The CPC and Promoting Effective Practices With Justice Involved Youth and Adult Offenders With Mental Illness

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COMID Committee on Diversion
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Focus

• The Evolution of EBP Implementation in SD
• The Correctional Program Checklist (CPC)
  • Developmental approach
  • Educational intervention for treatment community
  • What we have learned from the data
• Behavioral Health Providers Must Target Criminogenic Needs to Reduce Recidivism
  • Strategies to get the message out AND effect change
  • Next steps
Vision and leadership make a difference

Thank you Mack Jenkins

Someone needs to connect the dots and fill the gaps
Probation took the lead with EBP
Development of new position “Treatment Director”

Treatment Director

1. Identify and procure evidence based interventions
2. Training
   TIC and Suicide Prevention
3. Liaison to justice agencies and providers
4. Project Development
   MOCR-Trauma, Trauma Responsive Unit
5. Education
   Treatment fidelity, best clinical practices, MH screening and assessment
6. Quality Assurance – CPC
   Assessing provider use of evidence based practices
Evolution of evidence based practices

Began with officers (IBIS)  Expanded to treatment providers

EBPOST provides training, coaching and mentoring to ensure that Evidence Based Practices become part of the culture.

The CPC provides education on EBP for the offender population.

Evolution of evidence based practices

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The CPC provides education on EBP for the offender population.

Treatment return on investment

What kind of treatment is most cost effective

Return on Investment

The Iowa Department of Corrections conducted a study in May of 2012 that projected the cost-benefit of community based programs for prison releases. CBT was significantly more cost effective.

The Iowa Department of Corrections, "Return on Investment: Evidence-Based Options to Improve Outcomes" (May 2012).

Source: Iowa Department of Corrections, "Return on Investment: Evidence-Based Options to Improve Outcomes" (May 2012).

http://www.doc.state.ia.us/Research/DOC_HandoutROI_OffenderPrograms.pdf
Traditional concepts VS “What Works”

Mental illness is a direct cause of crime

Poverty causes crime

Symptoms bring contact with police for low level offenses

Mental illness is not a “driver” of criminal behavior

Symptoms rarely cause crime

Psychiatric services rarely reduce crime

Specialty supervision + psychiatric treatment reduces recidivism

How did we get here?

Public Safety Realignment (AB 109) and Prop 47

A new population

Merging philosophies

New laws quickly shifted non-violent offenders from institutions to treatment.

Current public health providers were asked to take on treatment of a population with unique needs without direction.

It has become necessary to merge treatment of psychiatric risk with meeting criminogenic needs.
Public Safety/Public Health
Bridging two schools of thought

The criminal justice system focuses on risk of violence and recidivism

The public health system focuses on psychiatric risk, reducing symptoms, and increasing functioning

The Bridge: Correctional Program Checklist (CPC)

We can provide a bridge by evaluating treatment provider’s adherence to evidence based practices using the CPC.

The CPC provides a validated neutral assessment that can be used as an educational tool and a guide for contract development.
The Correctional Program Checklist
Developed by Ed Latessa at the University of Cincinnati Corrections Institute (UCCI)

- A program evaluation tool developed from research on evidence based practices that reduce recidivism.
- Programs can identify areas that need improvement and measure change over time.
- Promotes use of EBP and accountability via:
  - More focus on treatment methods/proper targets
  - Less focus on documentation/compliance

Purpose of the CPC

- Answer three basic questions
  - Where is the program now?
  - Where does the program need to go?
  - How can the program get there?

