JUSTICE REINVESTMENT INITIATIVE (S.B. 371)

July 1, 2019 – June 30, 2020

ANNUAL REPORT

State of West Virginia
Jim Justice, Governor

Department of Homeland Security
Cabinet Secretary Jeff S. Sandy CAMS, CFE

DIVISION OF ADMINISTRATIVE SERVICES
Justice & Community Services

Jennifer Wilson, Director, Division of Administrative Services

Justice and Community Services Section
1124 Smith Street, Suite 2100
Charleston, West Virginia 25301-1323
Joseph C. Thornton, Deputy Director
Jeff D. Estep, Operations Manager
Marty A. Hatfield, Criminal Justice Program Manager

Executive Summary

West Virginia's Justice Reinvestment Initiative (JRI), known colloquially as Senate Bill 371, was passed by the 2013 regular session of the Legislature. Among the many changes to West Virginia criminal procedure was added §62-15-6.a., relating to "Treatment Supervision" of offenders sentenced to a community correctional setting, but requiring that substance abuse treatment be ordered and accepted by the felony offender as a condition of the less than incarceration alternative sanction. In order to encourage compliance with this sanction, judges were empowered to impose intermediate incarceration not to exceed thirty days for violations of the terms of treatment supervision.

The "treatment" component of this effort was designed by the Division of Justice and Community Services (DJCS) in consultation with the Governor's Advisory Council on Substance Abuse (GACSA), and to use appropriated funds to serve those offenders under "treatment supervision" in each judicial circuit and on parole supervision. Additionally, the DJCS, in consultation with the GACSA, is to submit on or before September 30th, an annual report to the Governor, the Speaker of the House of Delegates and the President of the Senate addressing specific items related to the implementation and measuring the success (if any) of the treatment supervision "program" with a projection of the amount of funding necessary to continue the program into the next fiscal year. The effective date for beginning of treatment supervision under this code section was January 1, 2014, while the effective date for JCS to work on developing this program was July 1, 2013. As the specific elements of the annual report required by §62-15-6.a.(h) are premised on treatment supervision having been fully implemented in the field – which it is still being fully realized– this annual report will focus on the efforts that the JCS, along with sister state agencies, has made at this point to develop the program envisioned by the legislature. Because funds to support this program have been appropriated through fiscal year 2016, when appropriate, this report should also eventually contain a projection of the amount of funding necessary to continue the program into the next fiscal year. A copy of §62-15-6.a is attached to the end of this document for easy access to the portions of the code that are referenced within this report.

This report will focus on three primary efforts of the Division as they relate to Justice Reinvestment: The Treatment Supervision Effort, the Evidence-Based Practices and Quality Assurance Effort, and the Reentry Effort.

The **Treatment Supervision Effort** was to be designed by DJCS in consultation with the GACSA using $3 million in appropriated funds to serve offenders under "Treatment Supervision" where such offenders are referred to Treatment Supervision by the Court system or parole services. The Division began this effort by opening a dialog with representatives from the West Virginia Department of Health and Human Resources (DHHR) Bureau for Behavioral Health and Health Facilities (BBHHF). As a result, DJCS and BBHHF developed the comprehensive "West Virginia Implementation Plan" for treatment supervision programming and the release of funds to pilot sites to support this

initiative. The purpose of the West Virginia Implementation Plan is to set forth strategies to reduce recidivism of offenders with substance use disorders, thus decreasing the overrepresentation of individuals with behavioral health disorders in the justice system. This will be accomplished through the development of a common structure for community supervision agencies and behavioral health treatment providers in an effort to enhance collaborative partnerships and coordinate care for offenders being supervised in the community.

The initial phase of funding began in May 2014. The first year of grant awards supported the development of nine (9) projects serving twenty (20) counties throughout the state. The collaboratively developed treatment supervision plan and roll-out of initial funding was a significant coordinated achievement within the overall JRI framework. The work completed, and lessons learned, have proven to be a valuable effort to inform the statewide rollout of funding that began in November 2015 and has grown the number of projects supported to sixteen (16) projects serving thirty-nine (39) counties.

Remaining consistent with goals of implementing evidence-based practices to best serve the needs of the offender population and reduce recidivism for those struggling with substance addiction, especially opiate addiction, the use of evidence-based medication-assisted treatment will be further researched with goals of incorporating these treatments into the Justice Reinvestment Treatment Supervision plan.

The **Evidence-Based Practices and Quality Assurance Effort** involves the West Virginia Office of Research and Strategic Planning (ORSP) to develop policy and procedures, field trainings, quality control, and empirical research.

The ORSP has developed a statewide program titled, Quality Assurance for Treatment Intervention Programs and Supervision or QA-TIPS, which has resulted in the development of an official report on evidence-based quality assurance practices and is firmly rooted in the scientific evidence to date on what makes effective community supervision programs.

QA-TIPS measures staff performance and provides feedback for improvement. The Division of Corrections and Rehabilitation (DCR) and community corrections program staff in the state are participating in the program. Data is submitted every six months and analyzed by the ORSP and submitted back to the agencies, providing feedback on their performance. This data is used to provide specific, targeted feedback to staff and track improvements over time.

The ORSP provides trainings to correctional and community supervision staff (including treatment providers) on the use of the Level of Service/Case Management Inventory (LS/CMI), as well as a variety of other evidence-based curricula including, but not limited to, Motivational Interviewing (MI), Thinking for a Change (T4C), Cognitive-Behavioral Interventions for Substance Abuse (CBI-SA), and Effective Practices in Community Supervision (EPICS). To date, there have been more than 697 LS/CMI users

trained by the ORSP, including over 50 staff who received additional training to become certified as trainers. These trainings have helped to establish a base of certified LS/CMI users throughout the state and have helped build the capacity of the DCR and other state agencies to conduct independent LS/CMI trainings. In addition, the ORSP has also trained another 180 staff in other evidence-based curricula, thereby enabling day report centers and other offender treatment facilities to deliver services that have been proven by research to be effective at reducing recidivism. In order to ensure the highest standards of quality for service delivery, the ORSP has also expanded the QA-TIPS program to encompass all trainings in evidence-based practices offered by the ORSP. As of September 1, 2017, quality assurance policies and procedures had been developed for each of the evidence-based curricula offered by the ORSP and the collection of quality assurance data is underway.

As part of the QA-TIPS program, the ORSP also maintains the only central database for tracking staff certifications and trainings in evidence-based practices. This database is continually updated and reviewed in order to ensure that all staff trained by the ORSP are in compliance with established quality assurance policies.

The ORSP continues to conduct research and analysis to support the work of SB 371. SB 371 calls for the conducting of outcome studies on community supervision programs and the validation of the LS/CMI across the different correctional populations. A series of research and evaluation studies have been conducted to accomplish these goals. These include but are not limited to the following reports: (1) Predicting Recidivism of Offenders Released from the DOC: Validation of the Level of Service/Case Management Inventory; (2) Recidivism by Direct Sentence Clients Released from Day Report Centers in 2011: Predictors and Patterns over Time; (3) West Virginia Correctional Population Forecast, 2014-2024; (4) Evidence-Based Offender Assessment: A Comparative Analysis of WV and U.S. Risk Scores; (5) The Correctional Program Quality Index: Measuring Adherence to Evidence-Based Practices; (6) Recidivism by Direct Sentence Clients Released from Day Report Centers in 2011: Five Year Update; and (7) Drug Offenders Incarcerated in West Virginia: Characteristics and Population Trends, 1998-2015. These publications can be accessed online at the ORSP's section of the DJCS website at the following link: https://djcs.wv.gov/ORSP/SAC/Pages/publications-2010-present.aspx.

The **Reentry Effort** involves collaboration between the JCS and DCR in the development of a master agreement to provide reimbursement to counties for the use of community corrections programs for eligible parolees. This agreement is currently using an established "cost per client per day" as the basis for reimbursement. See attached Cooperative Agreement.

Annual Report

TREATMENT SUPERVISION

§62-15-6: SB 371 establishes that a new "Treatment Supervision" sentencing option be implemented. This is contemplated to be a new "tract" of referrals. Referrals could be from the DOC, and from the Supreme Court of Appeals of West Virginia for those individuals not meeting the intensity level of a Drug Court program. This has and will continue to require substantial policy development and capacity building within our day report centers and should present community corrections as a major treatment option in West Virginia.

The effective date for DJCS to begin initial program development was July 1, 2013. DJCS submitted improvement packages in both the 2013 and 2014 legislative sessions to create two essential positions (Criminal Justice Program Specialist and Research Specialist) and pay salaries and benefits and provide for ancillary costs (travel, office supplies, etc.) associated with these positions. These requests were not realized and slowed the Division's efforts. A percentage of administrative funds from the total appropriation has been approved and DJCS began hiring efforts for these two positions. The Criminal Justice Program Specialist began work on September 1, 2015. The actual flow of funds into the field for treatment supervision efforts were to begin January 1, 2014.

Sub-paragraphs (d) and (e) of §62-15-61 direct DJCS, in consultation with GACSA, to develop proposed substance abuse treatment plans to serve offenders under treatment supervision. Further they are to develop (1) qualifications for provider certification to deliver a continuum of care to offenders; (2) fee reimbursement procedures; and (3) other matters related to the qualify and delivery of services. The Division began this effort by opening a dialog with representatives from the BBHHF. This dialog began as a vehicle to discuss the implementation of the JRI Treatment Supervision provisions but has expanded into a colloquy about the role of community corrections programs in a broader continuum of care that is fully integrated with non-correctional human services agencies. While the transition from a punitive-focused intervention to a treatment-focused model has long been underway, the collaboration with the BBHHF has guided the next steps in this transition. Together, DJCS and BBHHF developed a comprehensive implementation plan for treatment supervision programming and the release of funds to pilot sites to support this initiative.

The Division has re-evaluated the idea of the day report center as a "one-stop shop" for all community supervision interventions. The paradigm being explored and facilitated with JRI funding is one in which the day report center should not function simply as an isolated treatment/supervision center, but as a hub, networked to specialized community resources in that particular area/region. Day report centers should become the conduit by which correctional populations plug-in to community resources. The day report center would still provide all the necessary services needed to address the client's risks and needs, but if a particular need exceeds the threshold of what the program can provide, and there is a community resource better suited to address it, the center will

collaborate with that resource to ensure an appropriate level of service. In communities where these resources are limited or absent, such as rural communities, resources would be allocated to provide more specialized services within the day report center than would be necessary in communities where resources are abundant. Under the treatment supervision implementation plan, day report centers within the initial targeted area are linked with the behavioral health provider in their region with the goal of fostering and/or enhancing a partnership that seeks to provide all necessary interventions for the targeted offender population.

§62-15-6 (f): SB 371 directs the Division to report on the following measures as they relate to the Treatment Supervision program:

1) **The dollar amount and purpose of funds provided for the fiscal year.**

   During fiscal year 2020 a total of $3,028,758 has been awarded to sixteen (16) projects serving fifty-five (55) counties throughout the state.

2) **The number of people on treatment supervision who received services and whether their participation was the result of a direct sentence or in lieu of revocation.**

   As of June 30, 2020, a total of 521 CCIS offenders have received services through the Treatment Supervision program throughout the state.

