MIDD Advisory Committee / Steering Committee Modification Review Form

RR-02 Behavioral Health Services at Center for Community Alternative Programs (CCAP)

(formerly Behavioral Modification Classes at CCAP)

Proposed Change:

- ☐ **Fiscal Change to Existing MIDD 2 Initiative(s):**
  - ☐ Net Total Dollar Amount Change in Funding Level:
  - ☐ Net Percent Change in Funding Level: _____%
- ☒ **Programmatic Change(s):**
  - ☒ Population Served or Impacted[1]
  - ☐ Outcomes or Results
  - ☒ Intervention
  - ☒ Performance Measures
- ☐ **One-Time Use of MIDD Funds**
  - ☐ Temporary Reallocation of Funds from Initiatives
    Initiative(s) whose funds are proposed to be reallocated:
  - ☐ Undesignated or Underspent Funds
  - ☐ Net Total Dollar Amount: _____%
- ☐ **Proposed New Ongoing Initiative(s)**
- ☐ **Other (describe):**

Revision Details:

a. High-level summary[2] of affected MIDD 2 initiative(s) prior to the change, if any

Initiative RR-02, formerly known as Behavioral Modification Classes at CCAP, has used a Moral Reconation Therapy (MRT) model which creates a positive group dynamic to alter inappropriate thought and behavior among domestic violence (DV) offenders. The MRT-DV pilot program adaptation, called Promoting Peace and Recovery, is a cognitive-behavioral program designed to change how DV offenders think, and change behavior toward equality and acceptance. The MRT-DV adaptation takes approximately 55 sessions to complete, and are conducted twice weekly at CCAP.

This initiative enhances program services offered at CCAP in the areas of behavioral health education and intervention, and addresses criminogenic risk factors specifically associated with DV. Since 2014, MIDD has supported a clinician trained in MRT and the specialized DV version to prepare and facilitate groups for one caseload of 15 men who are randomly assigned to the MRT-DV program at CCAP by the King County Prosecuting Attorney's Office or referred by CCAP caseworkers. All MRT-DV participants have a substance use disorder (SUD). Participants are clinically assessed and enrolled in appropriate SUD treatment at CCAP, per American Society of Addiction Medicine (ASAM) criteria.

b. Details of the proposed change, including:

i. Origination of the change[3]

This MIDD initiative also represented a *Pay for Success* initiative sponsored by the King County Executive's Office. The change was prompted by concerns raised by the Office of Performance, Strategy and Budget (PSB) in meeting *Pay for Success* evaluation requirements in terms of

[1] "Populations served or impacted" should include geographic regions and/or cultural communities where applicable.

[2] One-paragraph summary adapted from the MIDD 2 Implementation Plan initiative description that also reflects any revisions that may have been made to the initiative prior to this proposed change.

[3] How did the proposed change come to the County's attention as a needed action?

numbers served. Upon meeting with the PSB Director in March 2019, the decision was made to terminate the Pay for Success component and repurpose the MIDD RR-02 funds for other service needs at CCAP. This change request proposes using MIDD RR-02 funds to cover the costs of CCAP participants who are not Medicaid enrolled with equitable access to mental health services at CCAP, thereby providing equitable access to mental health care regardless of Medicaid status.

The initiative name change to RR-02 Behavioral Health Services at Center for Community Alternative Programs (CCAP) would be effective for the 2019 reporting year and related communications.

ii. Reason/basis[4]

The number of CCAP participants with psychiatric issues has increased over recent years and there is a growing need to provide mental health services at CCAP. Medicaid funded mental health services were introduced at CCAP effective March 1, 2019 for participants receiving Medicaid benefits. Similar services are not yet available for people without Medicaid.

