

Forensic  
Conditional  
Release Program

CONREP Digest

Forensic Services  
Department of Mental Health  
State of California

April 2008

***FORENSIC CONDITIONAL RELEASE PROGRAM***

**CONREP**

**DIGEST**

**April 2008  
(Revised)**

**Forensic Services  
Department of Mental Health  
1600 Ninth Street  
Sacramento, California 95814**

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# CONDITIONAL RELEASE PROGRAM DIGEST

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## **PREFACE**

This **CONREP Program Digest** was prepared by the California State Department of Mental Health, Conditional Release Program. This Digest was developed to provide an overview about the program's philosophy, organization, administrative and clinical operations in an easy to read and reference manual format. This Digest summarizes many of the policies and procedures presented in the CONREP Policy and Procedure Manual. The contents of that manual are subject to change due to legislative, policy and programmatic developments. It is our intent that this publication will broaden the reader's scope of understanding about the program's purpose and model of operation.

Please contact the California Department of Mental Health, Forensic Services Branch at (916) 654-1471 if you have questions about the Digest.

## **INTRODUCTION**

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### ***PROGRAM OVERVIEW***

#### **Establishment**

The Forensic Conditional Release Program (CONREP) is the State Department of Mental Health's (DMH) statewide system of community-based treatment, evaluation and supervision services for judicially committed individuals and Mentally Disordered Offenders (MDO).

In 1984, legislation was enacted which established the CONREP program. The program was instituted on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code [WIC] Section 4360 (a) & (b).

#### **Program Mission**

The primary mission of CONREP is the protection of the public through the reduction or prevention of individual reoffense.

#### **Program Philosophy**

The program mission is accomplished by providing standardized, intensive community outpatient mental health services based on the individual's treatment plan. These services integrate the close monitoring of the individual through supervision, assessment and appropriate treatment.

Program emphasis on reoffense prevention is achieved through:

- \* An integrated system of community treatment services;
- \* Active case management;
- \* Treatment and rehabilitation of individuals to enhance their competent functioning within society;
- \* Continuing clinical assessments of individuals to evaluate effectiveness of treatment plan and treatment progress and support early identification of possible relapse;
- \* Rehospitalization and preventive revocation of outpatient status; and
- \* Liaison with state hospitals, community agencies and outpatient programs for continuity of care.

## **INTRODUCTION**

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### ***PROGRAM OVERVIEW***

#### **Target Populations**

The target populations are persons found to be:

- \* Not Guilty by Reason of Insanity (Penal Code [PC] Section 1026);
- \* Incompetent to Stand Trial (PC 1370);
- \* Mentally Disordered Offender (PC 2964/PC2972);
- \* Mentally Disordered Sex Offender (former WIC 6316);
- \* Sexually Violent Predator (WIC 6604/6608).

#### **Terms & Conditions of Outpatient Treatment**

All individuals have agreed to follow their individualized Terms & Conditions of Outpatient Treatment. This document incorporates court-sanctioned provisions for involuntary outpatient services and formally specifies the conditions of that treatment and supervision.

#### **Core Treatment Standards**

In order to protect public safety and provide adequate services to conditionally released individuals, program performance standards are required for all contractors. These performance standards are implemented, in part, through core treatment service requirements that specify minimum mental health services to be provided.

## **INTRODUCTION**

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### ***CONREP ADMINISTRATION***

#### **Service Contracts**

In accordance with WIC Section 4360, the DMH contracts with county programs willing to provide relevant services for a reasonable cost. In those counties where there is no contract with the county mental health department, the State contracts directly with private agencies to provide the services within those communities.

#### **Funding Types and Contingency**

Through CONREP, the DMH funds a local services system to assure a dedicated staffing capacity to provide core treatment services. A Net Negotiated Amount (NNA) contract provides a minimum level of funding appropriate to the anticipated caseload.

Supplemental services are specific treatment services which may be provided to individuals in addition to core services. Supplemental services are typically reimbursed by a Negotiated Rate (NR) contract. All services are 100% reimbursable by the State with no local funding match required.

Funding for CONREP contractors is contingent upon the funds contained in the Budget Act as passed by the Legislature and signed by the Governor. Furthermore, any restrictions, limitations, or conditions enacted by the Legislature may affect the provisions, terms or funding of the contract.

