Delaware Department of Correction

Professional Services Request for Proposal

Correctional Mental Health Services/Substance Abuse Treatment/DUI Programming and Sex Offender Treatment

Contract No. DOC1202—Mental

Submitted by: Connections Community Support Programs, Inc.
April 27, 2012

TABLE of CONTENTS

Cover	Page 1
Expertise and Reputation of the Applicant	Page 3-6
Certificate of Liability Insurance	Page 7
Accreditations	Page 8 – 10
References and Contracts	Pages 11 – 17
Overview	Pages 18 – 20
Clinical Management Philosophy	Pages 21 – 29
Scope of Services	
Mental Health Services	Pages 30 – 53
Substance Abuse Services	Pages 54 – 107
Sex Offender Programming	Pages 108 – 116
DUI Programming	Pages 117 – 123
Special Populations	Pages 124 – 127
Discharge and Reentry Planning	Pages 128 – 132
Evaluation Plan and Continuous Quality Improvement System	Pages 133 – 144
Coordination Requirements	Pages 145 – 151
Transition Plan	Pages 152 – 156
Human Resources Management and Training	Pages 157 – 168
Work Schedules	Pages 168 – 177
Pricing Structure	Pages 178 – 211
Appendix A – Resumes	
Appendix B – Evaluation Tools	
Appendix C – Letters of Support	

Expertise and Reputation of the Applicant

Connections Community Support Programs, Inc. (Connections) is pleased to present to the Delaware Department of Correction (DDOC) this proposal for a single-vendor solution to provide Mental Health/Substance Abuse /DUI and Sex Offender Treatment services with a wide range of re-entry and transition resources. Connections is a multifaceted organization with a budget of more than $25 million, 55 sites, and 500 employees. In 2011, we served 10,000 unduplicated individuals in Delaware. Connections is well qualified to assist the Delaware Department of Correction (DDOC) to meet the goals of the mental health, substance abuse, DUI, and sex offender Request for Proposals because of

- our long history of providing evidence-based community mental health, substance abuse, DUI treatment, and related services
- our statewide presence and breadth of programming, and
- the many successes we have had in helping people to re-enter the community from incarceration and institutionalization.

Since 1985, Connections Community Support Programs, Inc. (Connections) has worked in partnership with the State of Delaware to develop and operate a comprehensive, community-based system of care that includes housing, healthcare, and employment opportunities for Delawareans who are living with serious mental health, substance use and other co-occurring conditions. Connections is a professional provider of behavioral and primary health care services and has a staff that includes seven physicians four psychiatric nurse practitioners, 30 nurses, and almost 100 master's level and/or licensed/certified social workers and counselors. We currently provide clinic-based, intensive case management, and residential treatment services to thousands of Delawareans in a wide variety of settings, including the Probation and Parole field offices in Kent and Sussex Counties, at Cherry Lane for special populations, and at Youth Rehabilitative Services inside Ferris and Cleve White schools. For the last three years we have been providing prisoner reentry services to both male and female offenders as part of a nationwide network of grantees who were awarded grants under the Prisoner Reentry Initiative. As such, we have many employees who have DDOC clearance and who have participated in the I-ADAPT process. In addition, we are currently a key partner in helping the Delaware Division of Substance Abuse and Mental Health to implement Delaware's U.S. Department of Justice settlement regarding adults with severe and persistent mental illness. Our experience with this process, including meetings with the court-appointed monitor, will also be valuable to DDOC.

Experience

Connections is the largest public provider of mental health and substance abuse services and related supports including affordable housing and employment services in Delaware. For more than 25 years, Connections has reached out to people with extremely low incomes, struggling with substance use and mental health conditions and other disabilities and disadvantages, to help them find needed community-based supportive services, including healthcare, housing, and employment. We bring to this RFP our solid grounding as a community behavioral health provider throughout Delaware as well as some unique assets—almost 600 units of affordable housing; documented experience helping hundreds of previously institutionalized and/or incarcerated individuals to obtain needed public benefits; and an economic development component that literally *creates* new jobs for people with barriers to employment through a robust social enterprise program.

Since 2001, Connections has provided clinic-based mental health and substance abuse treatment and assessment services for individuals referred by the courts and the DOC. Since 2002, we have provided mental health, substance abuse and gambling assessment, education and treatment services directly to persons under the supervision of the Delaware DOC in its Probation and Parole Field Offices. From February 2009 until last month, we were the recipient of a U.S. Department of Labor Re-entry grant, working in conjunction with the Delaware Criminal Justice Council and the Delaware Center for Justice, to provide re-entry services in four designated ZIP codes in Wilmington and New Castle where the majority of prisoners returned from incarceration. In 2011, Connections provided services to more than 5,000 individuals who were adjudicated and mandated or referred to treatment by the courts, the DOC Office of Probation and Parole, I-ADAPT or DCJ re-entry case managers.

In 2008 a U.S. DOJ PRI grant was awarded to the Delaware Criminal Justice Council and in 2009, a corollary U.S. DOL grant was awarded to Connections to provide employment services along with access to housing, substance abuse treatment and mentoring for offenders reentering to designated ZIP codes. As the DOL grant recipient, Connections worked with the Delaware Center for Justice, a PRI subgrantee, to carry out a coordinated reentry approach to reduce recidivism and improve outcomes. Between February 2009 and February 2012, Connections enrolled 344 reentering prisoners in the program, placing 268 (78%) in employment, post-secondary education, and/or advanced skills training (including vocational/occupational skills training and obtaining a certificate). Of those enrolled, 72% were retained in the program with a rate of recidivism of 21%--23% below the DOL-stated recidivism goal of 44%. The rate of participation among enrollees in our program was 94%, exceeding the DOL-stated goal for participation by 34%. Also in 2009, Connections used two ARRA grants to expand and enhance its extensive network of housing, substance abuse, mental health and primary medical services to specifically serve reentering offenders. Between January 1 and December 31, 2011, Connections provided 89,953 visits to 8,202 unduplicated persons in walk-in clinics, prison reentry programs, and at the locations of two federally qualified health centers. During the period from July 1, 2010 through June 30, 2011, we placed 558 people in competitive employment.

The Delaware Court of Common Pleas has both Mental Health and Drug Diversion Courts and the Delaware Superior Court has a Mental Health Court, which expedite cases related to behavioral health issues through the Treatment Access Center (TASC). TASC performs initial assessments, provides treatment recommendations and works with treatment providers and probation officers to ensure effective and timely service delivery and continuity of services. Connections receives a large number of referrals from TASC for the full range of substance abuse and mental health services. In addition, Connections has a presence in the Mental Health Court in Superior Court and the Mental Health and Drug Diversion Courts in the Court of Common Pleas. Connections' case managers and clinicians attend all sessions of the Superior Court Mental Health Court, accepting and coordinating referrals on the spot. For the Court of Common Pleas, in New Castle and Kent Counties, we attend when requested or when an ongoing service recipient has a scheduled case, and we provide reports and feedback to the judges.