3) **The number of people on treatment supervision who, pursuant to a judge's specific written findings of fact, received services despite the risk assessment indicating less than high risk for reoffending and a need for substance abuse treatment.**

   JCS is currently working to implement the necessary mechanism in order to track any referrals that fall outside of the target population of high risk with a substance abuse need. This will be done through the sharing of information from the OCMS and CCIS databases, monthly progress reports from each project, and onsite program monitoring that will be completed by JCS staff members.

4) **The type of services provided.**

   During the planning and development phase of the Treatment Supervision project, a tremendous amount of thought and discussion went into the identification of the specific services that were needed throughout the state to address the needs of the target population. The following services were identified as the most appropriate and needed services to make available through this project.

Outpatient and Intensive Outpatient Services (OP/IOP) are designed for individuals who are functionally impaired as a result of their co-occurring mental health and substance use disorders. OP/IOP provides for therapy, case management, psychiatric and medication services. Cross-trained psychiatric and mental health clinicians/addiction treatment professionals deliver the services.

Community Engagement Specialists (JRI-CES) who serve as the stewards of the program's implementation efforts. The JRI-CES are the brokers and facilitators of a wide range of community-based and collaborative efforts and strategies designed and intended to support the varying needs of those served. The JRI-CES can be characterized as someone who understands substance use and co-occurring/co-existing disorders; the varying manifestations associated with such disorders; appreciates the unique needs of individuals and therefore can create the synergy necessary to support successful community-based living. JRI-CES will engage and collaborate with all available community resources to prevent the need for involuntary commitment or re-offense, improve community integration, and promote recovery by addressing the complex needs of eligible individuals.

Peer Recovery Coaching is the provision of strength-based supports for persons in or seeking recovery from behavioral health challenges. Peer coaching (often referred to as peer mentoring or recovery coaching) is a partnership where the person working towards recovery self directs his/her recovery approach while the coach provides expertise in supporting successful change. Peer coaching, a peer-to-peer service, is provided by persons with lived experience managing their own behavioral health challenges, who are in recovery themselves and as a result have gained knowledge on how to attain and sustain recovery. To become a peer coach such persons must also complete training, education, and/or professional development opportunities for peer coaching.

Substance Use Recovery Residences provide safe housing for individuals, age eighteen (18) and older, who are recovering from substance use and/or co-occurring substance use and mental health disorders. These programs follow and/or operate concurrently with substance use disorder treatment and are intended to assist those individuals for a period of twelve (12) to eighteen (18) months or until it is determined that an individual is able to safely transition into a more independent housing.

Key components of a Level II Recovery Residence include but are not restricted to: drug screening, house/resident meetings, mutual aid/self-

help meetings, structured house/resident rules, peer-run groups, and clinical treatment services accessed and utilized within the community. Staff positions include, but are not restricted to, a certified peer (recovery) coach and other certified peer staff. Resident capacity: 8-15 beds.

Key components of a Level III Recovery Residence include but are not restricted to: drug screening, house/resident meetings, mutual aid/self-help meetings, structured house/resident rules, peer-run groups, life skill development emphasis, and clinical treatment services accessed and utilized within the community. Staff positions include, but are not restricted to, a facility manager, certified peer (recovery) coach, case manager(s), and other certified peer staff. Resident capacity: 60-100 beds.

5) **The rate of revocations and successful completions for people who received services.**

Because referrals and service delivery has just begun it is too early to report on this measure. As referrals continue to be made and programs are fully realized, more data will be available to provide a clear and comprehensive report on the successful and non-successful program completions.

6) **The number of people under supervision receiving treatment under this section who are were rearrested and confined within two years of being placed under supervision.**

Because this project is still being fully implemented, not enough data is in place to track this measure well. As referrals continue to be made and programs are fully realized, more data will be available to provide a report on this measure.

7) **The dollar amount needed to provide services in the upcoming year to meet demand and the projected impact of reductions in program funding on cost and public safety measures.**

As of this date, the funds needed to support the current project has been allocated through fiscal year 2020. The Division will need a minimum of **$5,000,000** to support the services currently being implemented throughout the state beginning in fiscal year 2021.

8) Other appropriate measures used to measure the availability of treatment and the effectiveness of services.

As of this date, no additional measures have been fully developed to measure the availability of treatment and the effectiveness of services through the Treatment Supervision project. Work is currently underway to expand the services to area of need within the state. Upcoming steps for the expanded development of the Treatment Supervision project include the implementation of data tracking mechanisms to report on recidivism rates of the target population, successful completions of programs, and the quality and integrity of treatment services being delivered.

Remaining consistent with goals of implementing evidence-based practices to best serve the needs of the offender population and reduce recidivism for those struggling with substance addiction, especially opiate addiction, the use of evidence-based medication-assisted treatment will be further researched with goals of incorporating these treatments into the Justice Reinvestment Treatment Supervision plan.

EVIDENCE-BASED PRACTICES AND QUALITY ASSURANCE

§62-11c-3(d): SB 371 directs that the Community Corrections Subcommittee shall review the implementation of evidence-based practices and conduct regular assessments for quality assurance of all community-based criminal justice services, including day report centers, probation, parole and home confinement. In consultation with the affiliated agencies, the subcommittee shall establish a process for reviewing performance. The process shall include review of the agency performance measures and identification of new measures by the subcommittee, if necessary, for measuring the implementation of evidence-based practices or for quality assurance. After providing an opportunity for the affected agencies to comment, the subcommittee shall submit, on or before September 30 of each year, to the Governor, the Speaker of the House of Delegates, the President of the Senate and, upon request, to any individual member of the Legislature a report on its activities and results from assessment of performance during the previous year.

In May of 2013, the Community Corrections Subcommittee established a Quality Assurance (QA) workgroup to develop definitions and standards for the measurement of quality assurance in the implementation of evidence-based programs. This workgroup consisted of representatives of all community supervision agencies as well as staff from the ORSP. The workgroup reviewed the scientific literature on effective practices in community supervision and treatment, and in August of 2013, presented an official report on evidence-based quality assurance practices to the CC Subcommittee.

In 2014, the CC Subcommittee established the Evidence-Based Practices (EBP) workgroup to develop a plan for assessing adherence to EBP across community corrections agencies in West Virginia. This workgroup consisted of representatives from

community supervision agencies and treatment providers, with ORSP staff serving as technical consultants. The workgroup's plan was approved by the CC Subcommittee in August of 2015. A central part of this plan was the implementation of an EBP survey, which consisted of 129 questions that were designed to assess how closely supervision agencies adhere to EBP. This survey was distributed to community supervision agencies throughout the state in September of 2015, and the results were presented to the CC Subcommittee in December of that year.

In 2016, the ORSP began work on the development of a series of QA data dashboards for day report centers. The QA data dashboards provide a summary of current QA data for each day report center. This data is derived from several different sources including site visits (which are conducted using the evidence-based Correctional Program Checklist assessment tool), the review of administrative records and data (using the Correctional Program Quality Index developed by the ORSP), and peer-to-peer assessments provided by correctional staff (gathered as part of the QA-TIPS program). Preliminary results for several sample programs were presented to the CC Subcommittee in August of 2016.

In 2017, the ORSP produced data dashboards for all twenty-six (26) day report centers in the state and presented them to the CC subcommittee meeting in May. The ORSP is currently working with staff from the West Virginia Office of Technology, the West Virginia Supreme Court of Appeals and others to ensure that data collection efforts necessary for producing the dashboards continue despite recent changes to the data systems being used by day report centers. It is anticipated that the ORSP will continue to produce QA dashboards for day report centers on an annual basis.

Additional Coordinated Work

The ORSP is working in coordination on several projects at the center of SB 371. Given the close connection between quality assurance, research/evaluation, data sharing, and adherence to evidence-based practices in community supervision, the ORSP plays an integral role in ensuring the long-term success of SB 371. Present and future efforts of the ORSP include the development of policies and procedures, field trainings, quality control, and empirical research.

Quality Assurance for Community Supervision and Treatment (QA-Tips)

The quality of service delivery and the quantitative information specifically required in the annual report of the Division by §62-15-6a (h) require data collection from different sources in order to clearly evaluate its impact and successes. The "quality issues" are similar to those that are required per §62-11C-10 of West Virginia Code and relate to the implementation of evidence-based practices in community supervision agencies and programs. The ORSP has developed a statewide program titled, **Quality Assurance for Treatment Intervention Programs and Supervision or QA-TIPS**, which is engaged in the following four (4) important areas for instilling and monitoring quality in community supervision and treatment:

1) **Facilitating the statewide quality assurance system for the Level of Service/Case Management Inventory (LS/CMI) and Motivational Interviewing (MI), including continued development of policies and procedures.**

   ORSP's Justice Center for Evidence-Based Practices (JCEBP) continues its efforts under the statewide implementation of the LS/CMI, MI, and other evidence-based practices to measure staff performance and provide feedback for improvement. Both the DCR and day report center staff in the state are participating in the program, with DJS beginning their quality assurance data collection on July 1, 2014. Every six (6) months, data is submitted to the ORSP electronically via our website from all staff in each of the agencies. The electronic submission forms capture data on peer-to-peer performance reviews in the areas of LS/CMI inter-rater reliability, quality of case plans, and quality of motivational interviews. These data are analyzed by the ORSP/JCEBP and submitted back to the agencies providing the staff with feedback on their performance, as well as the entire agency. All agencies receive input on their performance in relation to state estimates. For instance, the data for Mount Olive Correctional Facility is compared to the data for all DCR facilities as a basis for comparing performance. These data are used to improve training by LS/CMI trainers; provide specific, targeted feedback to staff; and track improvements over time.

2) **Providing routine certification LS/CMI and MI trainings to all field staff (including treatment providers) and working with the Council for State Government's Justice Center on coordinating trainings from the University of Cincinnati.**

   The ORSP continues to provide trainings to all community supervision (including treatment providers) and institutional staff in the state on the LS/CMI, MI, and other evidence-based practices. The ORSP is also acting as the "coordinating office" for new trainings coming to the state under the Justice Reinvestment Initiative. The ORSP is committed to continuing to develop and maintain an infrastructure that will sustain fidelity in the use of evidence-based practices among community supervision agencies (probation, parole, day report centers, and home confinement), as well as institutional corrections agencies.

3) **Maintaining a certification database and Online Learning System (OLMS) for all field trainings and certified users and trainers for various workshops on EBP.**

   The ORSP/JCEPB continues to maintain the only central certification database for tracking LS/CMI and MI trainings and staff certifications. In 2011, the ORSP/JCEBP created statewide minimum standard policies for the certification/recertification of staff on the LS/CMI and MI. A statewide policy on

the minimum standard for quality assurance was also developed at that time. Similar policies are also in place for the use of the youth version of the LS/CMI to guide the DJS. It is widely recognized in the correctional rehabilitation field that training is not a "one-shot" event, but continuous process. These policies and procedures help ensure that staff are continually trained on "what works" and the proper assessment and application of the LS/CMI and MI which serve as a foundation for effective community supervision and treatment. Similar policies will be developed by the ORSP/JCEBP for the additional trainings funded through the Bureau of Justice Assistance, Justice Reinvestment Initiative grant (that is, Thinking for Change, Cognitive Behavioral Interventions for Substance Abuse, and Effective Practices in Community Supervision). These policies will help guide the quality assurance efforts and provide a basis for providing feedback to field staff and agency administrators.