#### **Policy Dissemination**

The **CONREP Policy and Procedure Manual** contains all current policies for the operation of this program. The manual is updated on an ongoing basis through the issuance of new and revised policies to be inserted into the manual. Contractors and employees must abide by these policies and procedures.

## **ORGANIZATION**

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### ***STATE DEPARTMENT OF MENTAL HEALTH***

#### **Forensic Services Branch**

The State administers CONREP through the Forensic Services Branch, which is the focal point within the Department to address policy issues related to the mental health needs of the forensic population. Forensic Services is organized into two sections: CONREP Operations and Mentally Disordered Offender (MDO) Unit.

The statutes that established CONREP also mandated responsibility to DMH for its operation. DMH is committed to local community implementation, rather than a state-operated direct services program and established a process by which services are provided for every county through service contracts with local providers.

#### **CONREP Operations**

CONREP Operations is responsible for monitoring local program operations. These functions are performed by clinical and fiscal staff and coordinated by the CONREP Operations Manager. Primary responsibilities include:

- \* Contract development and monitoring;
- \* Local program support and review;
- \* Policy development and implementation;
- \* Program assessment through the informal review process, which is established through regular contacts with each program throughout the year.

#### **State Hospitals**

##### **Role in Treatment**

Although CONREP is a community outpatient program, the state hospitals play an integral role in the treatment of the judicially committed individual and mentally disordered offender. In most cases, individuals are initially committed to a state hospital for inpatient treatment, and only later committed to community outpatient treatment (COT). The state hospitals serve as the inpatient treatment facilities for judicially committed individuals.

## **ORGANIZATION**

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### ***COMMUNITY PROGRAMS***

#### **Service Contracts**

The DMH contracts with local providers to provide community outpatient services. Often, the contractor is the local county mental health program. In other instances the contract may be with a private provider. Either of these types of contracts may be for individual counties or regional programs. Once the state has contracted with a provider for community outpatient services, it is the contractor's responsibility to fulfill all contract conditions.

CONREP programs maintain the capacity to respond to individuals on a 24-hour-a-day basis.

#### **Staff Requirements**

Pursuant to Penal Code 1605, the DMH designates a Community Program Director (CPD) responsible for the operation of the local CONREP program. The CPD and all professional staff who provide services must meet licensure requirements and possess identified knowledge and skills necessary in working with the target populations.

Given the authority delegated by statute to the CONREP program and the discretionary authority staff is allowed to exercise over individuals' liberty, all staff and clinicians are expected to exemplify the highest ethical standards. This is critical to credibly fulfilling the public safety and rehabilitation responsibilities and is essential to maintain the good will of the public, the courts and the engagement of individuals under the program's care and supervision.

## **ORGANIZATION**

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### ***COMMUNITY PROGRAMS***

#### **Program Structure**

Consistent with legislative intent (Chapter 1416, Statutes of 1985), the DMH requires local CONREP programs to structure their organization so that responsibility and clear authority are evident for all aspects of individual treatment and supervision. The following are some of the characteristics that are expected to be incorporated into the organization of CONREP programs.

#### **Program Characteristics**

##### **Central Administration & Responsibility**

The administration of all program functions should be centrally located. The responsibility for case management, placement evaluations, court liaison, individual treatment and supervision rests with the CPD. These functions and responsibilities may be assigned to staff members or specialized program units.

##### **Program Authority**

The program is vested with final treatment authority and management responsibility to direct all treatment and supervision, including that offered by other providers.

##### **Supplemental Service Subcontracts**

Subcontracts may be negotiated with other service organizations in the community to provide the individual with supplemental services.

## **TARGET POPULATIONS**

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### ***JUDICIAL COMMITMENT PROCESS***

#### **Evaluation**

When a person is found Incompetent to Stand Trial or Not Guilty by Reason of Insanity, the court orders an evaluation for placement [PC 1370 (a)(2) and PC 1026 (b)]. The CONREP program evaluates the person to determine the most appropriate treatment facility or site and submits a report to the court within 15 days of the court order.

