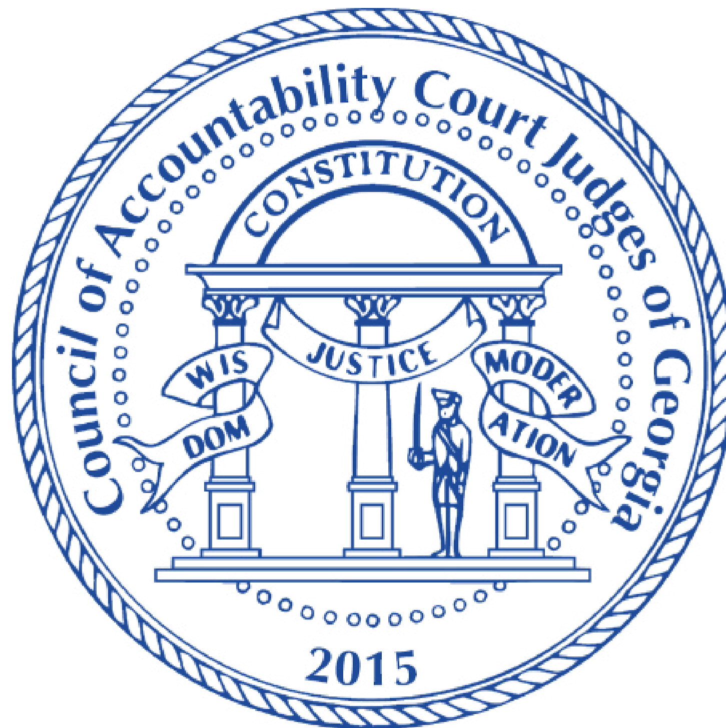
Council of Accountability Court Judges
Model Fidelity Handbook for Evidence-Based Programs
December 2017



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Council of Accountability Court Judges

The Council of Accountability Court Judges (Council) was created by House Bill 328 in 2015. The Council was established to effectively carry forth the constitutional by-laws and legislative responsibility to improve accountability courts and their quality through the expertise of judges. The Council was also formed to establish standards and practices for all drug court divisions based on the National Drug Court Institute and Substance Abuse and Mental Health Services Administration, with a state goal of reducing recidivism of offenders with drug abuse problems.

The Council's mission is *to provide a unified framework that promotes and improves the quality, accessibility and administration of Accountability Courts.*

Criminal Justice Reform and Accountability Courts

In February 2017, Governor Deal received the Criminal Justice Reform Report. Based on the findings in that report, Governor Deal said, "In the last five years, our efforts to improve Georgia's criminal justice system have improved overall efficiency, bolstered public safety and provided tools for incarcerated individuals to rebuild their lives."

Findings in the report include:

- At the start of 2009, 58 percent of the state's prison beds were occupied by Georgia's most serious offenders; now that proportion stands at 67 percent.
- Between 2009 and 2015, overall prison commitments dropped 16.3 percent to the lowest total number of commitments since 2002. In that same timeframe, commitments of African-American males dropped 25.3 percent to the lowest total since 1988.
- Since 2013, yearly juvenile commitments to the Department of Juvenile Justice have decreased by 46 percent.
- At the start of 2017, Georgia had 139 accountability courts in 47 out of the 49 judicial circuits. The number of new participants entering such courts statewide increased by 147 percent in 2016, more than doubling capacity.[1]

[1] To date Georgia now has 149 accountability courts in all 49 judicial circuits.

Target Population

Many operational requirements, including target population, for accountability courts are outlined in statute. For instance, O.C.G.A. § 15-1-15(a)(3) states,

> Each drug court division shall establish a planning group to develop a work plan. The planning group shall include the judges, prosecuting attorneys, public defenders, community supervision officers, and persons having expertise in the field of substance abuse. The work plan shall address the operational, coordination, resource, information management and evaluation needs of the drug court division. The work plan shall include drug court division policies and practices related to implementing the standards and practices developed pursuant to paragraph (4) of this subsection. The work plan shall ensure a risk and needs assessment is used to identify the likelihood of recidivating and identify needs that, when met, reduce recidivism. *The work plan shall ensure that drug court division eligibility shall be focused on* *<u>moderate-risk</u>* *and* *<u>high-risk offenders</u>* *as determined by a risk and needs assessment. The drug court division shall combine judicial supervision, treatment of drug court division participants and drug testing.*