The retention rates of domestic violence (DV) offenders in the prior program model for initiative RR-02 have been low from the outset with very few program graduates. Program retention has been negatively affected by no shows and court order violations at the Community Center for Alternative Programs (CCAP). As a result, the number of program participants who graduated or received minimum dosage of 8 sessions is projected to be insufficient to test for statistical significance in determining client outcomes and program effectiveness.

iii. Timing[5]

Expedited review is requested as referrals to the existing DV program at CCAP will cease effective April 30, 2019. Meanwhile, CCAP participants with mental health services needs who are not Medicaid enrolled do not have equitable access to services at CCAP.

c. How the proposed change addresses the Advisory Committee's guiding principles for MIDD

The proposed change addresses the following MIDD guiding principles:

- Fills a gap in funding as Medicaid funds cannot be used to reimburse behavioral health services provided to individuals who are not enrolled in Medicaid.
- Supports King County's vision for health care and the State's vision for integrated behavioral health and primary care; reflects the triple aim: improved patient care experience, improved population health, and reduced cost of health care.
- Supports integrated, transformational services and strategies designed to serve our most disenfranchised populations.
- Enhances partnering between criminal justice and human services with shared goal to divert and prevent justice system involvement.
- Builds on strengths of the criminal justice and human services systems.
- Enhances services which are recovery focused.
- Supports client centered services.
- Common goal (from MIDD Framework as "result of MIDD"): "*People living with or at risk of behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement.*"

[4] To the degree feasible, address under "reason/basis" the benefits of making the change, risks of not changing, and any tradeoffs or strategic questions. If the change represents partial funding of a larger request or concept, reference this.
[5] Address whether expedited review and action is needed, and if so, explain why.

d. How the proposed revision impacts the original intent of affected initiative(s)
No change in the primary MIDD policy goal. The proposed revision impacts the original intent of the initiative by shifting from an educational approach ("classes") to a treatment approach. However, both approaches are therapeutic and designed to positively affect/modify behavior in CCAP participants with criminal legal system involvement. As stated below (item 1.e.), the proposed revision may affect the target number of individuals to be served per year.

e. Funding impacts, if any – None.

f. Evaluation impacts, if any
The target number served may increase from 40 to approximately 60 estimated individuals per year. Moreover, the requested change proposes serving a different cohort/population in the middle of a funding cycle will need to be accounted for in the program evaluation.

g. Next steps
The DV program will cease accepting referrals effective April 30, 2019. An amendment to the behavioral health contract with Asian Counseling & Referral Service (ACRS) will be executed to revise the MIDD RR-02 funded services at CCAP to align with revisions described herein. Mental health services for non-Medicaid enrolled participants at CCAP are expected to begin by July 1, 2019 at the latest.

h. Include staff analysis, if available
A summary analysis providing more details about the change is provided.

Steering Committee Review:
Reviewed:

Full MIDD Advisory Committee Review:
Reviewed:
Action:

Steering Committee and full Advisory Committee comments, questions, and advice, if any:

King County

White Paper

Pay for Success: Promoting Peace and Recovery Pilot Program

April 2019

This white paper is submitted in response to the low number of referrals and admissions to the Promoting Peace and Recovery (PPR) pilot program over the past 12 months. The King County Community Center for Alternative Programs (CCAP) began offering the reconfigured and integrated PPR pilot program in Seattle, with services provided by Asian Counseling and Referral Service (ACRS), in February 2018. The PPR pilot is funded by MIDD 2 Initiative RR-02 and serves adult males charged with domestic violence (DV) charges (felony or misdemeanor) who also have a substance use disorder (SUD). Defendants may be referred to the program as a sentencing alternative or a condition of pretrial release. The program is designed to support up to 30 participants (two caseloads of 15 each) at any one time in obtaining measurable improvement in controlling abusive behavior and reducing their substance use. To date, only one caseload of 15 men has been activated, primarily due to the limited number of referrals and the high rate of participant attrition.

The King County Council adopted the 2019-2020 budget ordinance in November 2018 which contains an appropriation (expenditure restriction) that "shall be expended or encumbered solely to implement a south county pretrial services program." Essentially, this expenditure restriction creates a CCAP site in South King County to serve an average daily population of 40 participants as described in an implementation plan accepted by the council under Motion 15226. Given the low number of PPR referrals from Seattle and interest by public defenders based in South King County, the PPR Advisory Committee has recommended that the second caseload of 15 (funded by MIDD RR-02) be earmarked for the CCAP/pretrial services program in South King County. However, it is anticipated that the south county pretrial services program will not be implemented until late 2019 or early 2020.