- Using
  - Evidence based practices and principles of effective intervention

- Allowing
  - Better treatment funding decisions and a blueprint for program development
CPC Focus Areas

- Leadership Development
- Staff Characteristics
- Quality Assurance
- Offender Assessment
- Treatment Characteristics

CPC training

18 trainees from six agencies now certified to assess treatment programs

UCCI has provided two four-day trainings that allow us to conduct our own CPC evaluations
CPC site visit
A full day onsite at the program in operation

At least four evaluators visit a program

- Interview the Program Director and treatment staff
- Observe groups
- Interview clients and review files for treatment targets and goals

CPC final report
Overall Rating – Adherence to Evidence Based Practices

- Very High Adherence (65%+)
- High Adherence (55-64%)
- Moderate Adherence (46-54%)
- Low Adherence (45% or less)

Report includes
- Strengths
- Areas that need improvement
- Recommendations
Juvenile Program Results

**Very High Adherence to EBP (65%+)**
**High Adherence to EBP (55 - 64%)**
**Moderate Adherence to EBP (46% - 54%)**
**Low Adherence to EBP (45% or less)**

Adult Program Results

**Very High Adherence to EBP (65%+)**
**High Adherence to EBP (55 - 64%)**
**Moderate Adherence to EBP (46% - 54%)**
**Low Adherence to EBP (45% or less)**
## Adult Mental Health Results

![Bar Graph](image)

- **Very High Adherence to EBP (65%+)**
- **High Adherence to EBP (55 - 64%)**
- **Moderate Adherence to EBP (46% - 54%)**
- **Low Adherence to EBP (45% or less)**

## Mental Health vs. Other Programs

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Avg Capacity</th>
<th>Avg Content</th>
<th>Avg Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Outpatient Mental Health</td>
<td>47%</td>
<td>16%</td>
<td>29%</td>
</tr>
<tr>
<td>(2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Mental Health (9)</td>
<td>49%</td>
<td>35%</td>
<td>41%</td>
</tr>
<tr>
<td>All SD Programs (11)</td>
<td>49%</td>
<td>32%</td>
<td>39%</td>
</tr>
<tr>
<td><strong>National Average</strong></td>
<td><strong>56%</strong></td>
<td><strong>40%</strong></td>
<td><strong>49%</strong></td>
</tr>
</tbody>
</table>
Lessons learned

Language: Risk = Risk of recidivism

Everybody does “the CBT” (criminogenic focus?)

“Is that billable?” or “It’s not in my contract!”

Observation in real time is key

• PD and DA – Astounded at what really happens in groups
• BHS – Different sense of what takes place vs a typical audit

The top six common issues

1. Risk Levels
   Never mix high and low risk clients. High risk clients require more treatment.

2. Use more criminogenic targets
   Successful programs target criminogenic needs at 4:1.

3. Use role playing to practice skills
   Successful offenders consistently practice and rehearse alternative prosocial responses.

4. Use assessment data
   Successful programs use validated assessment tools for RNR.

5. Avoid mixing genders
   Less willing to disclose. Prior trauma could be exacerbated: distractions.

6. Behavioral Reinforcement
   Don’t be stingy, formal training & protocol necessary.
Already seeing success
Using the CPC has already brought changes to some of our programs

Genders Separated
CBT program no longer has men and women together in groups

Assessments
CBT program now conducting pre and post assessments

Separating Risk
An established drug and alcohol program has begun separating clients by risk level

Trauma Responsive Unit
Our new trauma responsive unit at Juvenile Hall is being designed with the CPC as a guide

Strategies
Behavioral health providers must ALSO target criminogenic needs to reduce recidivism

Criminogenic needs
Treating severely mentally ill offenders
Risk/needs assessments

Coordinating EBP implementation with public safety and public health

Education Seminars
CRD Expo
Offender Treatment Committee

Allows our providers to meet Probation Officers and other stakeholders
Next steps
After more than one year of conducting CPC evaluations, what is in the works?

Contracts
Items from the CPC are being placed in the scope of work for new contracts and contract renewals.

COMPAS
The COMPAS risk/need assessment is being made available through our online referral system.

Re-Evaluation
Some of the first programs evaluated will receive a follow up CPC to check on their progress.

Summary
Implementation of evidence based practices for offender populations includes education of treatment community, including providers who work with mentally ill offenders if recidivism is to be reduced.

Thank You
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