Empirical Research and Evaluation on Community Supervision

The ORSP continues to conduct a series of studies and analyses to support the work of SB 371. SB 371 calls for the conducting of outcome studies on community supervision programs and the validation of the (Y)LS/CMI across the different correctional populations. A series of research and evaluation studies are underway and being planned. These include the following:

1) Developing the Correctional Program Quality Index (CPQI) as a means of utilizing extant administrative data to assess adherence to evidence-based practices by correctional programs;

2) Assessing the quality of service delivery in day report centers using the Correctional Program Checklist (CPC) assessment tool;

3) Conducting a statewide survey of day report center clients to gauge offenders' perceptions of the quality of their interactions and relationships with treatment staff;

4) Publishing peer-reviewed research and participating in national forums on successful implementation of community supervision and quality assurance mechanisms;

5) Studying the nature and rates of recidivism among day report center clients, including the factors that contribute to recidivism; and
6) Producing reports which describe the results of LS/CMI risk assessments, compare the risk and needs of offenders in West Virginia to national norms, and assess the predictive accuracy of LS/CMI results for different correctional populations.

Development of Correctional Program Quality Index (CPQI): The ORSP/JCEBP continues to work on the development of the CPQI. This project not only supports the quality assurance work of the ORSP as it relates to assessing program quality, but also

contributes to the national discussion on how best to measure program performance in large-scale correctional contexts. The CPQI consists of a series of indicators developed by the ORSP which provide measures of the extent to which correctional programs adhere to evidence-based practices when delivering services. These indicators are designed to make use of administrative data that are routinely collected as part of program operations. The results of preliminary analyses using data gathered from day report centers indicate that CPQI scores provide an effective measure of program quality, with programs that scored higher on the CPQI also tending to have lower rates of recidivism. The full report was published in November of 2016.

Assessing Program Quality Using the Correctional Program Checklist (CPC): The CPC is an evidence-based program quality assessment tool developed by the Corrections Institute at the University of Cincinnati. It provides researchers with a framework for structuring site visits in such a way that they directly assess whether programs adhere to more than 70 practices that have been shown by research to be effective at reducing recidivism. When conducting a CPC assessment, researchers directly observe program operations, sit in on group treatment sessions, and conduct detailed interviews with administrative, treatment, and supervision staff. Several JCS staff members have recently been trained in the use of the CPC and assessments have been conducted on nine (9) day report centers to date. It is anticipated that assessments will continue at the rate of about 4-5 assessments per year until all programs have been assessed.

Quality Assurance Questionnaire for Day Report Centers: In the fall of 2015, the ORSP completed the development of a survey instrument designed to measure day report center clients' perceptions of the quality of correctional service delivery and their relationships with supervision staff. This project builds on prior ORSP research involving state prison inmates which demonstrated that offender surveys could be utilized to effectively measure the quality of the correctional environment and staff-offender relationships, and thus provide a highly useful source of information about correctional operations. After receiving approval from the Institutional Review Board (IRB) at Marshall University, the survey was piloted during the winter of 2016. The results of these initial surveys suggested that responses could be significantly increased by modifying the way in which the surveys are administered. These changes have received IRB approval, and it is anticipated that the full survey will be delivered in the spring of 2018.

Peer-Reviewed Research and National Forums on QA and Successful Implementation: The ORSP and the efforts taking place in West Virginia in relation to quality assurance and successful implementation strategies continue to receive significant national attention. All of this work supports the goals and objectives of SB 371 and illustrates how this state is proactive in utilizing data and research to inform policy and practice. In December of 2015, ORSP staff published a research article titled "Use of Core Correctional Practice and Inmate Preparedness for Release" in the International *Journal of Offender Therapy and Comparative Criminology*, a leading multi-disciplinary journal which publishes research related to the theory and practice of offender rehabilitation. This article was based on the results of ongoing ORSP research related to the utilization of offender surveys to measure the quality of correctional service delivery. It supports

current ORSP research efforts involving offender surveys by providing peer-reviewed evidence that these surveys can be used to provide an accurate measure of the level of staff adherence to evidence-based practices. In addition, the ORSP Director has presented at the National Justice Reinvestment Performance Measurement Conference in October of 2016 on building research and evaluation capacity in states. This presentation featured discussion of the CPQI and other ongoing efforts by ORSP researchers to assess JRI performance utilizing administrative data.

Outcomes Research on Day Report Centers: The ORSP has recently published the second in a series of studies designed to inform the state on the overall quality of day report centers and their impact on recidivism reduction. The first report was published in June of 2014 and examined the predictors of successful program completion by day report center participants and its impact on recidivism. This report won the national publication award in the research/policy analysis category presented by the Justice Research and Statistics Association (JRSA). It was also the basis for a peer-reviewed article titled "Predicting Client Success in Day Report Centers: The Importance of Risk and Needs Assessment" which was published in *The Journal of Offender Rehabilitation* in August of 2015. The second, most recently published report, investigates the factors associated with recidivism by day report center clients, and the timing of recidivism events in the first two years after release. This report also received the national publication award in the research/policy analysis category from the JRSA. The third study has not yet been published but will examine the relationship between program quality and recidivism utilizing the CPQI.

The findings of the two reports underscore the importance of risk assessment for predicting program completion, as well as treatment duration and other factors. Level of risk (as determined by the LS/CMI) was found to be the strongest predictor of successful program completion. As level of risk increased, so did the rates of recidivism among clients directly sentenced to community corrections programs. This finding provides partial support for the predictive validity of the LS/CMI for day report clients. In addition, the study found that clients who successfully complete their stay at a DRC are significantly less likely to recidivate. Only about 24% of clients that successfully completed a DRC program were subsequently booked into a regional jail within two years. This is compared to a booking rate of about 43% for clients unsuccessfully terminated by a DRC.

LS/CMI Norming and Validation: Under SB 371, the ORSP is mandated to conduct validation studies on the LS/CMI across all community supervision agencies. The ORSP has developed a plan that includes the validation of the LS/CMI on both community-based and institutional offender populations. The plan involves the release of four reports, three of which have been completed. The first report was a study of the predictive validity of LS/CMI risk scores for a sample of DOC inmates released in 2012-2013. This report was published in September of 2015. It demonstrated that the LS/CMI was an effective predictor of recidivism for the inmate population in WV, but also highlighted several areas where the delivery of LS/CMI assessments could be improved. The second report was published in October of 2015, provided a summary of the results of all LS/CMI assessments conducted on institutional and community-based offenders in 2013 and

2014 and compared the characteristics of WV offenders to national norms. This report received the JRSA national publication award in the statistical/management category. The third report in this series was a recidivism study of day report center clients which is described in greater detail in the section above on outcomes research on day report center clients. The fourth report is a planned study which will examine the predictive validity of the LS/CMI for parolees. It is anticipated that it will be published sometime in 2018.

Information Sharing for Fidelity in Community Supervision and Treatment

The ORSP continues to work with other agencies to foster information sharing in order to support effective community supervision and treatment. Information sharing on the part of the ORSP has taken on many forms and involves several different data sources. The ORSP facilitated the inception of the LS/CMI Online System. ALL AGENCIES IN THE DEPARTMENT OF MILITARY AFFAIRS AND PUBLIC SAFETY (DMAPS) AS WELL AS SEVERAL NON-PROFIT AND PRIVATE TREATMENT PROVIDERS CONTRIBUTE INFORMATION TO THE LS/CMI ONLINE SYSTEM MANAGED BY THE ORSP. This system was established in 2009 and has continued to grow; thereby helping to foster a continuum of care across all agencies and departments, with the exception of probation, which is governed by a separate LS/CMI Policy promulgated by the Supreme Court requiring the administration of LS/CMI assessments and their use in case planning, and utilizes its own online system, the OCMS, to conduct LS/CMI assessments. The probation division also participates in sharing offender information across agencies through its Memoranda of Understanding with the JCS and DCR.

As an integral part of SB 371 and the “Treatment Supervision” plan and initiative, the ORSP is in process of providing access to all BBHHF and treatment provider staff funded as part of the treatment supervision initiative. This will allow providers to view prior LS/CMI assessments conducted by other agencies including day report centers and allow them to conduct their own reassessments of clients as they progress through treatment. This will reduce the duplication of services and assessments and streamline the implementation and monitoring of case supervision and treatment plans.

In addition, the ORSP is working with BBHHF and treatment providers to provide access to the CCIS. Several treatment providers have successfully completed the LS/CMI User certification course and been given access to the online system. Given the close working relationship between day report centers and treatment providers as part of the treatment supervision initiative, it is essential that treatment providers have the capacity to view “collateral information” necessary for conducting valid LS/CMI’s and enter their own data on a client’s treatment progress. This will help ensure LS/CMI’s conducted by treatment providers are valid, and also help in the collection of the necessary data and information to ensure treatment integrity. The ORSP, along with DHHR/BBHHF, are committed to providing the necessary technical assistance to treatment providers for proper assessment and information sharing.

REENTRY

§62-12-17(f). and §28-5-27(n) and (m): SB 371 directs that DJCS affect the usage of community corrections programming on the post-incarceration side of the correctional continuum. In summary, there will be a significant increase in parolee and/or early release referrals to our community corrections programs.

A master agreement and protocol with JCS and the DCR was developed to provide reimbursement to counties for the use of community corrections programs by eligible parolees. This agreement is using an established “cost per client per day” as the basis for reimbursement. The established rate, policy and protocol will continue to be assessed and revisions may be made as needed.

In order to facilitate the closer relationship between parole and community corrections programs necessitated by the above-referenced sections, the Community Corrections Subcommittee of the Governor’s Committee on Crime, Delinquency, and Correction revisited a section of the Community Corrections Program Guidelines pertaining to the acceptance of parolees. In their former state, the guidelines excluded some types of parolees from being accepted to programs based on the nature of the offense(s) for which they were convicted. The Subcommittee has revised this section to make it consistent with the language and intent of the JRI. The revised language only excludes parolees who are not moderate or high risk from receiving services from day report centers, rather than offense-based exclusions while continuing to allow day report center discretion in accepting those parolees based on their programs capacity to do so.

The master agreement and the protocol developed to facilitate the reimbursement to counties by the DCR began May 1, 2015. During the current fiscal year, twenty-two (22) day report centers participated in this project with a total of $182,124.80 paid to them by the DCR for services to support a variety of treatment, education, and supervision services to parolees throughout the state.

Attachment 1

WV Code §62-15-6a. Treatment Supervision

WV Code §62-15-6A

§62-15-6a. Treatment supervision.

(a) A felony drug offender is eligible for treatment supervision only if the offender would otherwise be sentenced to prison, and the standardized risk and needs assessment indicates the offender has a high risk for reoffending and a need for substance abuse treatment: Provided, That an inmate who is, or has been, convicted for a felony crime of violence against the person, a felony offense where the victim was a minor child or a felony offense involving the use of a firearm, as defined in subsections (o) and (p), section twenty-seven, article five, chapter twenty-eight of this code, shall not be eligible for treatment supervision.

(b) As a condition of drug court, a condition of probation or as a modification of probation, a circuit court judge may impose treatment supervision on an eligible drug offender convicted of a felony: Provided, That a judge may impose treatment supervision on an eligible drug offender convicted of a felony, notwithstanding the results of the risk assessment, upon making specific written findings of fact as to the reason for the departure.