The PPR pilot program was identified and approved by the *Pay for Success* (*PFS*) Sponsor Group in 2017, facilitated by Third Sector Capital Partners (Third Sector), to be one of two *PFS* programs in King County involving the Department of Community and Human Services, Behavioral Health and Recovery Division. However, due to the low number of referrals over the past 12 months from the designated referral sources—King County Prosecuting Attorney's Office (PAO), King County Department of Public Defense (DPD), and CCAP—and the very low number of program participants satisfying the eligibility criteria for inclusion in the calculation of *PFS* incentive payments, the author recommends taking one of the following corrective actions:

1) Eliminate the *PFS* component of PPR,
2) Apply the *PFS* component to another, more appropriate program,
3) Expand PPR eligibility criteria and significantly alter the *PFS* incentive payment structure, or
4) Discontinue the PPR pilot program and replace it altogether.

Background

The PAO's DV Unit processes over 1,800 DV cases per year (over 150 per month). Studies show exceptionally high rates of recidivism among batterers[1] and no measurable effect of batterer's treatment on recidivism.[2] Given the pervasiveness of DV, and risk to victims, the legal system has an obligation to identify and implement effective interventions with clear cost-saving benefits. Further, evidence from multiple studies suggests that substance use/abuse precipitates or exacerbates intimate partner violence,[3] and substance abuse has been found to co-occur in 40-60% of intimate partner violence incidents.[4] For over 20 years, state-certified DV batterer's treatment was the typical legal response for DV criminal cases in Washington State, though its effectiveness has been called into question, resulting in updates to the Washington Administrative Code effective June 2018.[5]

In 2014, an initial pilot was launched at CCAP-Enhanced utilizing a cognitive-behavioral approach called Moral Reconation Therapy (MRT) adapted specifically for DV offenders (MRT-DV), which has been deemed a promising practice by the Washington State Institute for Public Policy.[6] To continue exploring new and promising practices for not only preventing DV recidivism, but also to address its intersection with SUD, King County developed and funded the PPR pilot program and partnered with Third Sector to design performance-based payments to incentivize the contracted agency's performance.

Intervention

The PPR pilot program offers an alternative to incarceration for adult men charged with domestic violence who have an SUD. PPR combines MRT-DV with SUD treatment and supportive case management. Participants are expected to attend group sessions (both MRT-DV and SUD intensive outpatient treatment) twice weekly for 12-16 weeks and individual counseling at least once per month.

MRT is a cognitive-behavioral therapy intervention which has been shown to decrease recidivism. MRT is widely used for the general offender population in King County and by the Washington State Department of Corrections. MRT facilitates resocialization through perspective taking and

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[1] See Drake, E., Harmon, L., & Miller, M. (2013). *Recidivism trends of domestic violence offenders in Washington State* [Document No. 13- 08-1201]. Olympia, WA: Washington State Institute for Public Policy.

[2] See George, T. P. (2012). *Domestic violence sentencing conditions and recidivism*. Olympia, WA: Washington State Center for Court Research, Administrative Office of the Courts; Gill, C. (2012). *Evidence-based assessment of the City of Seattle's crime prevention programs*. Seattle, WA: City of Seattle Office of City Auditor; Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes* [Document No. 12-04-1201]. Olympia, WA: Washington State Institute for Public Policy; Miller, M., Drake, E., & Nafziger, M. (2013). *What works to reduce recidivism by domestic violence offenders?* [Document No. 13-01-1201]. Olympia, WA: Washington State Institute for Public Policy; National Institute of Justice. (2011, May). *Batterer intervention programs often do not change offender behavior*. Available at: http://www.nij.gov/nij/topics/crime/intimate-partner-violence/interventions/batterer-intervention.htm

[3] See Fals-Stewart, W. (2003). Intimate partner violence and substance use: a longitudinal day-to-day examination. *Addictive Behaviors*, 1555-1574.

[4] See Moore, T., & Stuart, G. (2004). Illicit substance use and intimate partner violence among men in batterers' intervention. *Psychology of Addictive Behaviors*, *18*(4), 385-389.

[5] W.A.C. 388-60-0045 and -0055. Effective June 29, 2018, W.S.R. 18-12-034 repealed chapter 388-60 of the W.A.C. and created chapter 388-60A to update rules in order to raise the standards of domestic violence perpetrator treatment.