Since 1993, Connections has offered integrated mental health and addictions treatment services in residential and clinic settings throughout Delaware. These services include treatment for DUI offenders, medication assisted treatment and opiate replacement therapy, services for reentering prisoners and juvenile offenders, and family reunification and strengthening. Today, we operate clinics in Brandywine Hundred, west center city Wilmington, Newark, Smyrna, Dover, Georgetown, Millsboro, and Seaford, inside the Federally Qualified Health Centers operated by Westside Health Family Healthcare and La Red, and in the family practice offices of St. Francis Hospital. Connections was the first Delaware provider of integrated co-occurring treatment services, when we were the successful bidder for a Center for Substance Abuse Treatment (CSAT) Capacity Expansion grant in 1993 to provide both residential and intensive case management services that concurrently address substance use and mental health conditions. That program, known as Cornerstone, exists today, and is frequently recommended by TASC and sentencing judges. In 2001, we added a transitional housing program, known as Chance House, to provide post-detoxification services for individuals awaiting residential treatment. For most of the residents, Chance House is their only hope to make it to residential treatment. With only a few days of sobriety and the clothes on their backs, most people come to Chance House in an acute state of crisis. Amazingly, despite this difficult start on the journey to recovery, more than 90% of the more than 1,000 individuals who have been served there over the past ten years have achieved a positive outcome.

In 2002, we entered into a contract with Division of Substance Abuse and Mental Health and the DDOC to provide substance abuse and mental health assessments to individuals on probation in the Probation and Parole field offices in Kent and Sussex County. Over the past year, we have expanded those services to include individuals with mental health problems who are reporting to the Probation and Parole office at Cherry Lane in New Castle County. The intent of these services is to determine the need for treatment among offenders--the large majority of whom commit crimes that are related to untreated or inadequately treated behavioral health conditions--and to refer them to the appropriate level of service to mitigate criminogenic factors that lead to recidivism. We have been a DUI treatment provider since 2009, serving 785 individuals in New Castle and Kent Counties in 2011 alone.

Connections has a long history of providing true 24/7 services, 365 days per week in Delaware, regardless of weather or other adverse conditions. We have demonstrated our ability to maintain staffing around-the-clock and to carry out disaster plans when needed in our group homes, affordable housing programs, licensed substance abuse residential treatment center, and in our Homeless Café. We also have a long history of serving everyone who is referred to us regardless of their condition or resources. We are in a strong position to provide services statewide. Through our housing, employment and treatment programs, we served more than 10,000 unduplicated individuals in 2011 in 55 locations throughout Delaware in all three counties, where we have significant infrastructure. In addition to our New Castle County presence, we have fully operational program sites in Smyrna, Dover, Georgetown, Seaford and Millsboro where we can make use of both human and capital resources to achieve the goals of the RFP. Connections has the experience, the infrastructure and the management staff needed to make the proposed project a success.

Licensure and Insurance: Connections is a nonprofit 501 (c) 3 organization in Delaware, and as such, does not require a Delaware business license. Per the Department of Finance Division of Revenue website:

> 'Any corporation granted an exemption by the IRS as a non-profit organization under Section 501(c) is exempt from Delaware Corporate Income Tax.
> Additionally, Non-Profit Corporations are exempt from obtaining a Delaware business license and paying the accompanying gross receipts tax on the sales of most goods and services. (Some services such as leasing tangible personal property or providing accommodations are taxable regardless of the entity providing such services.)
> Non-profits Corporations in Delaware are required 1) to register with The Division of Revenue and withhold Delaware State income taxes on employees performing services within Delaware, 2) to register with the Delaware Department of Labor and 3) if the non-profits activities are conducted in Delaware, to file a copy of Federal Form 990 PF with the Delaware Attorney General.'

Connections is licensed by the Delaware Division of Substance Abuse and Mental Health Services to provide mental health and substance abuse treatment services, including DUI and Medication Assisted Treatment, in Wilmington, Newark, Smyrna, Dover and Millsboro. Individuals who are hired to carry out the services outlined in this proposal will be licensed in or certified in Delaware as required, will complete all required background checks, and will have DOC clearance. Connections carries an umbrella liability policy, including professional liability insurance, with an aggregate limit of $5 million. The currently in-force certificate is attached on the following page.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/1/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur Hall Insurance
7450 Lancaster Pike, Suite 201
PO Box 1676
Hockessin DE 19707

CONTACT NAME: Chuck Panetski, CPCU, ARM
PHONE (A/C, No, Ext): (302) 658-0100 FAX (A/C, No): (302) 235-2975
E-MAIL ADDRESS: cpanetski@arthurhall.com
PRODUCER CUSTOMER ID #: 00018238

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Philadelphia Indemnity	18058
INSURER B: Liberty Mutual Insurance	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Connections CSP, Inc.
500 West 10th Street
Wilmington DE 19801

COVERAGES CERTIFICATE NUMBER: CL113105151 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			PHPK690669	3/1/2011	3/1/2012	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 300,000 $ 15,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			PHPK687155	3/1/2011	3/1/2012	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) PIP-Extended Uninsured motorist BI-single	$ 1,000,000 $ $ $ $ 270,000 $ 1,000,000
A	X UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DEDUCTIBLE X RETENTION $ 10,000			PHUB337773	3/1/2011	3/1/2012	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		TBD	6/1/2011	6/1/2012	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

Proof of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

G D. Burcham, CIC, CR

© 1988-2009 ACORD CORPORATION. All rights reserved.
The ACORD name and logo are registered marks of ACORD

Accreditation

Connections has been accredited continuously by CARF…the Rehabilitation Accreditation Commission since 1999. We were also continuously accredited by the Joint Commission (JCAHO) from 1999 until 2009, when, because we could not afford the cost of maintaining two accreditations in the weakening economy, we voluntarily elected not to seek re-accreditation. If we are the successful bidder for this contract, we will seek and obtain NCCHC/ACA accreditation for every facility in which we provide services for DOC. Because of our experience obtaining and maintaining accreditation, we believe that we will be able to achieve this milestone rapidly using the NCCHC Standards for Mental Health Services in Correctional Facilities. Table 1 below depicts our currently accredited facilities.

Table 1: Accreditation of Connections Facilities

Name of Facility	Type of Facility	Current Accreditation/Licensure	Other
Cornerstone Residential Treatment Program Governor Bacon Health Center, Delaware City	Co-occurring mental health and substance abuse treatment facility (15 beds)	Accredited by CARF since 1999; full license as substance abuse facility from DSAMH since 1994.	Was accredited by JCAHO from 1999 to 2009 when we voluntarily relinquished our accreditation for financial reasons.
Gordy Place Group Home 204 Gordy Place, New Castle	Mental health group home (opened in 2008; 5 beds)	Accredited by CARF since 2010; full license as a mental health group home from DLTCRP since 2008; certified by DSAMH since 2008	N/A
Cardinal Avenue Group Home 722 Cardinal Avenue, Bear	Mental health group home (opened in 2009; 5 beds)	Accredited by CARF since 2010; full license as a mental health group home from DLTCRP since 2009; cert'd DSAMH since 2009	N/A
Clint Walker Group Home 676 Black Diamond Road, Smyrna	Mental health group home (opened in 1986; 10 beds; initial opening predates licensure laws)	Accredited by CARF since 1999; full license and certification by DHSS as a mental health group home form DLTCRP since 1991	Was accredited by JCAHO from 1999 to 2009 when we voluntarily relinquished our accreditation for financial reasons.
Camden Group Home 124 West Street, Camden	Mental health group home (opened in 1986; 10 beds; initial opening predates licensure laws)	Accredited by CARF since 1999; full license and certification by DHSS as a mental health group home form DLTCRP since 1991	Was accredited by JCAHO from 1999 to 2009 when we voluntarily relinquished our accreditation for financial reasons.
Still Road Group Home 2197 Still Road, Camden	Mental health group home (opened in 1986; 10 beds; initial opening predates licensure laws)	Accredited by CARF since 1999; full license and certification by DHSS as a mental health group home form DLTCRP since 1991	Was accredited by JCAHO from 1999 to 2009 when we voluntarily relinquished our accreditation for financial reasons.