#### **Court Order for Commitment**

After considering the CONREP evaluation and placement recommendation, the court may order the individual committed for treatment and determines the most appropriate treatment site:

- \* State hospital;
- \* Local public/private inpatient treatment facility; or
- \* COT.

Penal Code section 1601(a) requires a 180-day inpatient stay prior to outpatient treatment for those charged with particular crimes.

#### **Progress Reports and Annual Review**

Following commitment to outpatient status, pursuant to PC 1605(d), quarterly progress reports are due to the court regarding the status and progress of the individual. PC 1606 requires that an annual review and report be forwarded to the court with recommendations regarding renewal of the commitment.

## **TARGET POPULATIONS**

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### ***INCOMPETENT TO STAND TRIAL [PC 1370]***

#### **Introduction**

Under California law, no person formally charged with commission of any felony criminal offense may be tried or adjudged to punishment while "mentally incompetent." At any time during a criminal proceeding and prior to imposition of sentence, an order may be made to inquire into the mental competency of the defendant.

#### **Definition**

A defendant is mentally incompetent if, as a result of mental disorder or developmental disability, the person is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner [PC 1367(a)]. If the person is found to be mentally incompetent, further criminal proceedings are thereupon suspended by the court until the person is restored to competence or the matter is otherwise disposed of according to law.

#### **Focus and Length of Treatment**

Treatment pursuant to PC 1370 is directed toward restoring the individual's trial competency. It is inappropriate to address culpability or to insist on the individual's acceptance of responsibility for the alleged offense. A person found mentally incompetent may be committed for treatment no longer than three years or a period equal to the maximum term of imprisonment the court could have imposed, if the person had been found guilty of the offense as charged, whichever is shorter.

#### **Certification of Competence**

When the program to which the individual has been committed determines that the person has regained mental competence, the medical or program director shall certify this fact to the court of commitment. If the court determines that the individual has been restored to mental competency, the court will terminate the commitment for treatment and reinstitute criminal proceedings.

## **TARGET POPULATIONS**

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### ***NOT GUILTY BY REASON OF INSANITY [PC 1026]***

#### **Definition [PC 25 (b)]**

If the court finds by a preponderance of evidence that a person was incapable of knowing or understanding the nature and quality of his or her act and/or of distinguishing right from wrong at the time of the commission of the offense, that person may be acquitted of a crime after entering a plea of Not Guilty by Reason of Insanity (NGI).

#### **Restoration of Sanity**

An individual committed to inpatient or outpatient treatment may apply for release upon the grounds that sanity has been restored. Application is made to the Superior Court of commitment. A hearing on an application for release can be held after an individual has been confined or placed on outpatient status for at least 180 days from the date of commitment.

If the court determines that the individual will not be a danger to self or others, it commits the individual to the appropriate CONREP program for a minimum of one year. The court retains jurisdiction over the person placed in a court-approved program. After the individual has successfully completed one year in outpatient treatment or upon the recommendation of the CPD, the court will conduct a trial to determine if sanity has been restored.

Sanity is restored when the court determines that the individual is no longer a danger to the health and safety of him/herself or others. When the judicial finding is that sanity is not restored, the individual remains in treatment (either inpatient or outpatient) and may not reapply for a restoration hearing for one year.

## TARGET POPULATIONS

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### *MENTALLY DISORDERED SEX OFFENDER [WIC 6316]*

**Definition**

A Mentally Disordered Sex Offender (MDSO) is a person who, by reason of mental defect, disease, or disorder, is predisposed to the commission of sexual offenses to such a degree that he/she is dangerous to the health and safety of others. All MDSOs were convicted of a sex crime.

**Repeal of MDSO Commitment**

The laws relating to the MDSO commitment for treatment were repealed in 1981. However, Sections 3 and 4 of Chapter 928, Statutes of 1981 (SB 278), express legislative intent that the provisions of WIC 6300 et seq. shall continue to apply to persons who remain under commitment as Mentally Disordered Sex Offenders.

**Authority for Treatment**

Therefore, WIC Section 6300 et seq. continues in effect for those persons remaining under an MDSO commitment that occurred prior to 1981. Reference to those statutory provisions, otherwise repealed, must be made in determining the ongoing status and procedures still applicable to the remaining MDSO population.