[6] See Miller et al. (2013).

role playing, short- and long-term goal setting, and emotion regulation and problem solving. The curriculum addresses salient criminogenic risk factors, such as poor self-control, antisocial thoughts and attitudes, SUDs, and the patterns of strained and disruptive relationship behaviors that play out in the family, workplace and other settings.

PPR participants use the MRT-DV workbook, *Bringing Peace to Relationships*, which is available in English and Spanish. Motivational Interviewing (MI)—an evidence-based, directive, client-centered counseling approach found effective with special populations—is used to engage participants. The suggested time for completing the 24 MRT-DV modules is 24 group sessions. Participants are expected to finish homework exercises prior to coming to a group session. During group sessions, each client presents their homework and the group facilitator and other participants collectively determine, based on objective criteria, whether the client is ready to progress to the next module or should redo their homework.

ACRS administers MRT-DV and SUD treatment programs at CCAP-Enhanced. ACRS staff are trained in MI, which are applied to foster and sustain relationships with PPR participants and understand and enhance their motivation to change. Furthermore, ACRS has a diverse staff capable of serving participants whose primary language is not English, and tailors treatment for each participant in a culturally responsive manner that considers the impact of institutionalized racism and historical trauma.

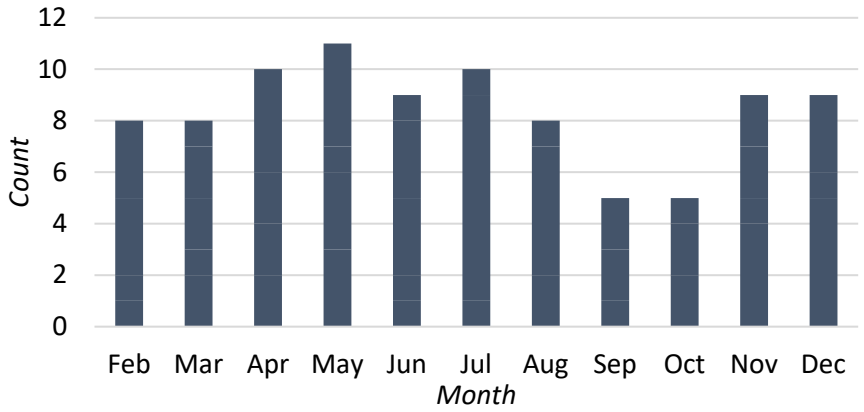
CCAP caseworkers, in partnership with ACRS counselors, monitor participant attendance and progress and connect participants to social services, housing, job training, and other services, resources, and support as needed.

ACRS and CCAP began administering the PPR program and serving participants in February 2018. The program is designed to serve up to 120 participants annually, based on the facilitation of two concurrent caseloads of 15 men each with the length of participation in PPR averaging 12-16 weeks.

Referral, Enrollment, and Participation Patterns to Date

During the 11-month period between February and December 2018, CCAP workers documented 92 referrals (of 80 unique individuals) to the PPR program, with the majority of referrals stemming from the PAO. Figure 1 displays the number of referrals to the PPR program per month, as documented by CCAP caseworkers. The current rate of referral extrapolates to 100 referrals (of 87 unique individuals) to the PPR program annually. One hundred referrals to the PPR program annually would be sufficient (for evaluation and *PFS* incentives) if all of the referrals were served by the program; unfortunately, a large number of those referred individuals (39 percent) were never served by PPR due to ineligibility or failure to complete screening/intake. Fifty-nine of the referrals over the 11-month period satisfied the eligibility criteria and were screened into the PPR program (i.e., authorized to receive services). Given the low number of referrals identified as eligible and screened in, as well as the high rate of attrition (discussed below), a significantly greater number of referrals to the PPR program are required to achieve participation levels high enough to warrant an evaluation and *PFS* incentive structure.