Name of Facility	Type of Facility	Current Accreditation/Licensure	Other
Roxana Group Home 35906 Zion Church Road Frankford, DE	Mental health group home (opened in 1986; 10 beds; initial opening predates licensure laws)	Accredited by CARF since 1999; full license and certification by DHSS as a mental health group home form DLTCRP since 1991	Was accredited by JCAHO from 1999 to 2009 when we voluntarily relinquished our accreditation for financial reasons.
Blackbird Landing Group Home 994 Blackbird Landing Road Townsend	Mental health group home (opened in 2001; 8 beds)	Accredited by CARF since 2003; full license and certification as a mental health group home by DHSS since 2001	Was accredited by JCAHO from 2002 to 2009 when we voluntarily relinquished our accreditation for financial reasons
Dover Clinic 698 Bay Road Dover	Outpatient substance abuse and mental health; medication assisted treatment; DUI treatment; intensive outpatient treatment (opened in 2001)	Accredited by CARF since 2003; full license as a substance abuse treatment facility by DSAMH since 2001.	Was accredited by JCAHO from 2002 to 2009 when we voluntarily relinquished our accreditation for financial reasons
Smyrna Clinic 222 N. DuPont Highway Smyrna	Outpatient substance abuse and mental health; medication assisted treatment; DUI treatment; intensive outpatient treatment (opened in 2001)	Accredited by CARF since 2003; full license as a substance abuse treatment facility by DSAMH since 2001.	Was accredited by JCAHO from 2002 to 2009 when we voluntarily relinquished our accreditation for financial reasons
Newark Clinic 1423 Capitol Trail 3304-3305 Drummond Plaza Newark	Outpatient substance abuse and mental health; medication assisted treatment; DUI treatment; intensive outpatient treatment (opened in 2001)	Accredited by CARF since 2003; full license as a substance abuse treatment facility by DSAMH since 2001.	Was accredited by JCAHO from 2002 to 2009 when we voluntarily relinquished our accreditation for financial reasons
Millsboro Clinic 24832 John J. Williams Highway Millsboro	Outpatient substance abuse and mental health; medication assisted treatment; (opened in 2011)	Licensed by DSAMH since 2011; CARF accreditation pending	N/A
Wilmington Clinic 2205 Silverside Road 503 West Ninth Street Wilmington	Outpatient substance abuse and mental health and DUI treatment (opened in 2009)	Accredited by CARF since 2010; full license as a substance abuse facility by DSAMH since 2010	N/A
Chris Sturmfels Youth Center 800 Bellevue Road Wilmington	Residential Alternative to Detention for pre-adjudicated youth (10 beds, opened in 2011)	Licensed by DSCYF since 2011; CARF accreditation pending	N/A

Name of Facility	Type of Facility	Current Accreditation/Licensure	Other
Hancock Avenue Community Home 1430 S. Hancock Dover	Licensed community living arrangement for adults with cognitive disabilities (3 beds; opened in 2012)	Licensed by DHSS in 2012; CARF accreditation pending	N/A

Connections has had no fines for non-performance of duties under any contract; we have lost no contracts as the result of fines or damages; and we have no facilities operating on probation.

Financial Resources

Connections is one of the largest nonprofit organizations in Delaware with an operating budget in SFY 2012 of almost $28 million and net assets of more than $8 million. We have a long-standing and solid banking relationship with WSFS, enabling us to obtain access to both operating and capital resources rapidly. We currently have contracts with the Delaware Departments of Health and Social Services; Labor; Children, Youth and Their Families; State Housing Authority; and Homeland Security worth more than $20 million. We are the recipient or sub-recipient of 17 federal grants including 15 from the U.S. Department of Housing and Urban Development and two from the Substance Abuse and Mental Health Services Administration. During 2010 and 2011, we were the recipient of four American Recovery and Reinvestment Act (ARRA) grants of almost $2 million, which we successfully completed. We own or operate almost 600 units of affordable housing. We have an A-133 single audit annually and have not had a deficit, finding or questioned cost in 15 years. A copy of our FY 2011 single audit is included with this bid.

Reputation

Connections was established in 1985 as a subsidiary of what is now known as Ingleside Homes, to provide community-based alternatives for older adults who had been institutionalized at the Delaware State Hospital (now DPC). In 1990, Ingleside Homes, Inc., as part of a merger negotiation, decided to divest Connections, spinning it off as a separate corporation. In 1991, Connections Community Support Programs, Inc. incorporated as a not-for-profit company in Delaware with its own 501 (c) 3 ruling. During the past 20 years, Connections has steadily grown in terms of programs, budget, and staff. We have focused 100% of our energy in Delaware, developing strong grass roots affiliations and services in each community where we operate.

Connections has been on the Diamond State Health Plan Behavioral Health panels since the Delaware Medicaid Managed Care waiver was implemented in 1996. Since 1990 Connections has maintained full licensure/certification of every program to which these pertain, and currently holds 13 such licenses/certifications. Connections' efforts to deliver healthcare, housing, and employment services have been recognized by several outside organizations. In 2002, we were recognized by the National Association of Case Management as the Case Management Organization of the Year, and in 2006 won the Lilly Reintegration Award for excellence in housing. Also in 2006, we were the inaugural winner of the Bank of America Neighborhood Builders Award in the Delaware market, and we continue to bring philanthropic resources to the table to support and enhance the work we do in partnership with the State of Delaware.

References

Judge Jan Jurden
Superior Court
Telephone (302) 255-0665
(302) 255-2273 (fax)
Jan.Jurden@state.de.us

Andrea Guest
Director Division of Vocational Rehabilitation
4425 N. Market Street
PO Box 9969
Wilmington, DE 19809-0969
(302) 761-82750
Andrea.Guest@state.de.us

Charles Madden
CEO
Hope Commission
625 N. Orange St
Phone: 302-573-3735
cmadden@uwde.org

Laurie Pezick
Supervisor, Office of Probation and Parole
302-498-5323
Laurie.Pezick@state.de.us

Steven Dettwyler, PhD
Director, Community Mental Health and Addictions Services
Division of Substance Abuse and Mental Health
1901 North DuPont Highway
New Castle, DE 19720
302-255-9432
Steven.Dettwyler@state.de.us

Patricia Wright
Director of Collaborative Programs
Delaware Physicians Care Inc., an Aetna Co.
302-545-5889
Wrightp@aetna.com

Lolita A. Lopez, FACHE
President & CEO
Westside Family Healthcare
Phone: 302.656.8292
lopezjesse@westsidehealth.org

Table 2: Connections State of Delaware Contracts 2010, 2011, 2012

FY 2012

State Department/Division	Contact Person	Period of Performance	Amount
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011273 Supervised apartments 7/1/11 to 6/30/12	305,855
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041240 AOD Day Treatment in Kent County 7/1/11 to 6/30/12	218,665
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041260 Substance Abuse Assessments 7/1/11 to 6/30/12	233,759
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021280 CCCP 7/1/11 to 6/30/12	3,876,431
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021230 PATH 7/1/11 to 6/30/12	437,319
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011166 Mental Health Group Home 7/1/11 to 6/30/12	470,492
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011133 Mental Health Group Home 7/1/11 to 6/30/12	576,828
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011132 Mental Health Group Home 7/1/11 to 6/30/12	294,850
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011131 Mental Health Group Home 7/1/11 to 6/30/12	324,927
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021115 Mental Health Group Home 7/1/11 to 6/30/12	372,000
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041203 AOD Transitional House 7/1/11 to 6/30/12	180,642
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041288 AOD Outpatient 7/1/11 to 6/30/12	433,909
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011236 Dual Dx Residential 7/1/11 to 6/30/12	758,363
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021248 Services for deaf and hearing impaired services 7/1/11 to 6/30/12	10,000

DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011134 Group Home 7/1/11 to 6/30/12	357,670
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720	011135 Group Home 7/1/11 to 6/30/12	165,592
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720	010913 HUD 4 Trans. Housing 11/1/010 to 10/31/11	1,343,073
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	041213 COSIG Psychiatry Services 7/1/11 to 9/30/11	$24,209
DOL/DVR	Andrea Guest 4425 N. Market Street Wilmington, DE 19809 761-8275	Purchase of Service Agreements Job Placement/Training 10/1/11 to 9/30/13	No specified amount. Agreement is performance based.
Homeland Security/OHS	Lisa Shaw Office of Highway Safety PO Box 1321 Dover, DE 19903 302-744-2746	10-0140-02 DUI Treatment Services 7/1/09 to 6/30/12	No specified amount. Agreement is performance based.
DHSS/DDDS	Lois Brown 540 S. DuPont Hwy Dover, DE 19901 302-744-9608	13693-02-01 Residential Services 7/1/11 to 6/30/12	2,092,456
DHSS/DDDS	Lois Brown 540 S. DuPont Hwy Dover, DE 19901 302-744-9608	13974-02-01 Day Services 7/1/11 to 6/30/12	213,280
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	DE-HDF-326 Housing vouchers 1/1/08 to 12/31/2011	370,500
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	DE-HDF-341 Housing vouchers 1/1/09 to 12/31/2011	430,000
DHSS/DMMA	Greg Roane 1901 N. DuPont Highway New Castle, DE 19720 302-255-9530	Assessment of Residents in Public Institutions 3/1/10 to 2/28/11	100,000
DHSS/DSCC	Robert Broesler 1901 N. DuPont Highway New Castle, DE 19720 302-255-9876	35-12-30-12-OCS-10 Homeless Outreach 12/1/11 to 6/30/12	45,000
DSCYF/YRS	Lauren Suarez 1825 Faulkland Road Wilmington, DE 19805 302-633-2706	YRS(CCSP-NSD)FY11-11983 Residential Alternatives to Detention 7/1/2011 to 6/30/2012	503,928
DSCYF/DPBH	Ryan Bolles 1825 Faulkland Road Wilmington, DE 19805 302-633-2701	DPBHS(CCS-FPFS)FY11-11725 Promoting Safe and Stable Families 7/1/2011 to 6/30/2012	81,600
DSCYF/DMMS	Theresa Senio 1825 Faulkland Road Wilmington, DE 19805 3002-633-2535	DMSS(CCPS-EDU)FY11-117311 Employment Services	80,000

FY 2011

State Department/Division	Contact Person	Period of Performance	Amount
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011173 Supervised apartments 7/1/10 to 6/30/11	290,109
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041140 AOD Day Treatment in Kent County 7/1/10 to 6/30/11	216,482
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041160 Substance Abuse Assessments 7/1/10 to 6/30/11	244,883
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#020980 CCCP 7/1/10 to 6/30/11	3,298,448
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021130 PATH 7/1/10 to 6/30/11	541,292
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011166 Mental Health Group Home 7/1/10 to 6/30/11	323,057
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011133 Mental Health Group Home 7/1/10 to 6/30/11	504,341
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011132 Mental Health Group Home 7/1/10 to 6/30/11	308,594
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011131 Mental Health Group Home 7/1/10 to 6/30/110	257,847
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021115 Mental Health Group Home 7/1/10 to 6/30/11	363,652
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041113 AOD Transitional House 7/1/10 to 6/30/11	177,100
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#040988 AOD Outpatient 7/1/10 to 6/30/11	430,057
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720	#011136 Dual Dx Residential 7/1/10 to 6/30/11	731,826
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021148 Services for deaf and hearing impaired services 7/1/10 to 6/30/11	10,000
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011110 Supported Employment Services 7/1/10 to 6/30/11	66,000

DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011134 Group Home 7/1/10 to 6/30/11	440,779
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011135 Group Home 7/1/10 to 6/30/11	182,277
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	010913 HUD 4 Transitional Housing 11/1/08 to 10/31/10	1,308,401
DOL/DVR	Andrea Guest 4425 N. Market Street Wilmington, DE 19809 761-8275	Purchase of Service Agreements Job Placement Job Training 10/1/09 to 9/30/11	No specified amount. Agreement is performance based.
Homeland Security/OHS	Lisa Shaw Office of Highway Safety PO Box 1321 Dover, DE 19903 302-744-2746	10-0140-02 DUI Treatment Services 7/1/09 to 6/30/12	No specified amount. Agreement is performance based.
DHSS/DDDS	Lois Brown 540 S. DuPont Hwy Dover, DE 19901 302-744-9608	13693-00-00 Residential Services 7/1/10 to 6/30/11	1,006,524
DHSS/DDDS	Lois Brown 540 S. DuPont Hwy Dover, DE 19901 302-744-9608	13974-00-00 Day Services 7/1/10 to 6/30/11	173,108
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	DE-HDF-326 Housing vouchers 1/1/08 to 12/31/2010	370,500
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	DE-HDF-341 Housing vouchers 1/1/09 to 12/31/2011	430,000
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	TANF #02-09 Financial Assistance Grants 1/1/09 to 9/30/10	1,000,000
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	HPRP DSHA #02-09 Financial Assistance Grants 12/1/09 to 9/30/12	207,430

FY 2010

State Department/Division	Contact Person	Period of Performance	Amount
DHSS/DSAMH	Steven Dettwyler 1901 DuPont Highway, New Castle, DE 19720 255-9432	#021016 Supervised apartments 7/1/09 to 6/30/10	339,218
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011073 Supervised apartments 7/1/09 to 6/30/10	290,109

DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#040940 AOD Day Treatment in Kent County 7/1/08 to 6/30/10	199,030
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#040940 Substance Abuse Assessments 7/1/09 to 6/30/10	234,136
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#020980 CCCP 7/1/08 to 6/30/10	1,841,724
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#020930 PATH 7/1/09 to 6/30/10	541,292
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011066 Mental Health Group Home 7/1/09 to 6/30/10	323,057
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#010933 Mental Health Group Home 7/1/09 to 6/30/10	504,341
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011032 Mental Health Group Home 7/1/09 to 6/30/10	308,594
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011031 Mental Health Group Home 7/1/09 to 6/30/10	257,847
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#021015 Mental Health Group Home 7/1/09 to 6/30/10	363,652
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#010967 Supervised Apartments 7/1/09 to 6/30/10	296,989
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#041003 AOD Transitional House 7/1/09 to 6/30/10	237,653
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#040988 AOD Outpatient 7/1/08 to 6/30/10	825,493
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011036 Dual Dx Residential 7/1/06 to 6/30/07	742,826
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#011062 Supervised Apartments 7/1/09 to 6/30/10	342,066
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	#020948 Services for deaf and hearing impaired services 7/1/09 to 6/30/10	10,000

DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011004 Supervised Apartments 7/1/09 to 6/30/10	625,255
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011003 Supervised Apartments 7/1/09 to 6/30/10	407,679
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011010 Supported Employment Services 7/1/09 to 6/30/10	125,000
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011034 Group Home 7/1/09 to 6/30/10	440,779
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	011035 Group Home 7/1/09 to 6/30/10	182,277
DHSS/DSAMH	Steven Dettwyler, 1901 North DuPont Highway, New Castle, DE 19720 255-9432	010913 HUD 4 Transitional Housing 11/1/08 to 10/31/10	1,308,401
DOL/DVR	Andrea Guest 4425 N. Market Street Wilmington, DE 19809 761-8275	Purchase of Service Agreements Job Placement Job Training 10/1/09 to 9/30/11	No specified amount. Agreement is performance based.
Homeland Security/OHS	Lisa Shaw Office of Highway Safety PO Box 1321 Dover, DE 19903 302-744-2746	10-0140-02 DUI Treatment Services 7/1/09 to 6/30/12	No specified amount. Agreement is performance based.
DHSS/DDDS	Lois Brown 540 S. DuPont Hwy Dover, DE 19901 302-744-9608	13693-00-00 Residential Services 7/1/09 to 6/30/10	No specified amount. Agreement is client based.
DHSS/DDDS	Lois Brown 540 S. DuPont Hwy Dover, DE 19901 302-744-9608	13974-00-00 Day Services 7/1/09 to 6/30/10	No specified amount. Agreement is client based.
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	DE-HDF-326 Housing vouchers 1/1/08 to 12/31/2010	370,500
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	DE-HDF-341 Housing vouchers 1/1/09 to 12/31/2011	430,000
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	TANF #02-09 Financial Assistance Grants 1/1/09 to 9/30/10	1,000,000
DSHA	Kim Brokenbrough 18 the Green Dover, DE 19901 302-739-4263	HPRP DSHA #02-09 Financial Assistance Grants 12/1/09 to 9/30/12	207,430

Overview

Since 1982, Delaware has experienced a 100% increase in the number of sentenced persons who are incarcerated (not including those who are held in the Delaware prisons as pre-trial detainees). This is consistent with literature citing dramatic escalation in the nationwide number of persons incarcerated over the last 30 years. Tougher sentencing and 'zero tolerance' policies related to drug offenses have resulted in large numbers of probationers being incarcerated for violation of probation offenses. A disproportionate number of persons incarcerated as a result of these policies are people of color (Sorenson, et.al., 2003) who have more mental and physical health problems than the general population (Patersilia, 2001). Studies consistently find that 60% to 80% of inmates report substance use at the time of arrest (Conklin et. al., 2000; Langan & Pelissier, 2002). In Delaware, one out of every twenty-two (1 of 22) citizens is a client of the DDOC in its unified system with no local jails and virtually no parole. As in the rest of the United States, the 28,000 individuals who enter the Delaware correctional system each year are disproportionately Black (57% compared to 20% of the general population) and male (93% of all detainees).

Since 2000, arrests for all offenses in Delaware have steadily climbed (Delaware Statistical Analysis Center, February 2009). Arrests for drug offenses increased most significantly--125% between 2000 and 2007, as compared to 57% for all adult arrests. Changes in sentencing practices in Delaware have had a significant impact on the size of the prison population and the absolute cost of incarceration. Since 1982, Delaware has instituted mandatory minimum sentences for drug offenses and essentially abolished parole. On 12/31/82, there were 1,747 sentenced inmates in Delaware's highest levels of incarceration (out of a total population of 594,338) compared to 5,426 sentenced inmates on 12/31/09 (out of a general population of 875,953), a more than 100% increase in the number of persons sentenced and incarcerated over a period when the general population grew by only 47% (DelSAC).

In 1991, Regier et.al. reported that 82.2% of prison inmates used alcohol or other drugs and/or had other mental disorders (Regier et al., 1990), more than twice the rate found in the general population outside of corrections or other institutional settings. Fifty-six (56)% of the inmate population was found to have an alcohol disorder and 53.7% had another drug disorder. Other mental disorders were found in 55.7% of the prisoners in this study. In the same study, approximately 90% of the prisoners with schizophrenia, bipolar disorder, and antisocial personality disorder were also diagnosed with one or more addictive disorders. Other studies have demonstrated that among those inmates with a severe mental illness, as many as 72% (Abram & Teplin, 1991) suffer from more than one disorder (e.g., alcohol and other drug use). This is borne out in Delaware, where 1,215 level 5 inmates and 265 level 4 inmates are receiving mental health services.

Preexisting mental illnesses may be exacerbated by arrest and detention. The conditions of incarceration, including prolonged idleness, the threat of violence, and social isolation as well as feelings of hopelessness, and helplessness may contribute to psychological disorders including suicidal ideation. In addition to psychiatric disorders, it has also been estimated that between 2 and 10% of the incarcerated population are people with mental retardation (Anno, 1991). The President's Committee on Mental Retardation estimates that there are approximately 14,000

inmates with mental retardation in federal and state prisons nationwide. In addition, societal conditions, including the reduction in the number of beds at the Delaware Psychiatric Center and a relatively large homeless population are expected to lead to additional incarceration among individuals with serious mental health problems.

The need to reduce recidivism and address the issues that lead to probation violations and new crimes among inmates returning from incarceration to the community was identified as a critical issue by the Delaware Justice Reinvestment Task Force in its report released on April 4, 2012. The majority of recidivism in Delaware is related to violation of probation, often for testing positive for substance use. In *Reentry for Safer Communities* (2008), the Bureau of Justice Assistance (BJA) describes effective reentry practices that reduce public safety risk; show cost savings; improve quality of life and treatment for reentering offenders suffering from substance use and mental health conditions; and promote safe correctional facilities. In a study of six model programs conducted by the BJA, promising practices in local transition planning were identified: 1) collaboration between organizations and agencies, including corrections, treatment providers and faith-based providers; 2) assistance to access benefits such as SSI/SSDI, Medicare and Medicaid; 3) components to address cultural and gender needs; 4) community linkages to ensure housing, family reunification, employment and transportation. With good planning and service delivery, these practices can be initiated inside the level 4 and 5 facilities while individuals are incarcerated and then can carry over into the community on release.

Understanding the Challenges of Prisoner Reentry: Research Findings from the Urban Institute Prisoner Reentry Portfolio (2006) describes the impact of skyrocketing incarceration rates. Large numbers of returning inmates negatively affect the public health and safety, family, economic and community well-being of the neighborhoods to which they return. The research cites a prevalence of serious mental health and substance use conditions and infectious disease among reentering prisoners far exceeding the rates in the general population. The Urban Institute's *Returning Home* study found that reentering offenders consistently reported substance use in the six months before entering prison. Reentering prisoners who engaged in substance use after release had high rates of recidivism, while those who received in-prison treatment together with community-based aftercare had higher rates of reentry success.

In a 2005 Policy Brief on Offender Reentry, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) cited untreated substance use conditions, combined with lack of education and job skills, as reasons why 66% of reentering offenders recidivate within three years. Among state prison populations, 80% of inmates report histories of substance abuse, and 55% report using substances at the time of the crime for which they were incarcerated. At the same time, there is significant evidence that prison-based treatment can be effective: Among those who receive substance abuse treatment while incarcerated, NASADAD reports a recidivism rate of 27%, compared to 75% for those who do not receive treatment. These findings certainly suggest that good behavioral health treatment while incarcerated, coupled with adequate reentry and aftercare services to preserve the gains made in treatment, could positively impact the rate of recidivism among Delaware's offender population.