The National Association of Drug Court Professionals (NADCP) created the Adult Drug Court Best Practice Standards. Volume I recommends that drug courts target offenders for admission who are addicted to illicit drugs or alcohol and are at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision. These individuals are commonly referred to as high-risk and high-need offenders. If serving a mix of risk and needs, the program should develop alternative tracks with services that are modified to meet the risk and need levels of its participants. If a drug court develops alternative tracks, it should not mix participants with different risk or need levels in the same counseling groups, residential treatment milieu, or housing unit.

Assessments Utilized to Determine Risk and Need

The Council of Accountability Court Judges Adult Drug Court Treatment Standards (Section II);

1.2 Clinical: Drug courts will enroll participants who meet diagnostic criteria for a Substance-Related Disorder and whose needs can be met by the program. A brief screen for mental health problems should occur.

1.2.1 Recommended Tools: Texas Christian University, Substance Abuse II (TCUDS); Addiction Severity Index Drug Use Subscale (ASI-Drug); Substance Abuse Subtle Screening Inventory-2 (SASSI-2); Brief Jail Mental Health Screen, National GAINS Center.

2.1 Drug courts will employ an assessment tool that captures offenders' risk of recidivism and treatment needs. This should also include a short assessment for mental health needs.

2.1.1 Recommended tools: Level of Service Inventory Revised (LSI-R); Correctional Offender Management and Profiling Alternative Sanctions (COMPAS).

2.2 Appropriate assessment instruments are actuarial tools that have been validated on a targeted population, are scientifically proven to determine a person's risk to recidivate, and to identify criminal risk factors that, when properly addressed, can reduce that person's likelihood of committing future criminal behavior.

2.3 The assessment tool should be suitable for use as a repeat measure. Programs should re-administer the tool as a measure of program effectiveness and offender progress.

3.1 Drug courts will offer an appropriate level of treatment for target population

3.1.1 Recommended tools: ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (PPC-2R)

3.2 Drug Courts will match participant risk of recidivism and needs with an appropriate level of treatment and supervision. Ideal length of program is 18-24 months.

4 Addiction Treatment Interventions

4.1 Drug courts will use a manualized curriculum and structured [e.g. Cognitive Behavioral Therapy (CBT)] approach to treating addiction.

4.1.1 Recommended tools: Relapse Prevention Therapy (RPT); Motivational Enhancement Therapy

4.2 Aftercare services are an important part of relapse prevention. Aftercare is lower in intensity and follows higher-intensity programming.

5 Recidivism/Criminality Treatment Interventions

5.1 Drug courts will incorporate programming that addresses criminogenic risk factors: those offender characteristics that are related to risk of recidivism.

5.1.1 Recommended tools: Moral Reconation Therapy (MRT); Thinking for a Change (T4C).

5.2 Criminal risk factors are those characteristics and behaviors that affect a person's risk for committing future crimes and include, but are not limited to, antisocial behavior, antisocial personality, criminal thinking, criminal associates, substance abuse, difficulties with impulsivity and problem-solving, underemployment, or unemployment.

Evidence-Based Programs

A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) offenders receive behavioral or cognitive-behavioral counseling interventions, (2) the interventions are carefully documented in treatment manuals, (3) treatment providers are trained to deliver the interventions reliably according to the manual, and (4) fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Andrews et al.,1990; Andrews & Bonta, 2010; Gendreau, 1996; Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Smith et al., 2009). Adherence to these principles has been associated with significantly better outcomes in Drug Courts (Gutierrez & Bourgon, 2012) and in other drug abuse treatment programs. (Prendergast et al., 2013).

Behavioral treatments reward offenders for desirable behaviors and sanction them for undesirable behaviors. The systemic application of graduated incentives and sanctions in Drug Courts is an example of a behavior therapy technique (Defulio et al., 2013; Marlowe & Wong, 2008). Cognitive-behavioral therapies (CBT) take an active problem solving approach to managing drug and alcohol-related problems. Common CBT techniques include correcting participants' irrational thoughts related to substance abuse (e.g., " I will never amount to anything anyway, so why bother?"), identifying participants' triggers or risk factors for drug use, scheduling participants' daily activities to avoid coming into contact with their triggers, helping participants to manage cravings and other negative affects without recourse to substance abuse, and teaching participants effective problem-solving techniques are drug-refusal strategies.