**Termination of MDSO Commitment**

When the treating program determines that an MDSO individual has been treated to such an extent that he/she will not benefit by further care and treatment and is not a danger to the health and safety of others, a certification of that opinion is filed with the committing court.

Upon receipt of either the certification referred to above or the individual's request for a review, a hearing is held to determine whether the individual has recovered from the mental disorder to such an extent that the person will not benefit from further care and treatment and is no longer a danger to the health and safety of others. Criminal proceedings are then reinstated.

## **TARGET POPULATIONS**

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### ***MENTALLY DISORDERED OFFENDER [PC 2960]***

#### **Treatment as a Condition of Parole**

The Mentally Disordered Offender (MDO) Program was initially established in 1986, and following a court challenge was amended by statute and reestablished in 1989. A prisoner, who is eligible for parole, and who meets specific criteria (see below) shall be ordered by the Board of Parole Hearing (BPH, formerly Prison Terms) to be treated by the DMH as a condition of parole. Parole and the special conditions of parole are reviewed annually by the BPH.

Prior to a prisoner's release date, both the Department of Corrections and Rehabilitation (CDCR) and the DMH are responsible for clinically evaluating eligible inmates to determine whether or not the individual inmate meets the eligibility criteria.

#### **DMH Treatment Mandate**

The statutes mandate DMH to provide mental health treatment to parolees identified as Mentally Disordered Offenders. The MDO law provides a mechanism for annual extension of the MDO treatment conditions by BPT as long as the person is on parole. At the end of parole, certain MDOs may be civilly committed to further MDO treatment [PC 2970].

The treatment must initially be in an inpatient setting (state hospital). When the parolee/individual can be safely and effectively treated on an outpatient basis, the individual may be discharged from the hospital and continue treatment in CONREP.

## TARGET POPULATIONS

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### ***MENTALLY DISORDERED OFFENDER [PC 2960]***

#### **Criteria**

The following six (6) factors are the criteria established in the MDO law and are utilized by the evaluators to determine whether or not a prisoner may be certified to the MDO program under PC 2962. The criteria are:

- \* The person must have a *severe mental disorder*;
- \* *The severe mental disorder was one of the causes of or was an aggravating factor in the commission of the crime for which the prisoner was sentenced to prison*;
- \* The crime was one in which the *prisoner used force or violence* or caused serious bodily injury;
- \* The prisoner's severe mental disorder *is not in remission or "cannot be kept in remission;"*
- \* The prisoner *has been in treatment for the severe mental disorder for ninety (90) days or more within the year prior to the prisoner's parole or release*; and
- \* As a result of the severe mental disorder the *person represents a "substantial danger of physical harm to others."*

#### **Rehospitalization**

Once on outpatient status, under PC 2964, the CPD may place the parolee in a secure mental health facility if the parolee can no longer be safely or effectively treated in the outpatient program. (PC 1600 COT provisions do not apply to an MDO parolee.)

#### **Parole Violation**

A parolee on MDO outpatient status may also have his/her CDCR parole status revoked by a parole agent if he or she violates any condition of CDCR parole, including the special condition of MDO mental health treatment.

#### **PC 2970 Civil Commitment**

##### Description

At the end of the parole period, CONREP prepares an evaluation to determine whether or not the person meets the MDO criteria. This report is sent to the district attorney no later than 180 days prior to the termination of parole. The district attorney may petition the court to initiate an MDO judicial commitment.

## TARGET POPULATIONS

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### *MENTALLY DISORDERED OFFENDER [PC 2960]*

#### **PC 2970 Civil Commitment (cont.)**

##### Criteria

The criteria are the same as those which are applicable while the person is under parole status. A civil commitment may be sought if:

- \* The parolee/inmate has a severe mental disorder;
- \* The mental disorder is not in remission or cannot be kept in remission without treatment; and
- \* By reason of the severe mental disorder, he/she represents a substantial danger of physical harm to others.

##### Court Commitment [PC 2972(c)]

If the court or jury finds that the individual continues to meet the specific MDO criteria, the court shall order the individual recommitted to the inpatient facility or outpatient program in which the individual was being treated. The commitment shall be for a period of one year from the date of termination of parole or previous commitment. Effective January 1, 2001, only time spent in a locked treatment facility at the direction of the CPD counts toward the one year term of commitment. However, each individual under the MDO Civil Commitment who is on outpatient treatment shall have an outpatient hearing pursuant to PC 1606 and PC 2972.1.