There is also empirical evidence that some services and approaches to providing mental health, substance abuse, and sex offender treatment--both inside and outside of corrections facilities--

are more effective that others in reducing the criminal behavior of at least some offenders. The correctional treatment programs that have been demonstrated to reduce recidivism follow some basic principles:

- They are carefully designed to target the specific characteristics and problems of offenders that can be changed as well as those factors that predict the future criminal activities such as antisocial attitudes and behavior, drug use, and response to anger;
- They are implemented in a way that is appropriate for the participating offenders, use therapeutic techniques that have been proven to work, and require offenders to spend a reasonable length of time in the program, delivering a sufficient 'dosage' to impact the changes desired;
- They focus the most resources and intensive programming on offenders who are at the highest risk of recidivism;
- They use cognitive and behavioral treatment methods based on theoretical models such as social learning or cognitive-behavioral theories of change that emphasize positive reinforcement contingencies for prosocial behavior;
- They are individualized as much as possible (Andrews et.al., 1990; Lipsey, 1992).

It is Connections' intention in this proposal to describe evidence-based practices that will reduce recidivism among the inmates who are at high and medium risk to re-offend.

Clinical Management Philosophy

Abstract
Connections is proposing a comprehensive program to deliver mental health, substance abuse, DUI, and sex offender treatment for the Delaware Department of Correction on-site in all DOC facilities. Much recent correctional programming has been based on criminogenic risks and needs that are believed to be directly related to recidivism, specifically the attitudes and associations of offenders. In an environment of scarce resources, the evidence has led most researchers to the conclusion that interventions should be concentrated on those offenders who represent the greatest risk for re-offending (Andrews, Bonta, and Hoge 1990), and on changing the thought processes and personal characteristics most likely to lead to re-offending. Research suggests that there are evidence-based practices in the delivery of all of the services required under the RFP, which, when delivered with integrity and fidelity to the evidence-based practice, produce positive results including a reduction in recidivism. The clinical approach that has been shown to best reduce recidivism is the evidence-based practice (EBP) of Cognitive Behavioral Therapy (CBT), specifically as it has been applied in programs directed at individuals who are involved with the criminal justice system, such as *Thinking for a Change* (Glick, Bush and Taymans), *Differential Substance Abuse Treatment*, *Therapeutic Education System*, Motivational Interviewing (Miller) and *Seeking Safety* (a gender-specific program for women inmates).

Cognitive Behavioral Therapy
Early pioneers of CBT with prison populations, Bush and Bilodeau (1993), coined the concept of 'antisocial winning' in which offenders believe that they are a victim of society and that they have been unfairly treated, leading to feelings of rage and righteousness in which the only satisfaction they can experience is in 'winning' their way against the expectations of the dominant culture. Relationships become defined by power struggles and righteous defiance. Such 'victim-stance' thinking leaves little room for remorse, and the 'high' of winning in their struggle against the world is something that many offenders seek to repeat as if it were an addiction. The problem is that this type of thinking is self-reinforcing and creates a vicious cycle of offending. Bush and Bilodeau articulated a cognitive behavioral approach in which no assumptions are made about the motivation of offenders to change. Rather, the program teaches alternative thought patterns to 'antisocial winning', offering offenders an opportunity to choose a different course of action. These programs have been successfully replicated in many settings, including prison, home, school and community.

All CBT approaches are based on the assumption that how people think affects how they act. Particularly when it is used in criminal justice work, CBT helps participants to identify thought processes and attitudes that lead to anti-social and criminal behavior. The approach in the proposed program is to use the time in incarceration to teach each inmate a well-defined and specific set of skills. These skills include identifying thinking habits and the consequences of thinking that lead to criminal action, evaluating those consequences against individual goals (such as the desire to be out of prison or to be with one's children), and choosing to change thinking and action to better meet personal goals.

CBT-based interventions are designed to motivate people to change themselves based on self-understanding, the establishment of personal goals, and the evaluation of actions and their consequences in relationship to achieving those goals. The efficacy of CBT with offenders of various types is well established. One study was conducted at Vanderbilt University and included a review of more than 500 intervention practices and programs over a 45 year period, beginning in 1958 (Lipsey). That study showed that punitive interventions actually increased recidivism while cognitive behavioral skills building most effectively reduced reoffending over any other approach. In another study, conducted by Mark Lipsey and Nana Landenberger, cognitive behavioral approaches with juvenile and adult offenders were examined in a variety of settings, including residential programs. That study found CBT to be the most effective approach in terms of reducing recidivism, even among offenders who were seen as high-risk.

CBT is perhaps the most evidence-based of all forms of psychotherapy, having been applied successfully in many settings, with persons of various ages, genders, and abilities. It has been extensively researched and found to be preferred by persons receiving it to other interventions (Brown et al. 2007) and to be associated with significant positive change among individuals who receive it (Waldron and Kaminer 2004).

Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) or Motivational Interviewing, a specific variation of CBT, is the primary clinical approach used at Connections. All of our direct care workers and supervisors have been trained in MET. Counseling and other interventions follow the tenets of MET, focusing on assisting clients to meet their own goals. MET is described as an evidence-based practice by the US Center for Substance Abuse Treatment (CSAT) in its Treatment Improvement Protocol (TIP) #35, which notes that the approach has been used successfully with people who have substance abuse problems, including offenders, and with persons with schizophrenia in both individual and group clinical trials under research conditions. The developers of the theory have articulated five general principles that underlie the theory and have been proven to enhance engagement among individuals with a wide range of diagnoses and presenting problems, including mental health and substance use conditions. Principles include

- Avoiding argumentation
- Expressing empathy
- Supporting self-efficacy
- Rolling with resistance
- Developing discrepancy (Miller et al, 1992).

Using the life goals articulated by the service recipient during the assessment, the therapist elicits and reinforces the offender's own goals and motivations that are in competition with the inherently motivating properties of behaviors such as drug and alcohol use or self-initiated cessation of psychiatric medication. These competing motivations are the 'discrepancy' Miller describes, and, when developed in the context of a therapeutic alliance, can lead not only to a willingness to pursue treatment, but ultimately to positive outcomes.

The proposed project will use MET to help offenders to identify life goals and develop discrepancies between continued problem behaviors and the achievement of those goals. In MET, the therapist helps the client identify personal motivations that are in conflict with behaviors such as substance abuse and antisocial activities, in order to tip the scales toward willingness to engage and remain in services (Miller & Rollnick, 1991).

In an article written in 2007-- *The Use of Confrontation in Addiction Treatment History, Science, and Time for Change*--William L. White, MA, and William R. Miller, PhD (the developed of Motivational Enhancement Therapy) address the use of the confrontational counseling style that has been the hallmark of traditional therapeutic communities and suggest that it be replaced with the more collaborative style of MET. The confrontational style of counseling was adopted in criminal justice settings throughout the United States over the last 50 years, primarily because it is authoritarian and supports the view of inmates as dishonest, incapable of responsible self-direction, and pathologically defended against change. The counselor's role in the confrontational approach is one of correcting error, combating delusion, taking charge, educating, breaking down defenses, and being the client's link to reality. The fundamental message to clients is that "I/We have what you need." While there is some merit to these assumptions as it pertains to inmates, the use of them by one person (the therapist) to try to force change on another (the inmate) has been resoundingly unsuccessful.

On the opposite end of the spectrum is the client-centered approach articulated by Carl Rogers. In this approach, the counselor's role is to empathize with the client and evoke the client's own motivations for change (Miller & Rollnick, 2002). Miller states 'experiences of shame, guilt and humiliation favor the more of the same. Indeed, if suffering cured addiction, there wouldn't be any'.