Outcomes from CBT are enhanced significantly when counselors are trained to deliver the curriculum in a reliable manner as specified in the manual (Goldstein et al., 2013; Southam-Gerow & McLeod, 2013). A minimum of three days of pre-implementation training, periodic booster sessions, and monthly individualized supervision and feedback are required for probation officers and treatment providers to administer evidence-based practices reliably (Bourgon et al., 2010; Edmunds et al., 2013 Robinson et al., 2012; Schoenwald et al., 2013). In addition, outcomes are better when counselors give homework assignments to the participants that reinforce material covered in the sessions (Kazantis et al., 2000; McDonald & Morgan, 2013). Examples of homework assignments include having participants keep a journal of their thoughts and feelings related to substance abuse, requiring participants to develop and follow through with a preplanned activity schedule, or having them write an essay on a drug-related topic (Sobell & Sobell, 2011).

Research suggests treatment providers are more likely to be effective if they have substantial experience working with criminal offenders and are accustomed to functioning in a criminal justice environment (Lutze & Van Wormer, 2007).

Overview – Model Fidelity

Outcomes promised by evidence-based programs are only achievable if the programs are delivered exactly as designed and the curricula are followed. The CACJ is focused on getting the optimum results and is creating a fidelity review process for the evidence-based programs being provided to participants. By ensuring fidelity to the treatment model, the CACJ will work on improving evidence-based programs' effectiveness to include changing behavior and continuing to reduce recidivism. To ensure model fidelity, there should be proper training and ongoing support for staff. Per the expertise of the Treatment Support Fidelity Specialist, fidelity to program model integrity includes three parts: (1) Training of treatment providers in evidence-based curricula, (2) supervision and coaching of treatment providers, and (3) adherence to fidelity of evidence-based curricula.

Research on adhering to model fidelity demonstrates reductions in recidivism can be realized when the program is implemented as designed. However, when there are deviations from the model, recidivism reductions are not often achieved and in some instances recidivism rates have even increased (Washington State Institute of Public Policy, 2004, 2010).

The CACJ is committed to assisting all certified accountability courts with the implementation of evidence-based programs through coaching and feedback on model fidelity, and general programmatic operations. As such, the Treatment Support Fidelity Specialist is responsible for this effort and will conduct site visits to support the programs.

Model Fidelity Site Visit

Purpose

The purpose of the model fidelity site visit by the CACJ is to support treatment providers with the successful implementation of Cognitive Behavioral Interventions for Substance Abusers (CBI-SA), Thinking for A Change (T4C), and Moral Reconation Therapy (MRT). By providing coaching and feedback on curricula implementation, recidivism reductions can be achieved for Georgia's participants.

The site visit is intended to identify where the program may need support. Current strengths will also be highlighted so that they do not become diminished as a result of the program focusing solely on recommendations or next steps when they receive their site visit report.

The information below provides a description of the upcoming activities for the model fidelity site visits.

Site Visit Activities

Pre-Site Preparation

There are several activities that will occur prior to the model fidelity site visits to guide preparation for the on-site activities. The specific preparation activities and on-site activities follow.

- 1 month prior to visit
  - Treatment Support Fidelity Specialist will contact the program coordinator and treatment provider to let them know a visit will occur (Email or Phone Call).
  - Coordinator and Treatment provider will provide a detailed schedule of evidence-based classes and all parties will secure a date and time for visit to occur.
  - Coordinator/Treatment provider will provide licensure/certification copy, copy of evidence-based certificate to facilitate CBI-SA, MRT, or T4C, and any other trainings necessary to conduct groups.
- 2 weeks prior to visit
  - Email coordinator and treatment provider to remind them of upcoming visit.
  - Schedule conference call if coordinator or treatment provider has any questions related to model fidelity visit.
  - Ensure all documents needed from court have been submitted to Treatment Support Fidelity Specialist before initial visit.

CACJ may request additional materials be made available for review during the site visit.