##### Outpatient Status [PC 2972(d)]

PC 2970 individuals on outpatient status are subject to the outpatient placement and service provisions of PC 1600 et seq. similar to other judicially committed individuals on outpatient status.

##### Revocation

The PC 1609 revocation process applies to civilly committed MDOs, but the standard for revocation shall be that the person cannot be safely and effectively treated on an outpatient basis.

## **TARGET POPULATIONS**

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### ***SEXUALLY VIOLENT PREDATOR [WIC 6604/6608]***

#### **Overview**

The Sexually Violent Predator (SVP) law was established by legislation (Chapter 763, Statutes of 1995), codified in Welfare and Institutions Code (WIC) Section 6600 et seq. and became effective on January 1, 1996. Additional changes were made by subsequent legislation (Chapters 4 and 462, Statutes of 1996 Chapter 294, Statutes of 1997, and Chapters 19 and 961, Statutes of 1998).

This law provides for a civil commitment process by which persons with previous specified sex offenses, who meet identified criteria are committed for two years to the custody of the DMH. Upon commitment, the DMH is responsible for providing appropriate treatment and confinement in a secure facility designated by the DMH Director.

The commitment process involves the CDCR, BPT, DMH, as well as the superior court in the county in which the most recent offense that resulted in CDCR custody was committed. The statute assigns specific functions and responsibilities to each of these agencies that must be carried out at designated times.

#### **Program Purpose**

The intent of these statutes is to increase public safety and offer treatment for individuals who have a diagnosed mental disorder and, as a result of that mental disorder, are likely to engage in sexually violent criminal behavior. The purpose of the DMH program is to achieve the legislative intent through the provision of a safe and effective continuous system of inpatient and COT, supervision and management services for persons committed under this law.

## TARGET POPULATIONS

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### *SEXUALLY VIOLENT PREDATOR [WIC 6604/6608]*

#### **DMH Treatment Mandate**

DMH is mandated to provide treatment for persons who, at the end of their prison term, meet the specific criteria as a “sexually violent predator” and have a civil commitment established by the superior court. A SVP individual is a person who meets the criteria and is ordered to undergo DMH treatment.

When the individual is determined by the court to no longer be a danger, if under supervision and treatment in the community, he or she may be discharged from the state hospital and continue treatment in a Sexually Violent Predator Outpatient Program operated by a designated Forensic Conditional Release Program contractor pursuant to WIC 6608.

#### **Criteria**

Any person committed as a SVP pursuant to WIC 6604 must meet all of the following criteria:

- \* The person must be convicted of a sexually violent predatory offense for which a determinative sentence was received;
- \* There are one or more victims; and,
- \* The victims must have been strangers, persons of casual acquaintance with whom no substantial relationship exists, or the relationship was established or promoted for the primary purpose of victimization.

#### **Likelihood of Reoffense**

Likelihood of reoffense must be specifically determined in relationship to the diagnosed mental disorder. In making this determination, clinical indicators, institutional behaviors, risk factors for recidivism from research literature and elements of the controlling and/or past offenses are considered.

## **CLINICAL TREATMENT**

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### ***STATE HOSPITAL SERVICES***

#### **Correlation with CONREP**

The state hospitals play a central role in the treatment of the judicially committed individual and Mentally Disordered Offender (MDO). In most cases, individuals are initially committed to a state hospital for inpatient treatment and only later committed to COT under the CONREP program.

#### **Hospital Forensic Coordinator**

Each state hospital designates a Hospital Forensic Coordinator who is responsible for coordinating services to this population. This coordinator also serves as a liaison with the Forensic Services and local CONREP programs.

#### **Liaison Services**

CONREP programs from the "county of commitment" are responsible for providing liaison services to NGI, MDO and MDSO state hospital individuals from their county or region. Liaison services to SOCP state hospital individuals may be provided through another contractor. These liaison services include specified on-site visits to review individuals' progress and meetings with hospital staff to evaluate outpatient placement readiness.