(c) Whenever a circuit court judge determines that a treatment supervision participant has violated the conditions of his or her treatment supervision involving the participant's use of alcohol or a controlled substance, the judge may order a period of incarceration to encourage compliance with program requirements.

(1) Upon written finding by the circuit court judge that the participant would otherwise be sentenced to the custody of the Commissioner of Corrections for service of the underlying sentence, the cost of the incarceration order under this subsection, not to exceed a period of thirty days in any one instance, shall be paid by the Division of Corrections.

(2) Whenever a circuit court judge orders the incarceration of a treatment supervision participant pursuant to this subsection, a copy of the order of confinement shall be provided by the clerk of the circuit court within five days to the Commissioner of Corrections.

(d) The Division of Justice and Community Services shall in consultation with the Governor's Advisory Council on Substance Abuse, created by Executive Order No. 5-11, use appropriated funds to develop proposed substance abuse treatment plans to serve those offenders under treatment supervision in each judicial circuit and on parole supervision.

(e) The Division of Justice and Community Services, in consultation with the Governor's Advisory Committee on Substance Abuse, shall develop:

(1) Qualifications for provider certification to deliver a continuum of care to offenders;

(2) Fee reimbursement procedures; and

(3) Other matters related to the quality and delivery of services.

(f) The Division of Justice and Community Services shall require education and training for providers which shall include, but not be limited to, cognitive behavioral training. The duties of providers who provide services under this section may include: Notifying the probation department and the court of any offender failing to meet the conditions of probation or referrals to treatment; appearing at revocation hearings when required; and providing assistance with data reporting and treatment program quality evaluation.

(g) The cost for all drug abuse assessments and certified drug treatment under this section and subsection (e), section seventeen, article twelve of this chapter shall be paid by the Division of Justice and Community Services from funds appropriated for that purpose. The Division of Justice and Community Services shall contract for payment for the services provided to eligible offenders.

(h) The Division of Justice and Community Services, in consultation with the Governor's Advisory Council on Substance Abuse, shall submit an annual report on or before September 30 to the Governor, the Speaker of the House of Delegates, the President of the Senate and, upon request, to any individual member of the Legislature containing:

(1) The dollar amount and purpose of funds provided for the fiscal year;

(2) The number of people on treatment supervision who received services and whether their participation was the result of a direct sentence or in lieu of revocation;

(3) The number of people on treatment supervision who, pursuant to a judge's specific written findings of fact, received services despite the risk assessment indicating less than high risk for reoffending and a need for substance abuse treatment;

(4) The type of services provided;

(5) The rate of revocations and successful completions for people who received services;

(6) The number of people under supervision receiving treatment under this section who were rearrested and confined within two years of being placed under supervision;

(7) The dollar amount needed to provide services in the upcoming year to meet demand and the projected impact of reductions in program funding on cost and public safety measures; and

(8) Other appropriate measures used to measure the availability of treatment and the effectiveness of services.

(i) Subsections (a), (b), and (c) of this section shall take effect on January 1, 2014. The remaining provisions of this section shall take effect on July 1, 2013.

Attachment 2

Treatment Supervision Implementation Plan

Reducing Recidivism and Promoting Recovery

West Virginia Implementation Plan for Treatment Supervision

January 2014

Reducing Recidivism and Promoting Recovery

West Virginia Implementation Plan for Treatment Supervision

The purpose of the West Virginia Implementation Plan is to set forth strategies to reduce recidivism of offenders with substance use disorders, thus decreasing the overrepresentation of individuals with behavioral health disorders in the justice system. This will be accomplished through the development of a common structure for community supervision agencies and behavioral health treatment providers in an effort to enhance collaborative partnerships and coordinate care for offenders being supervised in the community. Senate Bill 371[1] provides a foundation for the development of a joint plan between the Department of Military Affairs and Public Safety (DMAPS) and the Department of Health and Human Resources (DHHR) to implement an effective system of treatment supervision for substance dependent or addicted individuals under community supervision.

The WV DHHR, Bureau for Behavioral Health and Health Facilities was asked by the Office of the Governor to partner with the WV DMAPS, Division of Justice and Community Services to facilitate the development and implementation of community based behavioral health services and support an action plan required for implementation of the treatment supervision sentencing option as outlined in the Justice Reinvestment Act. The partnership focuses on engagement of behavioral health services treatment providers, provision of targeted training on offender populations and increased collaboration between providers and community corrections professionals with the objectives of expanding effective substance abuse treatment services and reducing recidivism among the offender population. This collaborative approach to services development and coordination forges a long overdue partnership and avoids service system duplication. Extensive research on national best practice, key stakeholder interviews and data analysis were used to inform this treatment supervision implementation plan. It is important that national, state and local efforts be considered in the development and alignment of service systems.

National Perspective

According to the Substance Abuse and Mental Health Services Administration, half of all incarcerated people have mental health problems; sixty percent have substance use disorders and one third have both. Two thirds of people in prison meet the criteria for substance use disorders, yet less than fifteen percent receive treatment after admission. Twenty four percent of individuals in state prisons have a recent history of mental illness, yet only thirty four percent receive treatment after admission. Over 700,000 federal and

[1] Senate Bill 371 – a bill passed during the 2013 WV Legislative session to reform aspects of the criminal justice system to improve public safety and address the growing prison overcrowding and substance abuse problems in this state.

state prisoners are released to communities in the United States every year. Correctional behavioral health problems become community behavioral health problems.

Affordable Care Act and Justice Involved Populations

Healthcare coverage expansion means that individuals, while incarcerated or after leaving jails and prisons (generally without health insurance), will now have more opportunity for coverage utilizing exchanges or through Medicaid expansion upon re-entry to communities. There will be more opportunities to coordinate new health coverage with other efforts with the population to increase successful transitions. Addressing behavioral health needs can reduce recidivism and expenditures in the criminal justice system while increasing public health and safety outcomes.

National Framework

In 2012, the Council of State Governments Justice Center, the National Institute of Corrections, The US Department of Justice's Bureau of Justice Assistance and the US Department of Health and Human Service's Substance Abuse and Mental Health Services Administration cooperatively produced a white paper: *Adults with Behavioral Health Needs Under Correctional Supervision,* a guidance document for state systems development. The National Framework serves as a model for pretrial, jails, prisons, probation, parole, community correction and behavioral health providers in their shared commitment to help individuals with substance use /co-occurring disorders under correctional supervision.

National Framework Goals seek to:

- Advance collaboration and communication among systems
- Ensure that scarce resources are used efficiently
- Promote effective practices and accountability

Expanded Access to Health Care Needs

An estimated 22 to 30% of people newly eligible for Medicaid will have had contact with local criminal justice systems. Creating new levels of community engagement will be vital to HRSA-funded safety-net providers, given the complexity of health and behavioral health needs of individuals transiting out of criminal justice systems. Expanded access to healthcare brings abundant opportunities and showcases the need for new community partnerships with local criminal justice. ..systems.

-Substance Abuse Mental Health Services Administration, 2014

Justice Reinvestment in West Virginia

West Virginia participated in a bipartisan and inter-governmental effort to reduce prison growth and prevent crime using a data-driven "justice reinvestment" approach. A comprehensive analysis of the criminal justice system was conducted by the Council of State Governments Justice Center. A working group of legislative leaders from across the political spectrum, top court officials, state agency directors, and criminal justice stakeholders was established to review trends in the state's criminal justice system and develop policy options. The approach resulted in the passage of the Justice Reinvestment Act (JRA) during the 2013 legislative session.

CSG Involvement

The Council of State Governments (CSG) Justice Center provides technical assistance that helps states identify needs, gaps and unique opportunities for implementing best practices for recidivism reduction and reentry interventions. Consultants are currently supporting West Virginia in the implementation phase of the Justice Reinvestment Act and facilitating plan development through the Second Chance Recidivism Reduction and Reentry (SRR) grant program. These initiatives complement one another through shared research and data collection, cross-representation on planning and implementation teams and selecting aligned strategies that promote system integration, not duplication. The CSG has provided the following framework components to guide states in establishing strategies necessary to implement effective community based alternatives.

Reduce Substance Use

- Invest in community based treatment for people on supervision with substance use needs
- Establish partnerships and resources across systems
- Ensure effective substance abuse treatment in DOC

Improve Accountability

- Ensure all releases from prison are supervised
- Respond to violations with swift, certain and cost effective sanctions
- Strengthen community supervision

Strengthen Community Supervision

- Adopt a statewide risk/needs assessment and focus supervision resources on high risk offenders
- Maximize potential of day report centers (DRC's) to reduce recidivism
- Ensure implementation of evidence-based practices

Research on Community Supervision and Treatment: Guiding Considerations

During further review of national, state and local research, it was determined that key considerations must be acknowledged based on known best practices in supervising and treating offender populations. Considerations include:

Statutory and Financial Obligations

- Under the Eighth Amendment, corrections facilities are required to identify the health needs of inmates, including mental health needs and provide medication, treatment and other supports
- Correctional facilities are often not equipped with in-house expertise, housing options and funds to provide on-site behavioral health services
- Medicaid expansion will provide funding support for a population who has not been afforded the opportunity for healthcare
- A strong commitment to provide the necessary staffing and resources is necessary for monitoring supervision and treatment efforts and achieving positive outcomes.

Coordination, Collaboration, and Education

- Cross-agency coordination is critical in order to provide consistent and effective services across the continuum
- System reform education and on-going communication is necessary across multiple groups who share this overlapping population (prosecutors, community based treatment, Psi-Med, individual behavioral health providers, DRC's, drug courts, probation and parole and the recovery community)
- Community-based service providers often struggle with how to address the needs of offenders; thereby, often focusing on prevention rather than treatment. Training and education of providers on how best to address the criminogenic needs of offender populations is a necessity.
- Staff capacity to serve this population and differences in best practice interventions among varied systems may undermine effective communication and service provision.

Information Sharing

- Information and data must be efficiently (electronically) shared among all justice system agencies and treatment providers to support cross-systems implementation efforts, make informed decisions and maintain program integrity.
- Valid offender assessment is the first step in providing effective treatment and is contingent on sound interviewing skills, coupled with access to official record information and other collateral information (e.g., employers, family members, friends, etc.).
- Judges, prosecutors and defense attorneys must have access to accurate information on clinical needs and treatment alternatives to efficiently assess a case, determine disposition options and make informed decisions (diversion, supervision & treatment)

Offender Assessment and Addressing Criminogenic Needs

- Community-based settings are more cost effective than incarcerated settings and have a greater impact on recidivism.

- Screening for offender risk and needs post-conviction and prior to sentencing is necessary to individualize services, develop case plans targeting the criminogenic needs of individuals and make the best use of scarce resources.

- Clinical assessment to determine substance abuse treatment needs prior to discharge or release from the correctional setting is recommended to support timely engagement in appropriate services.

- The costs associated with treating incarcerated individuals with behavioral health disorders can be significantly greater than in the general population and provide management problems for administrators.
- High risk offenders should be prioritized and receive intensive treatment services targeting criminogenic needs, while treatment services to low risk offenders should be kept to a minimum.
- A "hybrid approach" combining intensive treatment with supervision and accountability is a best practice for reducing recidivism among offender populations.