On-Site Activities

Depending on group schedules and treatment provider feedback, most on-site program visits will last one to two days. Scheduling of on-site activities will be done in the most efficient manner and with great consideration for group schedules and program routines, with a focus on limiting disruption to both participants and treatment providers.

Group Observation: The Treatment Support Fidelity Specialist will observe two group sessions and will work with staff to sit in a place in the room that is not disruptive to group.

Follow Up-Activities

After the site visit, the CACJ Treatment Support Fidelity Specialist will continue to work with the program. These follow-up activities include the following:

- Model Fidelity Report: Within a month of the site visit, the program will receive a report that summarizes the findings based on the group observation of evidence-based curriculums. The report will give constructive feedback to the treatment providers. A copy will also be sent to the program coordinator for their records.
- Return site visit: Will be subject to review annually. CACJ will also provide technical assistance if the program requests it or if the Treatment Support Fidelity Specialists deems it necessary based on group observation findings.
- Training and Coaching: If any training or coaching needs are identified in the Model Fidelity Report, CACJ will continue to work with the program to provide that support.

Throughout this progress, program staff are invited and encouraged to ask questions and express concerns prior to, during, and after the model fidelity site visit.

Follow-Up Site Visits

A formal site visit will be subject to review annually and additional site visits may be scheduled as needed. The process for site visits, as outlined in this section, is consistently adhered to.

Introduction to the Curricula

Cognitive Behavioral Interventions for Substance Abusers (CBI-SA)

The Cognitive Behavioral Interventions for Substance Abuse (CBI-SA) curriculum is designed for individuals that are moderate to high need in the area of substance abuse and well suited for criminal justice populations. The curriculum can be delivered as a stand-alone substance abuse intervention, or incorporated into a larger program, particularly those designed for clients in the corrections system. As the name of the curriculum suggests, this intervention relies on a cognitive behavioral approach to teach participants strategies for avoiding substance abuse. The program places heavy emphasis on skill building activities to assist with cognitive, social, emotional, and coping skills development. Such cognitive behavioral strategies have routinely demonstrated high treatment effects, including when used in a correctional population.

The curriculum is non-proprietary but training is required. An adolescent version is also available.

Overview

Components of the 39-session curriculum include the following:

- Pre-Treatment Module (optional)
- Module 1: Motivational Engagement
- Module 2: Cognitive Restructuring
- Module 3: Emotion Regulation
- Module 4: Social Skills
- Module 5: Problem Solving
- Module 6: Success Planning

Moral Reconation Therapy (MRT)

The term "moral" refers to moral reasoning based on Kohlberg's levels of cognitive reasoning. The word "reconation" comes from the psychological terms "conative" and "conation," both of which refer to the process of making conscious decisions. MRT is a cognitive-behavioral treatment system that leads to enhanced moral reasoning, better decision making, and more appropriate behavior.

MRT was initially developed in the 1980's as the cognitive-behavioral component in a prison-based therapeutic community. Because of its remarkable success (notably with minority participants), the program was then tested and widely implemented in general inmate populations, with juvenile offenders, in parole and probation settings, community corrections, hospital and outpatient programs, educational settings, and in drug courts. Measured objective outcomes were consistent in all settings. The program leads to increased participation and completion rates, decreased disciplinary infractions, beneficial changes in personality characteristics, and significantly lower recidivism rates. Unlike other program outcomes, MRT research shows that participation and program completion by minority groups can significantly lower long-term recidivism rates-for more than 20 years after treatment. No other cognitive-behavioral treatment for offenders or substance abuse has shown such results.

All MRT groups must be operated by MRT-certified facilitators, professional staff who have completed the 32 hour training program.

MRT is typically conducted in weekly groups, where clients present exercises from one of the workbooks that have been completed as homework. Group facilitators use objective criteria to evaluate the participant's successful completion of each of the programs' steps.

Thinking for a Change (T4C)

T4C is an integrated, cognitive behavioral change program for offenders that includes cognitive restructuring, social skills development, and development of problem solving skills. The goal of the program is to effect change in thinking so that behavior is positively impacted, ultimately resulting in reduced recidivism. The ideal referral to T4C would be a moderate- to high-risk client who needs to learn skills to make better decisions.