In two studies, clients with alcohol problems were randomly assigned to counselors who varied in their level of skill. Some were more confrontational while others demonstrated more empathy. One study involved nine counselors, all of whom were delivering the same manual-guided behavior therapy for problem drinkers (Miller, Taylor, & West, 1980). Before collecting outcome data, their supervisors independently rank-ordered the nine counselors on their skill in accurate empathy. Follow-up data shows the percentage of each counselor's case load who were unimproved at 6 months. Although the clients were all ostensibly receiving the same behavior therapy, the single best predictor of their post-treatment drinking was the counselor to whom they had been randomly assigned. The more empathic their counselor, the less clients were drinking (Miller & Baca, 1983; Miller et al., 1980). A second similar study showed that outcomes were directly correlated with the ability of the counselor to whom they had been randomly assigned to demonstrate accurate empathy. These counselor differences are some of the largest therapeutic effects found in the substance abuse treatment literature, strongly suggesting that empathy is more effective than confrontation in facilitating change among substance abusers. (Miller, Moyers, Arciniega, Ernst, & Forcehimes, 2005). Motivational interviewing is essentially an evolution of the Rogerian client-centered approach, manifesting empathy, respect, and collaboration rather than confrontation as the primary means of helping a person to change problematic behaviors.

The clinical method of motivational interviewing has historically been taught as an alternative to confrontation (Miller & Rollnick, 1991). In its etymology, the word "confront" literally means "to come face to face." And MET does, in fact, encourage the individuals to come face to face with his or her problems and problematic thought processes. In this sense, confronting is a therapeutic *goal* rather than a counseling style: to help clients come face to face with their present situation, reflect on it, and decide what to do about it. Once confronting is understood as a goal, then the question becomes how best to achieve it.

Whatever the modality of treatment, the effectiveness of substance abuse treatment appears to be directly related to the length of time an individual remains in treatment. The ideal time chemically-dependent offenders should spend in an intensive treatment program is unclear. A review of ten community-based therapeutic communities found that clients needed to be in the programs for 6-12 months in order to see any reduction in recidivism and a year or more to reduce drug use (Condelli and Hubbard, 1994). Another study of community-based residential drug abuse treatment programs (therapeutic communities along with other residential drug treatment programs) found effectiveness of the programs in reducing drug use varying in duration from 3 to 12 months (McClusker et al., 1995). Studies addressing the question of length of treatment tend to find that the more time offenders spend in treatment, the less likely they are to be rearrested or returned to prison (Wexler et al., 1988; Field, 1992). Another consistent finding is that treatment appears to be effective regardless of whether offenders enter voluntarily or under some form of coercion (Anglin and Hser, 1990a, 1990b; Anglin and Maugh 1992; Falkin, Wexler, and Lipton, 1992; Leukefeld and Tims, 1992; Travis, Wetherington, Feucht, and Visher, 1996). For those reasons, the proposed program will emphasize continuity of treatment across facilities—from level 5 to level 4 to probation to community release--encouraging linkages to aftercare resources in the community, not only for those who complete the therapeutic community programs while incarcerated, but for all inmates who are found through assessment to have a mental health and/or substance use condition.

Integrated Dual Disorder Treatment

Connections has operated programs for persons with co-occurring substance use and mental health conditions since pioneering such treatment with a CSAT Treatment Capacity Enhancement grant made in 1993, using the *IDDT* model. *IDDT* is a comprehensive spectrum of services with empirical evidence of effectiveness that uses a stage-wise approach to promoting recovery from substance use and mental health condition when they occur together (SAMHSA EBP Toolkit).

There is significant evidence in the literature of a high frequency of co-occurring mental health diagnoses among persons with primary diagnoses of substance use disorders. Although the specific psychiatric diagnoses vary by gender and drug of choice, (i.e., more women than men have co-occurring Axis I disorders and many more cocaine users have Axis I disorders than do opiate users) all groups fall within the 30% to 60% range. Depressive and anxiety disorders (including PTSD) on Axis I and Antisocial and Borderline Personality Disorders on Axis II are the most commonly identified co-occurring disorders (Milby et al., 1996; Brooner et al., 1997; Halikas et al., 1994).

A 1990 epidemiological study published in the Journal of American Medicine reveals the high rate of co-occurrence of substance use disorders and mental disorders: 55% of persons admitted for substance use disorder treatment were found to have a co-occurring mental health disorder; 47% of persons with schizophrenia had a lifetime diagnosis of a substance use disorder (Kessler, 1990). In one study, the overall group of persons with dual diagnoses, regardless of which diagnosis was primary, comprised 70% of the highest users of Medicaid services (Minkoff, 1997).

The literature and experience confirm that individuals with co-occurring mental health conditions and addictive disorders, while not homogenous in their diagnostic or demographic characteristics

- represent most of the persons in need of behavioral healthcare
- are likely to be the highest users of services, and
- because of a historic lack of service integration, are the least likely to receive services that are either effective or efficient.

At the same time, both mental illness and addiction are examples of primary, chronic diseases that share many of the same characteristics

- they have a biological basis
- they have a chronic course, with periods of relapse and remission
- they are diseases of denial
- they have parallel courses of rehabilitation.

No single intervention works best for either disease. The selection of intervention depends on the diagnosis subtype, phase of treatment, level of acuity, severity, disability, motivation for treatment and a host of other factors (Minkoff, 1999). The ability to provide an appropriate range of interventions that can meet the needs of different individuals at different points in their disease course is best facilitated by systems integration.

The proposed mental health and substance abuse services will have the capacity to concurrently assess and treat mental health, substance use, and gambling conditions and will be operationalized assuming the characteristics of a Dual Diagnosis Enhanced (DDE) program as described in the substance abuse section of this proposal.

Gender Specific Interventions

Since 1980, rates of incarceration among women in the U.S. have risen dramatically. Women with children under the age of 18 are the fastest growing segment of the U.S. prison population. An important difference between male and female prison populations is that the women prisoners are usually custodial parents. When a woman goes to prison her children are left behind. Despite this fact, there is not a broad body of knowledge about the impact of incarceration on the ability of incarcerated mothers to function as parents, or the consequences for their children.

The increased incarceration of women appears to be the result of forces that have shaped U.S. criminal justice policy in general: the ‘war on drugs,’ which encourages punitive enforcement on the individual level; mandatory sentencing laws; and the public's fear of crime. Women in the criminal justice system are disproportionately poor, undereducated, women of color. Many come from impoverished urban environments, were raised by single mothers, or were homeless or in foster care as children. Women are more likely than men to have committed crimes in order to obtain money to purchase drugs, usually non-violent property crimes. Once they are incarcerated, their children are almost always left in the care of grandmothers in the same impoverished circumstances in which the women themselves were raised (Covington, 2001).

Incarcerated and addicted women and men have different employment histories, substance-abuse problems, criminal involvement, psychological functioning, sexual and physical abuse histories, and child support activity prior to incarceration (Messina, Burdon and Prendergast 2001). Incarcerated women tend to have more severe substance abuse histories, more co-occurring psychiatric disorders, lower self-esteem, and were more frequently the victims of sexual and physical abuse. In addition, an estimated 70 percent of women offenders have young children (BJS 1999a). Most are single mothers with an average of two children and prior to their arrests were the custodial parents (Bloom and Steinhart 1993; BJS 2000b). Separation from and concern about the well-being of their children are among the most damaging aspects of prison for women, and the problem is exacerbated by a lack of contact (Baunach 1985; Bloom and Steinhart 1993).