## **CLINICAL TREATMENT**

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### ***BASIC SERVICES***

#### **Description**

Contractors have the responsibility to provide various Basic Services. These services are primarily liaison services to the state hospitals and courts, evaluation as required by statute, and other support services that relate to both individual care and program administration activities that affect individual treatment and program integrity.

Within the program, Basic Services may be the delegated task of one or more professionals, or may be a part of each professional staff person's function. The task distribution should be determined by program needs and the demands of the region being served.

#### **Funding**

Funding is provided through the Negotiated Net Amount component identified in each contract and includes funding for travel, equipment, and other operating expenses necessary to support these services.

## CLINICAL TREATMENT

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### ***CORE SERVICES***

#### **Purpose**

In order to protect public safety and provide adequate services to conditionally released individuals, program performance standards are required for all contractors. These performance standards are implemented, in part, through core treatment service requirements that specify minimum mental health services to be provided.

These services must be specific to the individual and relate directly to his or her individual treatment plan. They provide a basis for aiding and evaluating individual adjustment to the community in various settings by assuring appropriate and necessary levels of supervision and treatment.

#### **Increased Services**

Public safety and treatment concerns may require that some individuals be provided higher levels of service than core service level minimums specify. (See **Supplemental Services**.)

#### **Reduced Services**

Any deviation below the specified performance standards will require prior written approval from DMH CONREP Operations. In the absence of an approved waiver, it is presumed that all individuals will meet one of the existing service standards unless the individual is reported AWOL or "not available" due to incarceration or hospitalization.

#### **Providers**

All mental health services rendered pursuant to the CONREP contract must be provided by the CONREP program or subcontractors unless exceptions have been approved by DMH CONREP Operations.

#### **Definitions**

##### **Forensic Individual Contact**

Forensic Individual Contact is a one-to-one, face-to-face session between an individual and a clinician with a typical duration of 45-60 minutes.

##### **Group Contact**

A Group Contact is a face-to-face session between a clinician and a group of two or more individuals who are usually at a similar level of functioning with a typical duration of 1-2 hours.

##### **Home Visits**

A Home Visit is a scheduled or unscheduled visit by a clinician to the home of each individual.

## **CLINICAL TREATMENT**

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### ***CORE SERVICES***

#### **Definitions (cont.)**

**Collateral Contact**

A Collateral Contact is a face-to-face (or occasional extensive telephone) session with persons who play a significant role in the individual's personal life. The person contacted may be a family member, friend, roommate, facility manager, employer, residential care facility staff or others important in the individual's life.

**Substance Abuse Screening**

Substance Abuse Screening consists of obtaining urine samples from each individual at random, unscheduled times and submission for analysis to the CONREP statewide contract laboratory.

**Annual Case Review (Assessment)**

The Assessment core service standard requirement is met by the program staff's Annual Case Review. The Annual Case Review is typically conducted in an interdisciplinary staff meeting to review an individual's clinical status prior to making the yearly dispositional recommendations to the court.

#### **Community Outpatient Treatment Levels**

**Description**

Community Outpatient Treatment Level of Care is the successor to the Minimum Core Services, which were formerly determined by year in the program, and recasts the minimum core service standards into five levels. The first five levels apply to individuals in the CONREP COT program. The sixth level applies only to individuals in one of the Statewide Transitional Residential Programs (STRP). (Treatment levels are not applicable to the CONREP/SVP program.)

**Assignment of Level**

The COT Level is determined on the basis of the placement (community outpatient or STRP) and on the program's assessment of the individual's performance and risk. Each Treatment Level is associated with specific minimum core service standards that must be met.

## **CLINICAL TREATMENT**

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### ***CORE SERVICES***

#### **Community Outpatient Treatment Levels (cont.)**

##### **Intensive Level**

This treatment level is appropriate for individuals who meet one or more of the following descriptions. The individual has:

- \* Recently been admitted to community treatment;
- \* Transferred from a Statewide Transitional Residential Program;
- \* Returned from a temporary hospitalization or Forensic IMD admission lasting more than 30 days;
- \* Demonstrated problems adjusting to community life, medications or program expectations; and/or
- \* Been assessed to be at the highest acceptable level of risk.