> The cognitive self -change component teaches individuals a concrete process for self-reflection aimed at uncovering antisocial thoughts, feelings, attitudes, and beliefs. The development of social skills module prepares participants to engage in pro-social interactions based on self- understanding and consideration of the impact of their actions on others. The development of problem-solving skills section integrates skills from previous interventions to provide the group with an explicit step-by-step process for addressing challenging and stressful real life situations.
>
> The curriculum is designed for delivery to small groups of 8-12 participants, in 25 lessons, two to three times a week. The social skills covered in T4C include: active listening, asking questions, giving feedback, knowing your feelings, understanding the feelings of others, making a complaint, apologizing, responding to anger, and negotiating. The cognitive self-change steps covered in the lessons include: paying attention to our thinking, recognizing risk, and using new thinking. The problem solving skills introduced at the end of the curriculum include stop and think, state the problem, set a goal and gather information, think of choices and consequences, make a plan, and do and evaluate.

In 2016, National Institute of Corrections (NIC) released T4C 4.0. According to NIC, "T4C 4.0 not only reflects the collective wisdom and experience of facilitators, trainers, and the authors, but also the newest innovations in program delivery. NIC worked in consultation with all three original authors to complete this project. Version 4.0 incorporates developments in the field of cognitive behavioral interventions, and it improves upon the original product in both format and content."

T4C developers include Barry Glick, Ph.D.; Jack Bush, Ph.D.; and Juliana Taymans, Ph.D. in cooperation with the National Institute of Corrections.

Observation Checklists

CBI-SA Group Observation Checklist

(1) Room set up with proper use of visual aids for the lesson (chalk board, white board or Table Top Easel Pad to write on),

(2) Room set up in U-shaped seating and tables,

(3) Review of Practice Work at the beginning and assignment of practice work at the end of every lesson,

(4) Appropriate modeling of new skill and role playing by facilitator and co-facilitator (if co-facilitator is needed),

(5) Full participation of group members and encouragement to participate by facilitators,

(6) Facilitators use active listening skills and use open-ended questions when interacting with participants,

(7) Facilitators modeling the skills in CBI-SA and the group rules. Facilitators should also redirect participants, as needed, to follow group norms/rules,

(8) Following the CBI-SA lesson script,

(9) Clear demonstration that facilitators are providing appropriate reinforcement to positive attitudes and behaviors and linking verbal praise to the attitude/behavior, and

(10) Promptly, but in a positive manner, redirecting participants who are not following group rules/norms, or demonstrating inappropriate attitudes/behaviors.

Moral Reconation Therapy Group Observation Checklist

(1) Room and chairs set up in U-shaped seating and tables,

(2) Group Rules posted in area of room that is visible to all participants,

(3) Group is once or twice weekly, with a day or two in between for completion of homework assignments,

(4) Facilitator ensures lower steps start first and MRT steps are read and discussed beforehand,

(5) Facilitator is well versed in the 16 objectively defined steps (freedom ladder) and understands what behaviors warrant being sent back to lower steps. (1, 2 or 3 depending on behavior exhibited),

(6) Full participation of group members and encouragement to participate by facilitators,

(7) Facilitators should redirect participants, as needed to follow group norms/rules,

(8) Facilitators follow the MRT instructors manual,

(9) Clear demonstration that facilitators are providing appropriate reinforcement to positive attitudes and behaviors and linking praise to the attitude/behavior.

Thinking for a Change Group Observation Checklist

(1) Room set up in a U-shape with proper use of visual aids for the lesson,

(2) Review of homework at the beginning and assignment of homework at the conclusion of the lesson,

(3) Appropriate modeling of new skill and role playing by the co-facilitators,

(4) Full participation of group members and encouragement to participate by facilitators,

(5) Facilitators use active listening skills and use open-ended questions when interacting with participants,

(6) Facilitators modeling the skills in T4C and the group rules. Facilitators should also redirect participants, as needed, to follow group norms/rules,

(7) Following the T4C lesson script,

(8) Clear demonstration that facilitators are providing appropriate reinforcement to positive attitudes and behaviors and linking verbal praise to the attitude/behavior, and

(9) Promptly, but in a positive manner, redirecting participants who are not following group rules/norms, or demonstrating inappropriate attitudes/behaviors.

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