Substance Abuse Treatment for Offender Populations

- Determining whether an individual dependent on a substance(s), rather than simply abusing a substance(s) is of critical importance in identifying who is in greatest need for services and prioritizing those services
- A drug-related arrest or positive drug test, by itself, is not sufficient for a diagnosis of dependence/addiction or determining the need for higher-intensity services
- Development and implementation of a therapeutic community approach to all addiction is essential to improved outcomes and cost-reduction associated with the disease.

Quality Assurance

- Monitoring and technical assistance are necessary for the successful delivery of supervision and treatment services.
- Treatment supervision programming will be governed strictly by standards applicable to all program components in full compliance with the requirements of SB 371 (*§62-15-6a*).
- Achieving quality supervision and treatment is a matter of policy and sustained quality assurance procedures are necessary for enhancing adherence to the risk-need-responsivity principles of effective correctional intervention.
- Managers and supervisors must attend to the relationship and structuring skills of service delivery staff via measurement and routine coaching/feedback processes.
- Selection, training, and clinical supervision of credentialed treatment staff and providers are critical for the development of programs effective at reducing offender recidivism.
- Involvement of researchers in program design, program delivery, program review, and process and outcome evaluations is associated with the most effective correctional interventions and programs.

Assessment of Current Practice

In addition to the results from empirical research described above, the Committee conducted an assessment of current practices to inform the implementation plan. Literature reviews on best practice and other qualitative research had to be considered to further develop the implementation plan. Joint planning meetings between the Division of Justice and Community Services and the Bureau for Behavioral Health and Health Facilities were held to identify key components of an implementation plan. In addition, interviews were conducted with key partners in community supervision to better ascertain current practice. In general, the Committee focused on:

1. Defining an appropriate target population to receive intensive community supervision and treatment services in line with SB 371;
2. Delineation of a phased approach to implementation taking into consideration:
    a. Current assessment and diagnostic methods and how best to identify the target population and distinguish them from offenders with less need for services;
    b. Appraisal of regional treatment system components, day report center capacity, as well as current gaps in availability and accessibility to intensive and other treatment services;
3. Assessment of current cross-system information sharing practices and needs; *and,*
4. Exploration of methods for assessing agency/provider performance and monitoring implementation, outcomes and progress of the efforts currently in place and designed to meet the needs of the population

Defining the Target Population

The JRA specifically refers to the prioritization of individuals who, based on risk and needs assessment, are high risk with moderate or high substance abuse treatment needs. The language in the JRA served as the foundation for identifying the characteristics of the population to be targeted. Of primary importance to the planning team was building a collaborative partnership between criminal justice system and community providers, eliminating gaps and building capacity, and expanding the access and availability of treatment programs in areas where the need is the greatest and where there was a better likelihood of successful implementation. In consideration of all the factors above, the Committee defined its target population as:

- Individuals who demonstrate a "high risk" for reoffending AND a "need for substance abuse treatment" - as indicated by the approved standard risk needs assessment (currently LS/CMI).
    - "High risk" is defined as a person with an overall LS/CMI risk score of high, meaning that the offender's risk of committing a new crime is high. "A need for substance abuse treatment" is defined as a person having a score within the "alcohol/drug problem" domain of the LS/CMI of moderate to high.

- In addition to being identified as high risk/moderate to higher substance abuse need, other individuals who may benefit from engagement in treatment supervision programming are those who have:
    - Substance abuse addiction or dependence as assessed by a qualified behavioral health specialist, and/or;
    - Repeat violations of conditions of supervision directly linked to substance abuse, and/or;
    - The presence of a co-occurring disorder identified by an offender risk assessment or other diagnostic instrument (a substance use disorder in combination with a mental health disorder)

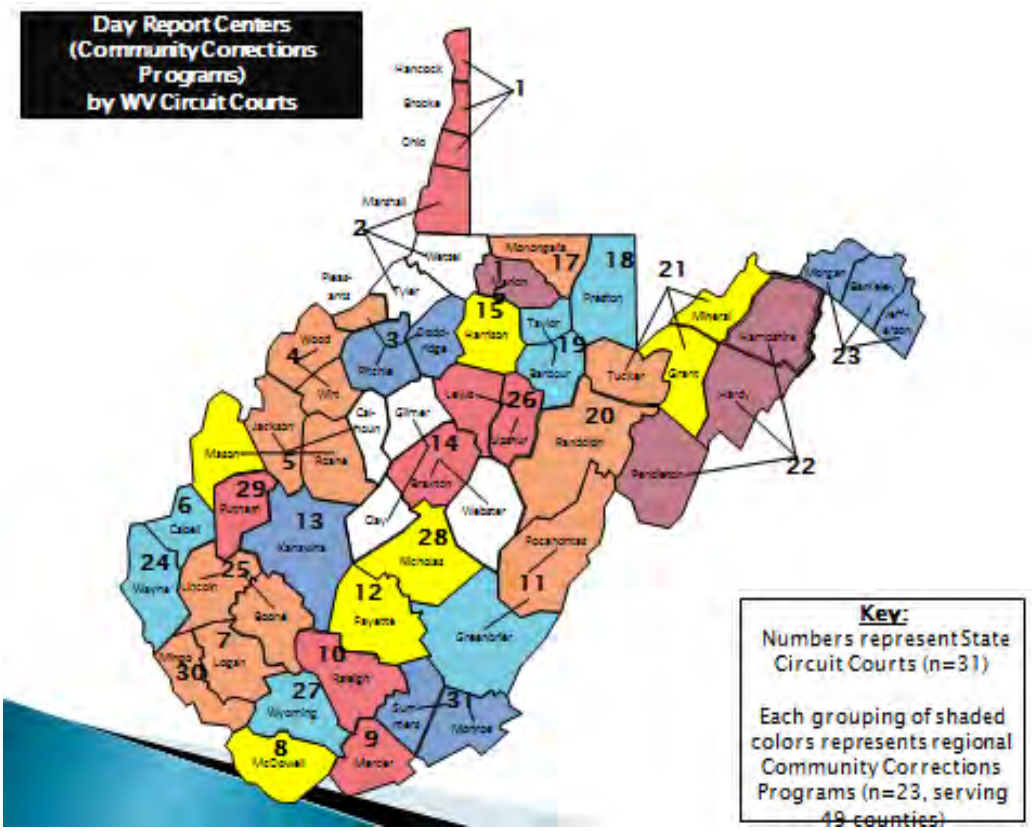
Selection of Phase One & Two Implementation Projects/Locations

Due to barriers most often associated with community re-entry, a two-phase approach has been adopted to support gradual and carefully monitored implementation. With over nine million individuals cycling through jails in the United States each year and two thirds of state prisoners rearrested within three years of release, this graduated process is necessary to support comprehensive systems change. The cooperation among community based providers will be the key to successful program implementation. Through cross-training opportunities and intense technical assistance monitoring, the capacity of phase one treatment providers will be increased. These highly trained individuals will serve as mentors and share lessons learned with phase two providers. Data collected during the first phase will also help inform and improve future practice.

Multiple sources of data were reviewed to identify the most appropriate project sites for each phase. Data sources included: 1) LS/CMI risk and needs data; 2) state police arrest data for fiscal year ending June 30, 2013; 3) parole release data; and 4) regional jail and supreme court data depicting numbers served. Information on the location of drug courts and day report centers was also taken into consideration. These data were combined with information on treatment provider capacity and availability to fully determine the sites to be included in each phase.

Figure 1 on the following page depicts the current location of all WV Day Report Centers (DRC's). DRC's will serve as one of the primary conduits for linking eligible individuals to treatment services in the community. The DRC's and community service providers will work closely together to manage referrals, share information, and develop treatment and supervision plans. While DRC's are a primary referral source, eligible persons may filter into treatment supervision from various sources.

Figure 1: Location of Day Report Centers in Operation, 2013



Selected Phase One and Phase Two Project Sites

Figure 2 on the following page represents the proposed pilot sites for phases one and two of this project. These sites were selected for their respective phases based on extensive review of the above referenced data, current research, and evidence based practices relevant to the target population. The selection of pilot sites was guided by information made available through the WV Department of Military Affairs, Division of Justice and Community Services, Division of Corrections, Regional Jail Authority, the WV Supreme Court of Appeals and the WV Department of Health and Human Resources, Bureau of Health and Health Facilities. Further delineation of phase one and phase two site development is offered in Table 1 on the next page. Given the collaboration set forth in SB 371, §62-15-6a (d) regarding the interface between the DJCS and the Governor's Advisory Council on Substance Abuse, the Governor's six substance abuse regions have been utilized to support alignment of all substance abuse related service system development initiatives that have been underway and planned through this effort.

Figure 2: Location of Phase 1 and Phase 2 Project Sites

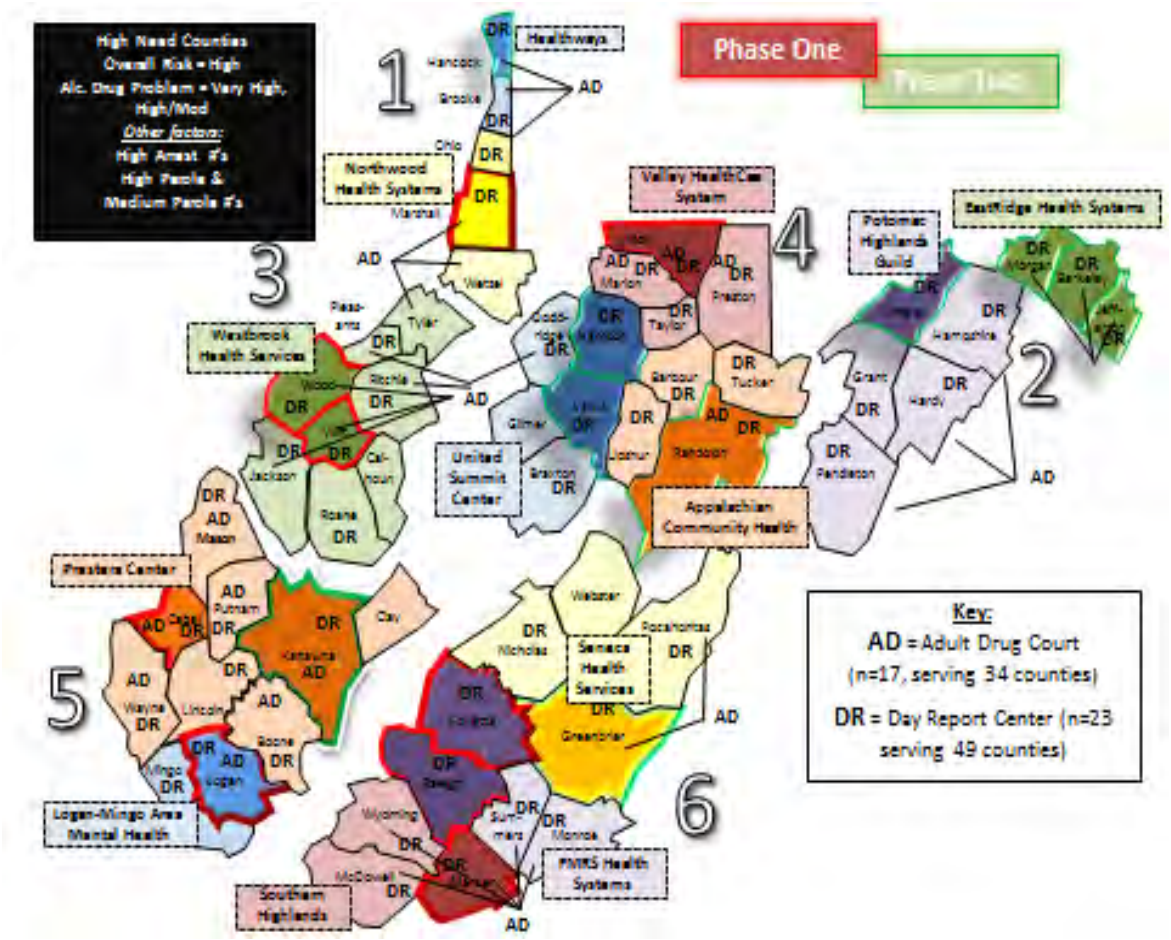


Table 1: Descriptive Characteristics of Selected Project Sites by Implementation Phase

