Reducing Recidivism and Promoting Recovery

West Virginia Implementation Plan for Treatment Supervision

January 2014

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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)

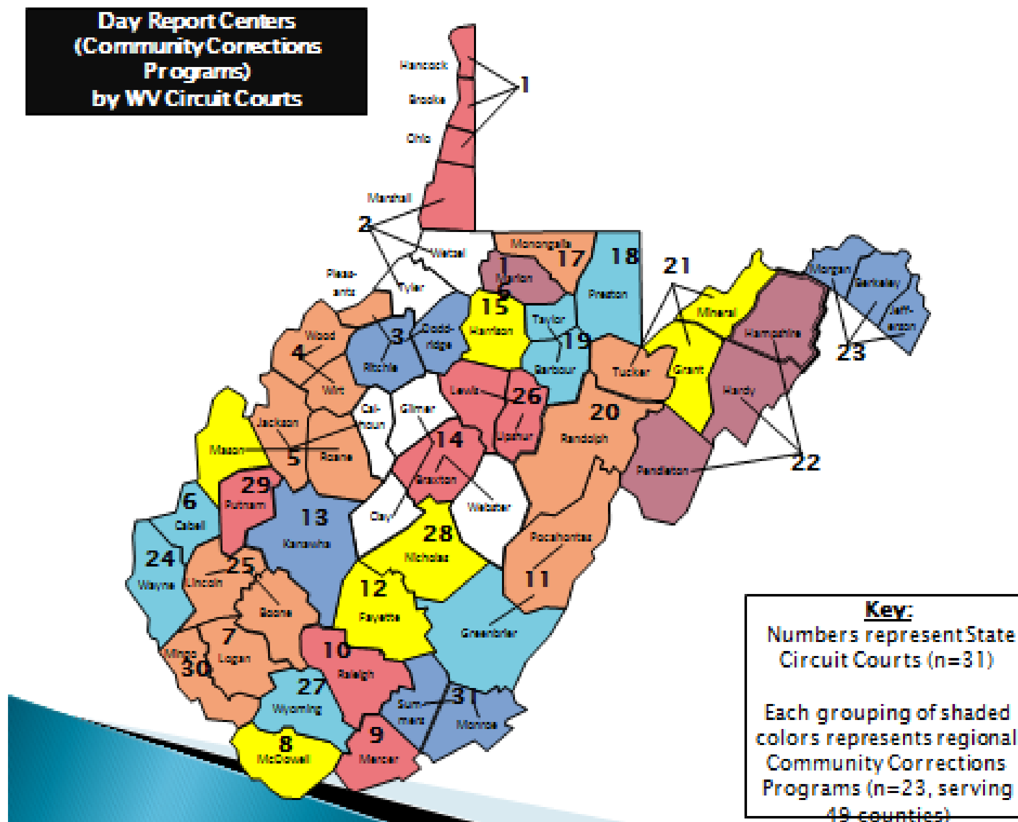
Selection of Phase One & Two Implementation Projects/Locations

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

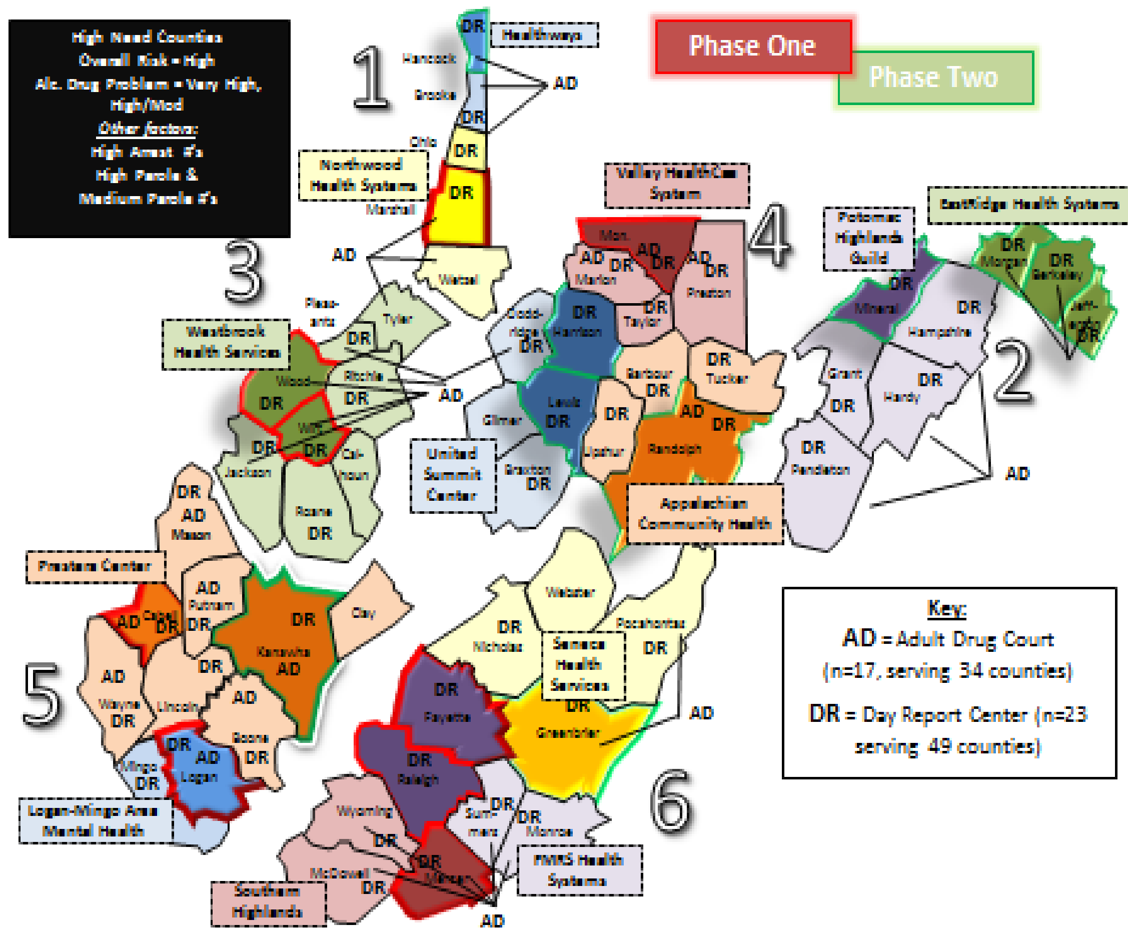


Table 1: Descriptive Characteristics of Selected Project Sites by Implementation Phase

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.

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[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/