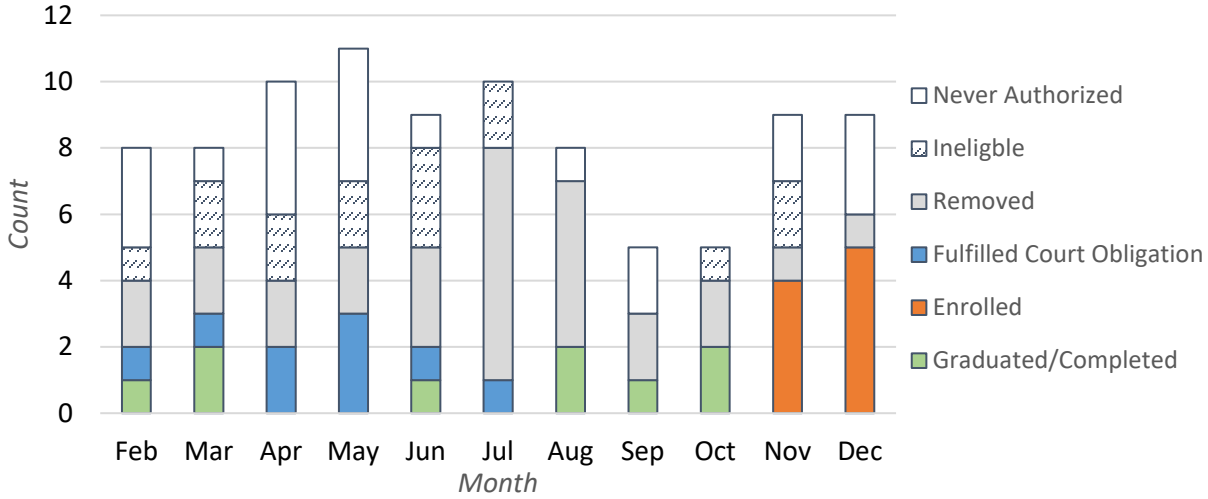
Figure 1: Referrals to PPR by Month, Feb - Dec 2018



Source: CCAP caseworker referral tracking log

Figure 2 (below) displays the progress of individuals referred to the PPR program. As stated above, 39 percent of those referred to PPR were never enrolled (i.e., deemed ineligible or never authorized). An additional 32 percent (n = 29) of referred participants were removed from the PPR program subsequent to enrollment; the most common reasons for removal from PPR include failure to attend sessions, new criminal charges or sentencing, and behavior/substance use. Further, 10 percent of enrolled participants fulfilled their obligations to the court and exited the PPR program prior to completing the curriculum.

Figure 2: Enrollment, Participation and Outcomes for PPR Referrals by Month, Feb - Dec 2018



Note: The referral and outcome information are based on the best data available from disparate sources and should be interpreted with caution.

As of the end of December 2018, nine individuals who were enrolled in the 11-month period have graduated from the PPR program, which includes completing the 24 modules of MRT-DV. An additional nine individuals were actively enrolled in PPR at the time of data collection for this white paper. Data from January 2019 is not included here as additional time is required for data collection

and for certain outcomes to come to fruition (e.g., participants are given time to begin attending PPR sessions before they are removed for failure to attend).

Implications for Evaluation

A preliminary statistical power analysis indicated that, in order for a 25 percent reduction in new protection orders (or a reduction in violations of existing protection orders) from baseline to be deemed statistically significant (i.e., to demonstrate PPR program efficacy), 300 intervention and 300 comparison group participants are required. Given program capacity and length, the PPR program could serve 120 participants per year; thus, the PPR enrollment period would need to be approximately three years to enroll at least 300 individuals. As indicated above, however, only 59 referrals were authorized to receive PPR program services over the first 11 months of the program. Of these, only 42 individuals could be classified as "participants," as defined by attendance in any group session of MRT-DV or SUD treatment. The majority of these participants were subsequently removed from the program or fulfilled their obligations to the court prior to program completion.

The low number of participants in PPR presents a number of challenges to the ability to evaluate the program's efficacy. First, the number of program participants would need to at least double in order to achieve the sample size required to evaluate the program with the proposed rigor. Even then, "participation" in the program was not envisioned as being defined as attendance at *any* MRT-DV or SUD treatment group session; some minimum threshold would need to be met to say an individual had actively participated in the program, further constraining the sample of the intervention group. Additionally, if the required rigor of the evaluation is relaxed and a comparison group design eliminated, programmatic outcomes will cease to be generalizable beyond the participants in the PPR program. We would not be able to say with any certainty that MRT-DV combined with SUD treatment works for DV offenders; we would only be able to describe the outcomes for individuals before and after participation in PPR. A large enough sample of individuals (though much lower than 300) meeting a defined threshold of participation in PPR would be required to assert that any reduction in new protection orders (or reduction in violations of existing protection orders) represents a significant improvement.