Phase 1 Program Area Selection	Phase 2 Program Area Selection
Region One: Marshall	Region One: Hancock
Region Two: *Implementation planned for phase two*	Region Two: Morgan, Berkeley, Jefferson and Mineral
Region Three: Wood / Wirt	Region Three: *No additional counties selected for phase two*
Region Four: Monongalia	Region Four: Harrison, Lewis And Randolph
Region Five: Cabell and Logan	Region Five: Kanawha
Region Six: Fayette, Raleigh, Mercer	Region Six: Greenbrier

Review of Cross-System Assessment, Treatment and Information Sharing Practices

In order to make implementation recommendations, it was essential to fully explore and understand current system components. Understanding and considering the assessment and treatment options afforded to individuals moving through the justice system and beyond (§16-15-2 (2)) was key to development of the plan. Summarized next are the findings of this cross-systems review:

Assessments and Treatment Options:

Pre-Trial- In West Virginia, individuals can be held in a county or regional jail, a day report center or at home prior to trial. Currently, an eight question risk assessment (ORAS) is conducted at the regional jail for all individuals, with the exception of the federally held inmates. The brief questionnaire was established to determine flight risk and was implemented in all regional jails beginning October 2013, in coordination with the Supreme Court. While ORAS is a useful tool for aiding decisions on which defendants are more or less at-risk to fail to appear in court, it is not adequate for guiding intensive treatment considerations for offenders at post-conviction.

Post-Conviction Prior to Sentencing- The Level of Service/Case Management Inventory (LS/CMI), the risk and needs assessment adopted by all state correctional agencies and treatment providers receiving treatment supervision funds, is conducted after conviction and prior to sentencing. Judges can request a clinical evaluation to determine behavioral health needs. All persons placed in the custody of the Regional Jail Authority receive a medical assessment covering physical and behavioral health needs within 72 hours of placement. The individual is then seen by a counselor who may determine that the person is in need of more intense assessment or intervention and is referred to PsiMed, a contractor through PrimeCare, the regional jail system medical provider. These assessment and diagnostic procedures should aide in sentencing decisions and assist in determining offender eligibility for treatment supervision.

Sentencing- If an individual is considered for Adult Drug Court, a clinical assessment is conducted. Evidence based programming, case management and treatment team meetings are required as part of the program. If an offender is sentenced to prison but is held at a regional jail facility, they will have access to substance abuse and life skills classes, which are offered at all regional jails across WV, as well as a DUI pilot program beginning January 2014. If sentenced to a WV prison, individuals are screened for their risk of recidivism, mental health and substance use needs at intake. A full assessment is completed when they screen positive for likelihood of a problem. Therapeutic treatment programming is provided for those who demonstrate a need. Residential Substance Abuse Treatment (RSAT) units operate within five Division of Corrections facilities and provide treatment beds for chronic alcoholics and addicts within prisons. The primary modality of treatment within these units is the Therapeutic Community, wherein offenders are exposed to values and principles consistent with those found in the larger society rather than within the prison subculture. At the same time, they are placed in intensive treatment programs to overcome their addictions.

The agency also operates one community-based center that serves as an aftercare unit for offenders completing the Therapeutic Community. This center is designed to provide a safe transition for the offender from prison to the community, with peer support and follow-up addiction services to the populations as they gradually transition back into society. This program is recommended after evaluating the inmates' past substance abuse history and criminal history as it relates to substance abuse. Offender programs are also available that include: rational thinking models, victim empathy, substance abuse, family-based violence, sex offender, adult basic education/GED preparation, vocational education and college courses. Day report centers offer an array of individual and group education, treatment, and supervision services either at the facility or through external contracts. Similar to the above, the LS/CMI combined with other diagnostic tools will serve as the basis for the determination of treatment eligibility and the development of case supervision and treatment plans rooted in the principles of effective correctional intervention.

Inter-Agency Information Sharing

Nearly all of the recommendations contained in this implementation plan are dependent on information sharing across systems (SB 371, §62-12-29). Critical to success is the efficient sharing of valid offender risk/needs assessment information, other diagnostic indicators, and official record information (e.g., pre-sentence investigations, prior disciplinary reports, prior performance on supervision, etc.) necessary for proper assessment and supervision purposes. To assist in this process, the Division of Justice and Community Services (DJCS), Office of Research and Strategic Planning (ORSP), Justice Center for Evidence Based Practice (JCEBP) has established an online LS/CMI system which contains assessment information on all offenders entering and exiting every correctional agency in the state, with the exception of Probation Services. The system allows for a single log-in point for access to all LS/CMI's conducted in the state on adult offenders. Access to the system is restricted to currently employed staff members who have met all official certification criteria for administering or utilizing the LS/CMI tool. The system is set up to allow for state agencies and community based treatment providers to enroll in the system in order to offer seamless access to all LS/CMI's.

In addition, the DJCS/ORSP captures information on all offenders sentenced to Day Report Centers in the state through the Community Corrections Information System 2.0. Access to data contained in the system must be provided to state agencies and treatment providers for valid completions of the LS/CMI. The DJCS/ORSP is prepared to provide such access once inter-agency agreements are in place. Similar mechanisms must also be put in place to readily share information from the OIS system (containing DOC and RJA information) and the Supreme Court. Treatment providers will also be required to electronically submit treatment integrity and offender performance outcomes and other information to correctional supervision agencies. The DJCS and BBHHF will continue to develop reporting requirements, measures, and methods for electronic information sharing.

Quality Assurance

Information sharing is further necessary for the development of an adequate system to measure performance and the quality delivery of services. This is an added reason for the efficient capturing and sharing of information on treatment services and correctional supervision practices. Best practices in offender supervision and treatment include measuring relevant practices of staff/programs and providing feedback. The ORSP/JCEBP has established a series of minimum standards, training and certification, and quality assurance policies. In addition, the ORSP/JCEBP currently captures data on the accuracy of LS/CMI assessments, case plans, motivational interviewing practices, and the use of core correctional practice among all correctional agency staff, with the exception of probation. This is a system that will be utilized in cooperation with the BBHHF and treatment providers funded for providing services to offenders.

The ORSP/JCEBP currently uses the Online Learning Management System (OLMS) to track certifications for all correctional agencies in the state, except probation. This provides a method for ensuring correctional staff have met professional standards for training. The OLMS system will be used to capture the information on treatment provider credentials and the completion of minimum certification/recertification requirements for extant as well as new trainings developed under the Justice Reinvestment initiative.

The DJCS/ORSP will work closely with the BBHHF to develop reporting requirements and track capacity for grantees and methods for sharing information across agencies.

The BBHHF will provide on-site monitoring of all treatment provider agencies through direct engagement of Programs leadership and staff. Treatment programming implementation will be monitored by the Program's Team to insure that all timeframes are met and that services capacity is achieved as quickly as is feasible. In addition, the BBHHF Monitoring and Compliance division will provide regular on-site monitoring to insure that providers are meeting the intent set forth in Statements of Work (SOW). The SOW is the official grant document that delineates all funding agreements put into place and captures the type of service/programming, location, scope, target populations, timeframes, evidence based programming and reporting requirements and cost, as well as other legal mandates that may be governed by local, state, federal or other entities. This monitoring will include fiscal monitoring as well as a review of the clinical scope of and fidelity of all programming developed. Technical assistance will be readily available to providers during start up and on-going. In addition to the BBHHF oversight for programming requiring behavioral health licensure, the Office of Health Facilities Licensure and Certification (OHFLAC), an Office governed by the Office of the Inspector General, will also provide regular monitoring and oversight to ensure full compliance with all applicable standards. For providers accessing Medicaid funding to support implementation of billable programming the WV

Bureau of Medical Services (BMS) will provide oversight of as well as technical assistance to providers.

Key Implementation Plan Recommendations and Strategies

Taking into consideration the vast amount of research, analysis and delineation of elements required to support the development of a comprehensive treatment supervision implementation plan, the DJCS and BBHHF have agreed on and set forth the following recommendations in Table 2. These recommendations, in concert with information outlined within or referenced within this document, will guide efforts to fully and effectively develop statewide capacity to serve offenders as part of reentry efforts.

Table 2: Plan Recommendations and Strategies

Recommendations	Strategies
1. Guide quality improvement and capture consistent process and outcomes through shared assessment and evaluation and information sharing practices across the criminal justice system	• Develop system and project-wide information sharing protocols among/ between justice services and community service providers • Create a single dashboard for capturing consistent agreed upon measures providing a readily accessible snapshot of performance and cost savings. (see example, Vermont Model) • Build on extant DJCS/ORSP quality assurance processes to ensure adherence to risk-need-responsivity principles • Utilize standardized fidelity measures for implementing assessments and service delivery • Enroll all treatment providers in the LS/CMI online system and Online Learning Management System to administer and track (re)certifications of all training requirements • Implement a standardized treatment planning document , to compliment and provide supplementary information for LS/CMI case plans
2. Improve person-centered, individualized care for offenders with behavioral health needs by implementing evidence-based programs and practices and administering risk/needs assessment and other diagnostic tools prior to sentencing and throughout the criminal justice process	• Clinical assessments would be given to 100% of individuals prior to sentencing and release who are considered for community treatment and support services • Provide consistent EBP training and interventions across the criminal justice and behavioral health systems • Build on existing quality assurance systems to improve monitoring of assessment quality, case plans, provider/DRC staff credentials, and outcomes

3. Ensure that all behavioral health and criminal justice providers/facilities (jails, prisons, drug courts, day report centers) offer a consistent continuum of assessment, treatment and community peer/recovery support services	• Consistent risk/needs and clinical assessments be provided in all systems to individuals at risk for substance use/co-occurring disorders • Consistent behavioral health services be provided to individuals diagnosed with substance use/co-occurring disorders • 100% of individuals considered for community supervision would be assigned a peer recovery/support specialist prior to release from any institution and/or upon placement into community corrections directly • Provide funding targeted to engagement and out-patient services • Provide targeted funding for community peer/recovery support services • Provide funding targeted to recovery residences to provide safe and stable housing for individuals in community support services
4. Improve consistency in community and peer support expansion by enhancing the monitoring and supervision of local day report centers	• Developing a clear policy framework for the implementation of treatment supervision • Co-monitor behavioral health services in coordination with BBHHF

Building State and Community Capacity

In spite of numerous training conferences and a volume of program guidance, the lack of cross-systems collaboration, training and information sharing within the justice system as well as between the justice and behavioral health systems has resulted in a fragmented system. This has impacted the capacity to provide adequate and quality services statewide. Local control, diverse administrative structures, and varied community resources from one locale to another often results in varying levels of service. Workforce capacity, transportation, and availability of treatment services have been noted by justice professionals, providers and the Governor's Advisory Council on Substance Abuse and Regional Task Forces as overall barriers to service provision.