Individuals assigned to this treatment level require ongoing assessment based on the nature of their offenses and risk factors, as determined from their criminal and mental health histories and the precursors to their offenses. Service duration is typically 6 to 12 months, but may be indefinite based on an ongoing clinical assessment of the individual.

##### **Intermediate Level**

This level is appropriate for individuals who are cooperative with the program but who still pose a relatively higher risk and/or have significant unresolved issues affecting their adjustment to stable community care.

Individuals receiving this treatment level still require frequent program interventions, close supervision and management. Service duration is typically two to four years, but may be indefinite based on an ongoing clinical assessment of the individual.

##### **Supportive Level**

This level is appropriate for moderate risk individuals with intractable symptoms who require on-going psychosocial and medication support. Persons on this level are not considered ready for discharge and need on-going program services for an indefinite period of time.

## **CLINICAL TREATMENT**

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### ***CORE SERVICES***

#### **Community Outpatient Treatment Levels (cont.)**

##### Transitional Level

This level is appropriate for individuals who have progressed through other COT levels and are being considered for progression to Aftercare Level or discharge. This level allows for the development of the community aftercare plan and an individualized program of services to meet the needs of the lower risk individual. Service duration is typically one to two years, but may be indefinite based on an ongoing clinical assessment of the individual.

##### Aftercare Level

This level is appropriate for individuals who might be unconditionally released in the near future. It permits for a community aftercare plan to be implemented on a trial basis (typically for up to one year). It is intended to prepare individuals for the final aspects of discharge planning and to assist them in fine-tuning community integration and independent living abilities.

##### Statewide Transitional Residential Services

A Statewide Transitional Residential Program (STRP) is a licensed non-medical Community Care Facility that provides a structured residential program to assist CONREP individuals' transition from the state hospital to the community. In other cases, if individuals experience difficulty adjusting or coping in the community, they may be placed in a STRP in lieu of rehospitalization. Service duration is typically three to four months and should not exceed 120 days.

Supplemental Services are specific treatment services provided to CONREP individuals and are in addition to Core Treatment Services and exist in order to provide CONREP programs with the flexibility to implement individualized treatment and supervision programs. The range of these services depends on the availability of local treatment and residential services.

Within the limits of the CONREP contract, funding is available for clinically justified services above the minimum core treatment service level, when included in the individual's treatment plan.

**CLINICAL TREATMENT**

**COMMUNITY OUTPATIENT TREATMENT  
MINIMUM CORE STANDARDS BY SERVICE LEVEL**

SERVICE FUNCTION TYPE	----- LEVELS -----					
	Intensive	Inter-mediate	Supportive	Transitional	Aftercare	Statewide Transitional Residential Programs
Forensic Individual Contact	Weekly (4 per month)	Three Times per Month	# Individualized Case Management Plan	Monthly (1 per Month)	Quarterly (1 every 3 months)	2 per Month
Group Contact	Weekly		# Individualized Socialization/ Vocational Rehabilitation Plan		None	* 10 per Month in Combination
Home Visits	Twice per Month	Monthly		Quarterly	Quarterly	Quarterly
Collateral Contact	Twice per Month	Every Other Month (6 per Year)			Quarterly (may be done in conjunction with Home Visit)	Twice per Month
Substance Abuse Screening	Weekly	Individualized Substance Abuse Screening Plan				Weekly
Annual Case Review (Assessment)	YEARLY (One per Year)					Yearly
<b>Additional services may be provided as determined by the individual's treatment plan.</b>						

# These service plans must specify the number of Individual or Group Contacts.

\* In addition to 2 per month baseline for individual contacts, other individual and group contacts may be combined for a total of 10 per month.

## **CLINICAL TREATMENT**

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### ***ADJUNCTIVE SERVICES***

#### **Vocational Rehabilitation Services**

The Department of Rehabilitation (DR) and DMH have an Interagency Agreement to provide cooperative vocational rehabilitation planning to appropriate state hospital individuals in preparation for their discharge to the community. State hospital individuals are eligible to participate in this agreement as part of their discharge plan.

In order to enhance community access to DR services, the interagency agreement established a DR statewide case service fund account to be utilized specifically for state hospital referrals. Upon referral from a state hospital Co-op Counselor, these individuals are eligible for a wide range of community-based DR services funded by this identified case service budget.