Implications for Incentive Payments through Pay for Success

Incentive payments for PPR participant outcomes are earned in two ways: successful linkages to ongoing SUD treatment following discharge from the PPR program and percentage reductions in criminal justice outcomes (new protection orders/violations of existing protection orders and domestic violence-related charges and offenses) for 6-month cohorts of PPR program participants meeting a minimum threshold of participation. The majority of the $200,000 in incentive payments (70 percent) can be earned by ACRS for meeting the percentage reductions in criminal justice outcomes.

Regarding linkages to ongoing SUD treatment, ACRS is eligible to receive an incentive payment for each participant enrolled in PPR, regardless of length of time engaged in programming, if the participant is admitted to continuing SUD treatment in the community within 60 days of discharge from the PPR program. The first cohort of eligible participants includes individuals who were enrolled in the PPR program and discharged between May and August of 2018; only one individual of the 22 whose authorization ended (i.e., was discharged) during the eligible time frame meets the criteria of a successful linkage.

The incentive payment structure is premised on approximately 300 participants enrolling in the PPR program over a three-year period. A total of $60,000 was allocated over two biennium budget cycles for these incentive disbursements, and given the anticipated enrollments in PPR, $222 is to be disbursed for each successful linkage to SUD treatment. The low rate of participation among the referrals to PPR over the first 11 months of the program, as well as the low number of linkages to continuing SUD treatment from the first cohort, make it very likely that ACRS will only earn a fraction of the SUD treatment linkage incentive payments by the conclusion of the *PFS* component of PPR.

Regarding criminal justice outcomes, ACRS is eligible to receive incentive payments for achieving target rates of recidivism for cohorts of PPR participants enrolled during six-month time frames who meet a threshold of participation in the program. Specifically, individuals enrolled in PPR who completed a minimum of 8 MRT-DV group sessions and 8 SUD treatment group sessions are eligible for inclusion in a cohort. Rates of recidivism are then calculated for the cohort as the percent of participants with King County filings of new protection orders or violations of existing protection orders within one year of enrollment and the percent of participants with King County bookings or charges for any new misdemeanor or felony charges with a DV flag within one year of enrollment. For example, if less than 25 percent of participants in a cohort have a new King County booking or charge with a DV flag within one year, ACRS will earn a payment of $15,556 for that cohort's outcomes.

The incentive payment structure is designed such that ACRS can earn disbursements for the criminal justice outcomes of 6 separate six-month cohorts of PPR participants. A total of $140,000 was allocated over two biennium budget cycles for these incentive disbursements. If 300 participants enrolled in PPR over the three-year period (May 2018 – April 2021), rates of recidivism would be calculated for approximately 50 participants per cohort. However, as of the writing of this white paper, King County staff identified only two participants in the first cohort (May-Oct 2018) who meet the eligibility criteria. Communication with ACRS is ongoing to acquire additional group session attendance data, however, current information indicates that even with additional data, the number of participants meeting the eligibility criteria for inclusion in the first cohort will be 10 or fewer.

As such, the incentive payments for the *PFS* component of the PPR program can be distributed under the current structure, however, they will not be disbursed as intended when enrollment and participation in PPR was estimated. It was envisioned that incentive payments would be earned for a substantially greater number of participants, with each cohort comprising up to 50 participants; instead, due to the low rate of eligible referrals who are successfully enrolled and participate in the PPR program to any degree (and, in particular, the number that meet the minimum threshold of participation for incentive payments linked to recidivism outcomes), ACRS has earned the incentive payment for SUD treatment linkage for only one participant in the first cohort, and the incentive payments for criminal justice outcomes will be based on the recidivism rates for fewer than 10 individuals. Further, there is little evidence to indicate that referral, enrollment, and participation rates have increased substantially since October that could justify continuing the *PFS* incentive payment component as currently structured.

Recommendation/Option

1. Discontinue the PPR pilot program entirely and repurpose MIDD RR-02 funds to other needed services for CCAP-Enhanced participants. All referrals to the PPR pilot program will cease effective April 30, 2019 and no individuals would be admitted to the program after that date. However, every individual admitted to the program would receive services until discharged from CCAP. The PPR program would gradually phase-out over a period of 60-90 days and terminate by July 31, 2019 at the latest.