According to SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, there are specific evidence-based programs and practices which have been deemed effective for treating substance abuse and dependence among the offender population. Cross-training among criminal justice and behavioral health providers who share responsibility for supervision and treatment of offenders in the community is critical. An offender population has unique characteristics that contribute to their risk for reoffending and it is important that community behavioral health providers are well-versed in the

principles and treatment strategies associated with effective correctional intervention. The following discussion provides an overview of the recommended training strategy for criminal justice professionals and treatment providers.

As shown in Table 3, there are a variety of system and grantee training needs that must be addressed to facilitate the successful implementation of treatment supervision. Basic concepts include education on implementation fidelity, offender assessment, quality assurance, performance measurement, and ensuring proper data collection in order to evaluate progress and assess outcomes. These "system training" concepts are encouraged across all agencies working with offender populations. Specific grantee training requirements relate to the types of skills and information that will be required of treatment providers offering services under the Justice Reinvestment Initiative.

While many of the training concepts are currently offered by DJCS and/or BBHHF, the Justice Reinvestment funds will provide an opportunity to bring in national consultants to offer evidence based program cross training among community providers. This will result in consistent programming and increased multi-system communication and collaboration. Trainings will be evaluated as well as certification processes promoted across systems in order to better ensure that work force capacity will be sustained over time, provider skills will be maintained, and treatment integrity will be promoted and preserved.

Table 3: Overview of Criminal Justice System and Behavioral Health Grantee Training Needs

System Training	Grantee Training
JRI Implementation	Cognitive Behavioral Therapy
Reliable Administration of LS/CMI and Other Assessments	Offender Risk Assessment
Implementing Evidence-Based Practices with Fidelity	Motivational Interviewing
Data Collection and Reporting Outcomes Across Systems	Relapse Prevention
Quality Assurance and Performance Measurement	Medication Assisted Treatment
Community and Peer Based Supports	Offender Case Coordination
Trauma Informed Care	Clinical Assessment
Community and Peer Based Supports	Understanding Criminogenic Risk/Need and Principles of Effective Correctional Intervention
	Community and Peer Based Supports

Plan for the Delivery of Offender-Based Workshops

Table 4 provides a list and description of required trainings for community based treatment providers working with offenders on community supervision. The trainings are generally listed in an order in which the trainings should occur with each workshop building on the next. The DJCS in coordination with the BBHHF will provide coordination

for getting trainers established, overseeing the delivery of trainings in the field, and monitoring the quality of training efforts. The DJCS has established a train-the-trainer system for all correctional agencies in the Executive with policies designed to monitor and sustain fidelity over time. It is anticipated that this system can extend to community based providers; thereby, providing a strong partnership between human services and the criminal justice system as well as a system for monitoring professional standards and maintaining treatment quality.

As shown in Table 4, the initial training will provide an introductory overview of the principles of correctional intervention, with special emphasis on characteristics of effective programs and the issue of treatment integrity. Ideally, this training would be followed by a Level of Service/Case Management Inventory (LS/CMI) User workshop for those providers that plan to administer the tool. For providers who will *not* be administering the tool, a 2-day "Case Manager" training is recommended to assist them in interpreting the results of the LS/CMI and creating case plans that are consistent with the RNR principles. Provider organization staff will be expected to become trainers in order to help sustain knowledge of the LS/CMI among treatment providers. For quality or fidelity purposes, the DJCS has developed statewide minimum policies relating to the use of the LS/CMI and Motivational Interviewing (MI) for all correctional agencies in the state and can be used to guide our efforts to ensure the continuation of proper training and quality assurance mechanisms among treatment providers.

Motivational interviewing (MI) is recommended to follow the initial LS/CMI trainings. Currently, the DJCS offers training on fundamentals, followed by an additional day for trainers focusing on scoring, coaching/feedback, and measuring treatment integrity. Participants are taught how to utilize MITI for the purposes of scoring interviews and measuring the quality of treatment. These trainings are comprehensive and are recommended as an integral part in the administration of the LS/CMI, as well as for the daily interaction with offender populations. Lack of motivation is a common responsivity issue among offender populations and must be addressed to get offenders engaged in treatment and maximize reductions in recidivism. MI strategies are also important in the successful delivery of treatment programs and enhancing the therapeutic nature of programs.

A primary predictor of offender recidivism is the presence of "antisocial attitudes" or "criminal thinking." Thinking for a Change is highly recommended for treatment providers due to its focus on this central domain, and its comprehensive use of cognitive-behavioral strategies or tactics. This can be considered a foundational cognitive-behavioral curriculum for offender populations. All day report center staff delivery programming to offenders will also be required to become certified in this curriculum. The strategies learned in this training can be utilized to address other criminogenic needs, including substance abuse. Therefore, it provides a strong foundation for the substance abuse curricula recommended in this plan.

Table 4: Offender-Based Workshops for Providers – Key Partners

Workshop	Description
"What Works" in Offender Treatment	1 day. Introductory review of research and empirically supported principles, interventions, and strategies. Emphasis is on what makes effective treatment programs for offenders and establishing treatment integrity.
LS/CMI User Workshop[a]	3-4 day User workshop, with 1 follow-up interviewing coaching/feedback session. Reviews application of principles of effective correction intervention via offender assessment and case planning. Successful participants are certified to administer the instrument on offenders. Recertification every 2 years. (Note: 2 day Case Manager Training is recommended as a substitute for those who do not plan to administer the tool).
LS/CMI - User Trainer Workshop	3-4 day User Trainer workshop, with 1 follow-up coaching/ feedback session and teaching observation. Provides participants with teaching strategies and practice in training Users on every aspect of the standardized LS/CMI curriculum. Successful participants are certified to train Users in agency in which original certification was approved. Recertification once a year.
Motivational Interviewing Fundamentals	2 days, satisfactory completion of MI in accordance with the LS/CMI minimum standards policy for certification. Centers on understanding fundamentals with extensive practice of the 8 stages of MI.
Motivational Interviewing Treatment Integrity for Trainers	1 day. MI fundamental prerequisite. Completion of the Trainer Workshop, with satisfactory completion of Motivational Interviewing Treatment Integrity (MITI) Evaluation. Satisfactory completion of 1 interview with an offender/client. Focuses on teaching participants how to score an MI interview using MITI 3.1 and provide coaching/feedback for improving interviewing skills.
Thinking for a Change Training- An Integrated Cognitive Behavior Change Program	4 days. Other requirements TBA. Focus is on utilizing cognitive-behavioral strategies to recognize and change criminal thinking. Special emphasis is on cognitive self-change, social skills and problem solving.
Strategies for Self-Improvement and Change[b]	3 days. Other requirements TBA. Focus on steps or phases that are developed around three stages in the circle of change (challenge phase of change, commitment to change, and ownership of ones change).
Cognitive-Behavioral Interventions for Substance Abuse Treatment	3 days. Other requirements TBA. Relies on a cognitive behavioral approach to teach participant strategies for avoiding substance abuse. Emphasizes skill building activities to assist with cognitive, social, emotional, and coping skill development.

a. Necessary only for providers who have not received a MI training in recent years. A process will be established to review education and prior certifications/trainings.
b. Providers will be required to be certified on only 1 of the 2 substance abuse curricula, if they plan to deliver the curricula.

Treatment providers will also be required to become certified in at least one of the two substance abuse curricula listed in Table 4, if they plan to facilitate group substance abuse programs or deliver the curricula. The choice of two curricula include: 1) Strategies for Self-Improvement and Change or 2) Cognitive-Behavioral Interventions for Substance Abuse Treatment. Using Justice Reinvestment funds, trainers will be established across agencies to deliver each of the substance abuse curricula. The BBHHF and DJCS will co-monitor the quality of trainings by trainers and tracking certifications.

Treatment Supervision and Service Selection

The Planning Team has determined that application for funding announcements (AFA's) will be the mechanism utilized to announce, solicit and award funding to support the development of treatment supervision coordination and services availability in the regions/counties identified. All AFA's will provide an overview of the West Virginia Justice Reinvestment Legislation and Implementation Plan outlining specific requirements for those applying for funding including an emphasis on key partnerships and service system components that will be essential to project success. AFA technical assistance will include an emphasis on training and data reporting requirements, an overview of the scope and type of clinical and support services, as well as utilization of recovery/transitional housing. Increased capacity development will support the existence of a full continuum of behavioral health services for the target population in order to promote successful outcomes. Table 5 includes individual services that have been selected as part of a comprehensive funding announcement. These services are defined based on the Substance Abuse Mental Health Services Administration (SAMHSA) guidance and credentials listed are required for certification and aligned with Medicaid reimbursement policies.

Table 5. Service Selections Defined with Credential Requirements

Service Title	Definition	Education and Credential
Engagement Services	Includes the evaluation and service planning support needed to address the complex needs of individuals and their families impacted by mental disorders, substance use disorders and associated problems with specific services that include: Assessment, Specialized Evaluations including Psychological, Service Planning including Crisis Planning, Consumer and Family Education and Outreach and Advocacy	WV Medicaid Manual: MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN • STAFF CREDENTIALS - Staff must have a minimum of a master's degree in a field of human services or a bachelor's degree in a field of human services with proper supervision and oversight by an individual with a minimum of a master's degree. Staff must be properly credentialed by the agency's internal credentialing committee.
Outpatient	Out-Patient Services- is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual with mental, substance and other disorders aimed to achieve and maintain	WV Medicaid Manual: BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, INDIVIDUAL • STAFF CREDENTIALS - Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by

	sobriety, physical and mental health with maximum functional ability with services that may include: Individualized Evidence-Based Therapies, Group Therapy, Family Therapy, Multi-Family Counseling, and Consultation with Care-Givers	national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues. To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, GROUP • STAFF CREDENTIALS – same as above
Community Support Services	Community Support Services-meaningful daily activities such as a job, school, volunteerism, family caretaking or creative endeavors that are usually developed through the participation in social networks; gaining independence, income and resources to support participation in a safe and stable environment. Services include: Social, daily living and cognitive skill building, case management, continuing care, behavior management, supported employment, supportive housing, recovery housing and therapeutic mentoring	WV Bureau for Behavioral Health and Health Facilities: CARE COORDINATION • STAFF CREDENTIALS – High school graduate and working toward BBHHF Community Support Specialist Certification
Recovery Residence	Substance Use Recovery Residences sometimes referred to as Transitional Living‖, Oxford Houses, Recovery Homes, and Healing Place models provide safe housing for individuals, age eighteen (18) and older who need or are in recovery from substance use and/or substance use and co-occurring mental disorders. These services follow and/or are concurrent with short-term treatment (typically short-term	WV Bureau for Behavioral Health and Health Facilities: RESIDENCE STAFF • STAFF CREDENTIALS – High school graduate with lived experience

	residential) and is intended to assist those individuals for a period of twelve (12) to eighteen (18) months or until it is determined that an individual is able to safely transition into a more integrated environment. All applicants for funding to operate a Level II Recovery Residence must provide statements agreeing to meet the BBHHF's Substance Use Recovery Residence Standards that are aligned with national standards.	
Recovery Support Services	Provide opportunities of change whereby individuals work to improve their own health through social inclusion or engaging in supportive recovery communities with services that may include: Peer Support, Recovery Support Coaching, Recovery Support Center Services, Supports for Self Directed Care	WV Bureau for Behavioral Health and Health Facilities: RECOVERY COACH • STAFF CREDENTIALS – High school graduate with lived experience

Performance Measurement and Quality Assurance

The implementation of evidence-based practices requires evaluator involvement in the measuring of staff and program performance. Performance will be monitored throughout each phase of implementation, providing periodic feedback to DJCS, BBHHF, correctional supervision agencies, and funded services providers.