Vocational Rehabilitation services may only be provided to individuals who, with appropriate support services, would likely be able to be employed in a competitive (non-subsidized) work situation. This excludes sheltered workshop employment.

## **PROGRAM OPERATIONS**

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### ***CLINICAL ISSUES***

#### **Patient Rights and Protection**

CONREP policies address patient rights and protection of the public and include:

- \* Confidentiality of Patient Information;
- \* Patient Access to Records;
- \* Patient Grievance Process;
- \* Protection of Research and Evaluation Subjects;
- \* Duty to Warn (potential victims of harm);
- \* Possession of Dangerous Weapons;
- \* Registration Requirements; and
- \* Access to Voter Registration Information.

#### **Medical Concerns**

##### **Specific Infectious Diseases**

CONREP policy provides an overview of three infectious diseases that are of particular relevance to the populations served in CONREP, specifically Human Immunodeficiency Virus (HIV) Disease: Asymptomatic and Symptomatic (AIDS); Hepatitis B Virus (HBV) Disease and Hepatitis C Virus (HCV).

CONREP policies address general information about these diseases, related nondiscrimination policies and procedures which relate to the care of an individual who may have become infected and staff exposure to these diseases. Staff are expected to be aware of the universal precautions that should be practiced when working with infected individuals. Staff are also to be informed and familiar with the clinical, legal and practical ramifications of dealing with individuals who have or are at risk of developing these diseases.

##### **Psychiatric Medication and Practice Guidelines**

Psychotropic medications are used as part of an integrated, individualized treatment plan developed by an interdisciplinary team under the direction of the CPD.

## **PROGRAM OPERATIONS**

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### ***ASSESSMENT SERVICES***

#### **Assessment Definition**

An assessment is a comprehensive mental health clinical evaluation of the etiology, course, and/or current status of a CONREP individual's mental, emotional or behavioral disorder conducted by a clinician. The assessment process supplements the ongoing clinical determinations regarding an individual's mental status. The data derived from assessments provide treatment direction, as well as measurement of program effectiveness. The main types of assessments used by CONREP programs are listed below.

#### **Annual Case Review**

The Annual Case Review fulfills the yearly requirement for a clinical assessment defined in the Core Service Standards.

#### **Standardized Psychological Testing**

Individuals are tested with a minimum set of psychological tests at key decision points in treatment based on their legal class as defined by the CONREP Assessment Protocol.

#### **Specialized Psychological Testing and Consultation**

When clinically indicated during treatment, CONREP programs provide or obtain psychological testing and consultation in addressing specific clinical questions. Specialized testing is provided by either local or statewide psychology resources, depending on availability and priorities.

## **PROGRAM OPERATIONS**

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### ***RESEARCH PROJECTS***

#### **Legislative Mandate**

Legislation that established CONREP required DMH to research and report on the effectiveness of the program. Penal Code Section 1617 was amended to read: "The State Department of Mental Health shall research the demographic profiles and other related information pertaining to persons receiving supervision and treatment in CONREP. An evaluation of the program shall determine its effectiveness in successfully reintegrating these persons into society after release from state institutions. This evaluation of effectiveness shall include, but not be limited to, a determination of the rates of reoffense while these persons are served by the program and after their discharge."

#### **Longitudinal Tracking Study**

This mandate was addressed by a longitudinal research and tracking study conducted by DMH, whose objectives were to describe the target population and assess the program's impact in containing reoffenses and promoting the successful community reintegration of individuals. Community reintegration was based on several key indicators measuring patient employment, social supports, and program compliance and was derived from periodic staff rating of patients using the Behavioral and Psychiatric Functioning Questionnaire.

Data from a variety of sources is used to summarize lengths of time that patients stay in community settings, the proportions revoked back to state hospitals, and the proportions that have successfully completed the program.

#### **Findings**

The rearrest rate of CONREP patients was significantly lower than that of a comparison group of patients not treated by CONREP. The overall rearrest rate for CONREP was lower than rates of less intensive programs operated by the states of New York and Oregon.

Reoffenses that have occurred among CONREP patients are significantly less likely to have been violent than the original commitment offenses. DMH research shows CONREP treatment increases the numbers of patients who get jobs, who learn to live independently, and who build positive social supports in the community.