Founded in 1973, ACRS provides culturally competent and language specific counseling and prevention/treatment services targeting Asian Americans and Pacific Islanders immigrant and refugees, and underserved communities. ACRS is a licensed mental health (MH) provider since 1973, licensed SUD provides since 1999, and a state certified culturally competent DV Batterers Treatment Program since 1997. In 2018, ACRS expanded its scope of work to provide forensic treatment services at CCAP-Enhanced.

ACRS works with vulnerable individuals facing multiple stressors such as language (over 45 dialects spoken) and cultural barriers, family and generational trauma, MH, SUD, DV, poverty, and unemployment. ACRS assists individuals to address social determinants of health through a wide array of programs, including assistance with supported employment services, citizenship, nutrition programs, and a limited housing assistance program.

Lessons Learned

1. Lack of incentive for prospective referrals: There is little incentive for DV offenders to opt into an intervention when it will likely take them longer to complete the program than simply "doing time" in jail. DPD referrals, primarily from South King County, may help somewhat by reaching prospective referrals earlier on.
2. Impact on employment for prospective referrals who are working: Nearly all PPR participants are unemployed. This is not a surprise since individuals who are employed are less likely to opt into a program that conflicts with their work schedule. The County should look at the feasibility of providing some services during nontraditional hours.
3. ESJ and lack of equitable access: Attorneys and courts based in South King County (i.e., Maleng Regional Justice Center) are less likely to agree to send defendants to a program sited in downtown Seattle. Hence, the expenditure restriction adopted by Council in the 2019-2020 budget ordinance to create a pretrial services program in South King County.
4. Program retention: The difficulty retaining participants in the program, not simply due to employment, has been a problem from the beginning. The time demands of PPR are very high, and once engaged, some participants quickly realize those demands are too difficult to meet. Many enrolled participants are removed within a month, others stay in the program for several months, but only attend sessions sporadically.
5. Discrepancy between court requirements and PPR program requirements: In about 10% of the cases, enrolled PPR participants fulfilled their obligations to the court and were discharged from CCAP/left PPR before completing the program because they were no longer under court order. Greater alignment between court and program requirements may be needed.

Proposal for Repurposing MIDD RR-02 Funds

CCAP-Enhanced participants can gain seamless access as an additional resource to the full-range of human and social services offered by ACRS at their main clinic consisting of 13 programs. CCAP participants can access resources at their main office during their CCAP stay and post-CCAP. ACRS is located in an 82,000 square foot facility in Seattle's Rainier Valley neighborhood. The ACRS facilities include an activity center for people of all ages to exercise, a multipurpose room for elders to eat nutritious meals, a computer lab for jobseekers to learn computer skills, a classroom for youth tutoring, expanded space for more counseling, general meeting rooms and additional parking. ACRS is able to set its own operational hours and make the space available for groups and classes on weekends and evenings to accommodate participant needs and schedules. The repurposed option described below, supported by the Community Corrections Division leadership, will help to reduce recidivism, enhance treatment retention, and increase treatment completion.

New Program: Enhanced Mental Health Program at CCAP

At present, ACRS assigns a criminal justice liaison at CCAP who assists with interventions and linkages to mental health treatment providers. We propose to expand the scope of work to provide mental health (including domestic violence) case management and individual and group counseling services for both men and women who are court-ordered to CCAP.

The majority of CCAP participants have co-occurring disorders (COD); they often present complex needs including higher rates of illness and legal issues exacerbated by their behavioral health conditions. Isolation is common in their lives and there is a lack of confidence to seek external supports, which increases as SUD perpetuates. ACRS will provide a welcoming and supportive milieu to increase their self-worth to engage in specialized and integrated COD treatment.

ACRS counselors will facilitate a safe space where challenges can be expressed within the therapeutic relationship. Whether interventions are short- or long-term, the relationship itself should be carefully considered as therapeutic and modeling of healthier and more positive ways of interaction. ACRS will provide psychosocial education and harm minimization in the context of culturally and linguistically accessible and competent COD treatment.