Capturing and Reporting Outcomes

The BBHHF will provide clinical and fiscal oversight of the awarded grantees in cooperation with the Division of Justice and Community Services. The DJCS will also continue to monitor day report centers and collect data on service delivery and offender outcomes. Efforts will be made to develop joint monitoring procedures that account for treatment integrity specific to offender populations and common behavioral health modalities. Joint monitoring procedures will provide consistency in measurement and reporting for treatment providers and community supervision agencies. The assumption is that if provider staff is trained in best practice interventions, and quality programming is implemented, client outcomes will improve (see Figure 4).

Figure 4. Quality Improvement Model

Therefore, it is critical that training specific to offender populations occurs and continues on an ongoing basis and that training efforts and service delivery are closely monitored for quality. As mentioned in the recommendation, in order to report on the effectiveness of the JRA and understand cost savings, it will be necessary to capture consistent measurements program-wide that include, but are not limited to:

1. # individuals eligible for community supervision services
2. Percentage of clients with completed RNR offender assessments
3. # individuals selected for community supervision
4. Percentage of high risk clients being served
5. # and type of services for individuals participating in community supervision services
6. Percentage of clients moderate to high in substance abuse need being served by an evidence-based treatment or service
7. # individuals completing community supervision services
8. # individuals in safe and sober housing
9. # individuals employed
10. Percentage of clients with responsivity concerns being addressed in case plans
11. # individuals engaged in educational opportunities
12. # revocations
13. responsiveness to treatment with relation to baseline
14. # qualified/trained staff

In addition to the summary measures above, correctional interventions require the consistent measurement of relevant, evidence-based practices accompanied with feedback to both providers and clients. Relevant practices for offender populations include, but are not limited to, monitoring the quality of offender assessments, case plans, motivational interviewing, and staff interactions. Use of core correctional practice and adherence to the risk-need-responsivity principles is also necessary for influencing outcomes. Therefore, DJCS and BBHHF will adjust performance measures throughout the project. Changes in performance measures will be informed by preliminary monitoring and outcomes results as well as evidence-based practices and research from both the correctional and behavioral health fields.

Program Monitoring

Several types of monitoring activities are necessary to ensure proper implementation. These include: compliance monitoring, fiscal monitoring, and performance monitoring. Compliance monitoring will center on whether grantees adhere to the terms of the grant, program rules, and requirements. This process typically includes examining how closely implementation match the program plan, any deviations to the plan, and how processes can be brought back into compliance. Fiscal monitoring will be completed to assess adherence to budgetary requirements.

Performance monitoring involves a much more intensive process to assess the "quality" of services and treatment integrity as described in the section "Capturing and Reporting Outcomes." This monitoring will include observations, analysis of official data, examination of quality assurance measures and interviews with key stakeholders. The DJCS has systematically developed in conjunction with agency program monitors a correction program assessment inventory which will aide programmatic monitoring visits and analysis. The DJCS will work with the BBHHF to develop joint-methods for informing performance monitoring reviews. At minimum, performance reviews will occur on bi-annual basis. It is anticipated that a formal research evaluation designed to assess the effectiveness of enhanced treatment supervision on offender recidivism will be after the implementation of both phases.

Additionally, a simple summary of outcomes that are developed in coordination with all criminal justice entities statewide will be necessary to help lawmakers and key stakeholders plan for future funding and program support. The State of Vermont in coordination with the Council on State Governments has developed a dashboard[2] that supports this common outcomes framework and is recommended as a cross-system resolution. While the dashboard is not specific to treatment supervision, it will provide summary indicators for the Justice Reinvestment efforts as a whole.

Quality Improvement

The planning team will continue to meet regularly throughout the implementation phases and will ask additional members to join the team as necessary to support and guide system improvements as outlined in the plan recommendations.

[2] http://csgjusticecenter.org/nrrc/posts/vermonts-innovative-system-for-tracking-correctional-data-and-trends/

Timeline for a Phased Approach- Phase One

November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014	June-December 2014
Research of National Best Practice Models for State System Improvements	Focus group with members of target population	Finalize Treatment Supervision Implementation Plan	AFA Technical Assistance Workshop provided by February 14, 2014	AFA's reviewed and awarded by March 24, 2014	Programs and services launch	Programs and services launch	On-going
Planning Meetings with Key Stakeholders		AFA's Developed and Released by January 27, 2014	Monitor and support timely response for all AFA questions during open period	Initial meetings with granted providers to review applications, make final adjustments including budget documents	Monitoring and TA for Community Based Providers	Monitoring and TA for Community Based Providers	On-going
Review of JRA, JRI Policy Recommendations; Current System Documents (Assessments, Data, Schedules, Trainings, Grants)		Initiate scheduling of required training for key partners and providers	Continue scheduling activities for training		JRI Systems Training	JRI Systems Training	Additional training scheduled and provided as needed
Implementation oversight team meetings to guide implementation, troubleshoot and plan for Phase Two initiation	On-going	On-going	On-going	On-going	On-going	On-going	On-going *Estimated Phase Two implementation beginning June/July 2014

Definitions

Assessment- An integrated series of procedures conducted with an individual to provide the basis for the development of an effective, comprehensive and individualized treatment plan.

Behavioral Health System-The service system that offers a continuum of mental health promotion, substance abuse prevention and early intervention programs universally for the general public as well as community based treatment and recovery support services for individuals with mental health and substance use disorders.

Care Coordination- A service which identifies, connects and provides personal and community supports to individuals with a diagnosis of mental illness, substance abuse, or co-occurring disorders, and who are committed, have a history of commitment, or are in danger of commitment to a state psychiatric or private diversion facility and would benefit from discharge planning and/or community based services

Community Corrections- An umbrella term for the supervision of criminal offenders in the community that includes probation, parole, home confinement, and day report centers but excludes institutional corrections. Community corrections is also referred to as community supervision.

Community Support Services- meaningful daily activities such as a job, school, volunteerism, family caretaking or creative endeavors that are usually developed through the participation in social networks; gaining independence, income and resources to support participation in a safe and stable environment. Services include: Social, daily living and cognitive skill building, case management, continuing care, behavior management, supported employment, supportive housing, recovery housing and therapeutic mentoring.

Conditions of Supervision- Stipulations with which persons placed on community supervision must comply or face possible sanctions up to and including revocation of their community supervision. General conditions, such as not engaging in criminal activity, apply to all individuals under supervision. Special conditions, such as participation in drug or mental health treatment, are added on a case-by-case basis.

Correctional Control and Supervision- The monitoring and management practices exercised by corrections agencies over individuals for whom they are responsible both in an institution and the community in order to maintain order and safety and to carry out the mandates of the criminal justice system.

Correctional Rehabilitation- Intervention targeting and individual's attitudes, thinking, behavioral, or other factors relating to their criminal conduct to reduce the likelihood of reoffending.

Criminogenic Needs- The characteristics or circumstances (such as antisocial attitudes, beliefs, thinking patterns and friends) that research has shown are associated with criminal behavioral, but which a person can change. These needs are used to predict risk of criminal

behavior. Because these needs are dynamic, risk of recidivism can be lowered when these needs are effectively addressed.

Criminogenic Risk- The likelihood that individuals will commit a crime or violate the conditions of their supervision. Risk does not refer to the seriousness of a crime.

Criminogenic Risk Factors- Characteristics, experiences and circumstances that are predictive of future criminal activity such as criminal history, antisocial attitudes, thinking, patterns and friends. Through risk assessments the presence of these characteristics can be used to predict the likelihood that the individual will reoffend.

Diversion- Offers persons charged with criminal offenses alternatives to traditional criminal justice proceeding and it permits participation by the accused only on a voluntary basis and it occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt and it results in a dismissal of charges or its equivalent, if the individual successfully completes the diversion process.

Day Report Centers- The West Virginia Community Corrections Act (Chapter 62, Article 11C of the WV State Code) provides a means for communities to develop, establish and maintain community based corrections programs to provide the judicial system with sentencing alternatives for those adult offenders who may require less than institutional custody.

Drug Courts- Intended to address addiction, and thus seek as participants offenders who are both high risk (of future offences) and high need (severity) of substance problems. Key team members include ADC Judge, Prosecutor, Probation Officer and Treatment Professionals

Engagement Services- includes the evaluation and service planning support needed to address the complex needs of individuals and their families impacted by mental disorders, substance use disorders and associated problems with specific services that include: Assessment, Specialized Evaluations including Psychological, Service Planning including Crisis Planning, Consumer and Family Education and Outreach and Advocacy

Evidence-Based Practices- Clinical interventions or administrative practices for which consistent scientific evidence demonstrates that, when they are implemented correctly, expected and desired outcomes are achieved. EBPs stand in contract to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Out-Patient Services- is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual with mental, substance and other disorders aimed to achieve and maintain sobriety, physical and mental health with maximum functional ability with services that may include: Individualized Evidenced-Based Therapies, Group Therapy, Family Therapy, Multi-Family Counseling, and Consultation with Care-Givers

Recovery Residence- Recovery Residences sometimes referred to as Transitional Living, Oxford Houses and Recovery Homes, provide safe housing for individuals, age eighteen (18) and older who are in recovery from substance use and/or substance use and co-occurring mental disorders. These services follow and/or are concurrent with short-term treatment (typically short-term residential) and is intended to assist those individuals for a period of twelve (12) to eighteen (18) months or until it is determined that an individual is able to safely transition into a more integrated environment.

Recovery Support Services- provide opportunities of change whereby individuals work to improve their own health through social inclusion or engaging in supportive recovery communities with services that may include: Peer Support, Recovery Support Coaching, Recovery Support Center Services, Supports for Self Directed Care

Research and Resources

- *Justice Reinvestment in WV, Policy Options for Consideration,* January 2013
- *Adults With Behavioral Health Needs Under Correctional Supervision*, 2012
- *DOC, Supreme Court Website Review*
- *ORAS,* University of Cincinnati
- *Regional Jail Medical Assessment,* 2013
- *DCJCS Data and Maps*
- *Division of Corrections RSAT/ TC Data Brochure*
- *SAMHSA GAINS Center for Behavioral Health and Justice Transformation*
- *SAMHSA, BEHAVIORAL HEALTH AND CRIMINAL JUSTICE: CHALLENGES AND OPPORTUNITIES, Pamela Hyde, July 2012*
- *Interviews with John Lopez-Regional Jails, Mike Lacy, Lora Maynard and Robert McKinley-Adult Drug Courts and Probation, Jennifer Ballard –DOC*
- http://csgjusticecenter.org/nrrc/posts/vermonts-innovative-system-for-tracking-correctional-data-and-trends/