Statistics Project collects and analyzes data relating to the work of our nation's courts.

Institute of Behavioral Research. http://www.ibr.tcu.edu/index.htm

IBR s mission is to evaluate and improve the effectiveness of programs for reducing drug abuse and related problems. Programs are based in communities or correctional facilities. This website provides access to information about IBR, staff, projects, newsletters, publications, web posters, manuals, sample forms, and other links. Fort Worth, TX: Texas Christian University.

Institute for Governmental Service and Research, University of Maryland, http://www.igsr.umd.edu/

With expertise in quantitative and qualitative assessment, as well as business process re-engineering, the Institute for Governmental Service and Research (IGSR) provides applied research, outreach, and technology innovations to meet the needs of state and local governments. Over the years, IGSR's main focus has been in the areas of criminal justice, including adult and juvenile courts, corrections, community supervision, prosecutors, and the police. Many projects span the interface between the criminal justice system and health and social service systems often entailing efforts to improve multi-agency collaboration.

Standardized instruments, rigorous designs, and large sample sizes are employed in across all of IGSR's organizations.
http://www.igsr.umd.edu/appliedresearch/reportsand publications.php?search=topic

MotivationalInterviewing,http://www.motivationalinterview.org/quicklinks/bibliography.html

The bibliographies provided here are not a comprehensive coverage of all Motivational Interviewing publications. They focus on the behavioral health arena, as well as MI training and implementation. Many of the citations in the bibliographies contain a Digital Object Identifier or DOI. The Digital Object Identifier (DOI) System was developed as a means to identify content and provide a permanent link to its location on the Internet. When articles are published and made available electronically, the publisher assigns them a DOI number. The DOI number is a unique alphanumeric string beginning with a 10 and containing a prefix and suffix separated by a slash.

National Criminal Justice Reference Service,
https://www.ncjrs.gov/App/AbstractDB/AbstractDBSearchResults.aspx?Title=_Author=_Journal=&NCJNum=&General=social+learning+theory_StartDate=_EndDate=_SearchMode=1_SortBy_4&_Offset=0

NCJRS services and resources are available to anyone interested in crime, victim assistance, and public safety including policymakers, practitioners, researchers, educators, community leaders, and the general public.

National Registry of Evidence-Based Programs. http://www.nrepp.samhsa.gov

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field. NREPP is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field.

NREPP is a voluntary, self-nominating system in which intervention developers elect to participate. There will always be some interventions that are not submitted to NREPP, and not all that are submitted are reviewed. In addition, new intervention summaries are continually being added, so the registry is always growing.

Pew Center on the States: www.pewcenteronthestates.org

The Pew Charitable Trusts applies the power of knowledge to solve today's most challenging problems. The Pew Center on the States identifies and advances state policy solutions. See Research topic: Corrections and Public Policy.

Public Behavioral Health and Justice Policy Evidence-based Practices. http://depts.washington.edu/ebpi/list.php

Faculty members in the Division of Public Behavioral Health and Justice Policy (PBHJP) have expertise in or can be a resource in obtaining additional information about the

following Evidence-Based Practices (EBPs). This list of EBPs is a "living document" - it is not comprehensive of all programs or providers and will be continually updated as information is available. University of Washington School of Medicine.

Risk Reduction Research. http://riskreduction.soceco.uci.edu/

"Our research team focuses on understanding why some people with mental disorder become involved in self-harm, violence, and/or criminal behavior. To develop more effective prevention and treatment strategies for this group, we must first understand how individual and environmental factors interact to increase their risk of such harmful behavior. This understanding can also be used inform legal decision-making about this high risk, high need group."

Urban Institute's Justice Policy Center,- http://www.urban.org/justice/index.cfm

Researchers in the Urban Institute s Justice Policy Center produce such research, evaluating programs, and analyzing data in an effort to guide federal, state, and local stakeholders in making sound decisions that will increase the safety of communities nationwide.

*Vera Institute of Justice, w*ww.vera.org

The Vera Institute of Justice combines expertise in research, demonstration projects, and technical assistance to help leaders in government and civil society improve the systems people rely on for justice and safety. Family Justice was picked up by Vera and focuses on strength-based, family-focused approaches to reentry.

What Works in Reentry Clearinghouse. http://nationalreentryresourcecenter.org/what works

This website "offers easy access to important research on the effectiveness of a wide variety of reentry programs and practices. It provides a user-friendly, one-stop shop for practitioners and service providers seeking guidance on evidence-based reentry interventions, as well as a useful resource for researchers and others interested in reentry." The current browse-able focus areas are brand name programs, employment, housing, and mental health. Program intervention is described along with a summary of results from the study, recommendations for practice, and suggestions for future research. In-depth details of the evaluation are also included with sections on program summary, research rigor level (high or low, study population, methodology along with its limitations, quality of implementation, findings, and the reviewed research publications about the program. http://nicic.gov/Library/026378

Agency Reports

Racine County Pretrial Risk Assessment. Milwaukee, WI: Zimmerman Consulting; Justice 2000, 2011. Information regarding the Racine Pretrial Risk Assessment process is provided. Documents contained in this collection include 'Racine County Pretrial Risk Assessment Report: January 1, 2009 ' December 31, 2009'; Racine County Pretrial Risk Assessment Instrument'; and Racine County Pretrial Services Risk Assessment Project: Status Report Questions and Answers. http://www.racineco.com/crepository/sheriff/20100405 001.pdf

Skilling, Nancy, and Debra Nonemaker. *DOCCR Validation of Two Domestic Violence Risk Instruments: Domestic Violence Screening Instrument (DVSI) Spousal Abuse Risk Assessment (SARA).* Minneapolis, MN: Hennepin County Department of Community Corrections and Rehabilitation Office of Planning, Policy and Evaluation, 2010.

The predictive validity of the Domestic Violence Screening Instrument (DVSI) and the Spousal Abuse Risk Assessment (SARA) Guide being used to assess misdemeanor domestic violence offenders is determined. "The results of this study provide strong evidence of validity of the SARA and the DVSI in predicting risk to reoffend in general and risk for domestic violence related offenses specifically. This is true for subpopulations of first time domestic offenders, repeat domestic offenders, males and females" (p. 10). 0Rehabilitation/Reports/Validation%20Study %20of%20Two%20 Domestic %20Violence% 20Risk%20Instruments.pdf

State of Colorado, Judicial Branch/Probation Services. *Research in Briefs:* 2006-2013.

The demands on probation and the courts are immense and the need for information on effective programming is critical. Districts often do not have the time to sift through research and consider how they might utilize the information and adjust practices to become more effective. In an effort to make this information more widely available and useful, "Research in Briefs" are being developed. These documents are intended to summarize potentially helpful information related to effective practices and suggest possible and practical application of the information.http://www.courts.state.co.us/Administration/Custom.cfm?Unit eval&Page ID=180

Vermont Center for Justice Research. *Evidence-Based Initiatives to Reduce Recidivism: A Study Commissioned by Act No. 41.*

This report was commissioned by the Vermont Legislature pursuant to Act 41 during the 2011-2012 Legislative Session. The study involved two parts: (1) a literature review of "innovative programs and initiatives, including local programs and prison-based initiatives, best practices, and contemporary research regarding assessments of programmatic alternatives and pilot projects relating to reducing recidivism in the criminal justice system;" (Act 41, Section 10); and (2) a survey of Vermont criminal justice service providers to identify innovative programs and assess the level of evidenced-based programming in the state. Although this report is not an exhaustive analysis of evidence-based initiatives which reduce recidivism, it does suggest an effective strategy for the future collection and dissemination of information regarding evidence-based programs and practices at both the national and state level.