Racial discrimination, weakened social controls, poverty, unemployment and anti-social subcultures create stress and lead to the complex interplay of drugs, poverty and crime that significantly impact the population of focus. Studies of motivation for treatment among prisoners in general have found that prisoners who have strong values of community, spirituality, racial pride and strong family identity were most likely to express motivation for treatment. For many women, the only source of hope and motivation they have while involved in the criminal justice system and in transition back to the community is the connection with their children. A pro-social emphasis, which includes family counseling and education, and promotes a view of recovery that is community- and family-centered rather than individually-centered, is the most likely to be effective among women offenders who have custodial age children.

The Cincinnati Women's Risk Assessment Project was based on work by feminist criminologists Kathleen Daly, Meda Chesney-Lind, Barbara Bloom, Barbara Owen, and Stephanie Covington stressing that women take unique "pathways to crime." The pathways model asserts that women's unique needs are not adequately tapped by risk/needs assessments that are more relevant to a male population. Rather, the women's assessments were specifically designed to address gender-specific issues including:

- trauma and abuse
- unhealthy relationships
- parental stress
- depression
- self-efficacy
- current mental health symptoms.

By incorporating these gender-specific concerns into the assessment process when working with women, the counselors will be better able to understand the unique issues of each participant—issues which led them to commit a crime and which might cause them difficulty maintaining their parental roles and staying out of trouble after they are released. These issues can then be addressed both with the participants themselves and with their probation officers and members of their families who will play crucial roles in helping them to achieve and sustain an effective reentry. The assessment will also help I-ADAPT teams to understand what each woman needs in order to successfully reunite with her children and maintain community tenure.

Cultural Competence

Problems related to social isolation and anti-social values are exacerbated in correctional settings, where employees are seen as representing the 'dominant culture' regardless of their backgrounds. The potential for miscommunication increases when the counselor *is* from a different background, especially if it is the dominant culture. The most common treatment misunderstandings are the result of differences in culture, socioeconomic class, and language. To ameliorate this, staff of the proposed program will be matched as closely as possible to the characteristics of the population of focus in terms of background, age, language preference, race and ethnicity. To ensure that inadvertent or unintentional miscommunication is minimized, employees will receive ongoing training in trauma-informed care and gender-related and cultural competencies.

Trauma Informed Services

For women inmates especially (but not exclusively) it is important that services be trauma-informed. Many male inmates have also experienced trauma, some as the victims of child abuse, others through military experience or by witnessing or being the victim of street violence. For many trauma survivors, life is about getting what they need, claiming limited resources and surviving—a thought process that easily leads to crime. Childhood trauma and addiction both can impact development, interrupting the mastery of specific tasks that lead to emotional maturity. Since these tasks are necessary building blocks for the mastery of the next developmental phase, deficits can and do affect adult functioning, including parenting. Such deficits in self-value are likely to be profoundly present in the target population. The tenets of trauma-informed care can be integrated into the service delivery system by focusing on a few key concepts. One manualized approach to trauma-informed care is Seeking Safety, a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, containing guidance for clinicians and handouts for clients. Seeking Safety is described in detail in the substance abuse treatment section of this proposal.

Evidence-Based Reentry Services

Carrying through on the theme that good prison-based mental health and substance abuse services should lead to reduced recidivism, if we are the successful bidder, we will bring some of our expertise in re-entry to the work release and violation of probation program components. Specifically, we will use our expertise to assist reentering offenders to obtain employment and public benefits that will help them to get the services they need in the community.

Facilitating access to public benefits is essential to helping individuals with limited financial resources to improve quality of life and access to healthcare, housing and other needs. Our skill, experience, and outcomes in assisting persons with behavioral health conditions to successfully obtain and manage entitlements and other mainstream resources is unparalleled in Delaware. In fact, **Connections, as part of a nationwide network of organizations participating in Social Security's SOAR initiative, has one of the best rates of success in obtaining timely eligibility determination among individuals with behavioral health issues in the United States**. In 2008, the Delaware State Housing Authority applied for and received one of ten SSI/SSDI Outreach, Access and Recovery (SOAR) technical assistance awards made in 2007. The Delaware SOAR Initiative, which is being implemented as a partnership between several government agencies and nonprofit providers including DSHA, DVR, DSCYF, the Social

Security Administration, and Connections, has developed training and a delivery system to ensure that all people who are likely to interact with a homeless person with a disability are able to quickly assess the person's potential eligibility and make a referral to a benefits coordinator who will assist the person to submit a strong SSI/SSDI application that will be approved within 90 days of submission. During 2009, as part of the initiative, Connections achieved an approval rate of 80% in an average of 68 days. This goal has been achieved by collocating trained and designated entitlements specialists in settings where clinicians and psychiatric practitioners are available to work in tandem to produce the documentary evidence of disability required for eligibility for SSI/SSDI. Such eligibility is often the gateway to other benefits, including Medicaid and Medicare and housing subsidies.

If we are the successful bidder, we will replicate the very successful SOAR approach to assisting reentering offenders to access public benefits, specifically the designation of a case manager who has training and experience in interfacing with the DOL Disabilities Determination Unit, the Social Security field office, and DSS. Data from our existing programs indicates that many people are eligible for disability income and/or medical assistance, and are eligible for but not receiving food stamps, transportation, or other assistance. Their indigent circumstances have more to do with their own--and the social service system's--disorganization than with absence of, or ineligibility for, economic, housing, and social services assistance. The proposed program will use proven case management practices to help offenders who are preparing for reentry to assemble and coordinate the multi-disciplinary resources (housing, economic, social, mental health, substance abuse, and healthcare services expertise) they need to improve their quality of life and access to healthcare and housing.

Connections is also a provider of Vocational Assessment, Direct Placement, On-the-Job Training, and specific training in culinary arts, pest control, and janitorial services for the Delaware Department of Labor and its Division of Vocational Rehabilitation. Connections operates an evidence-based supported employment program that has been the most successful such program in the state in placing and maintaining individuals with serious mental illness in employment. DVR has provided a commitment to us that they will assign a counselor to the proposed program, rotating among the sites, to assist service recipients to become open with DVR and to make the necessary linkages to the services they need. We will provide employment specialists to the proposed program in the work release and VOP facilities, to be paid for through our performance-based DVR contracts, to help reentering offenders to obtain needed job skills and at least transitional employment.

In an attempt to ameliorate high rates of unemployment and a lack of job opportunities generally in the depressed economy, in 2009 Connections formed an economic development company—Connect to Work--with the mission to create jobs for individuals who are hard to employ because of criminal records, disabilities and/or low rates of educational attainment. Connect to Work's primary focus is the development of small businesses in which persons served in the programs offered by Connections (reentering prisoners, homeless persons, individuals with mental health, substance use conditions and cognitive impairments) can obtain competitive employment. The social enterprises include 1) a janitorial service business; 2) a construction and building and grounds maintenance business; 3) a pest control company; and 4) a catering and restaurant business. Business development has been augmented by contracts with state agencies

that are ‘set aside’ under Delaware law and are required to be given to organizations that employ people with disabilities. We have obtained ‘set aside’ contracts to clean state office buildings and to provide temporary office workers to state agencies. Our food service program currently provides more than 2,000 meals per day to persons living in homeless shelters, at-risk children in after school and summer programs, and homebound adults, and operates a restaurant in the city of Wilmington.

This approach to job creation has led to some real success. At the end of February 2012, 78% of those who had enrolled in our offender reentry program had been placed in employment compared to 40% of persons served in other DOL-funded programs across the country. The Division of Vocational Rehabilitation reports that in their fiscal year ending on September 30, 2011, Connections placed more individuals with behavioral health problems in employment than all of the other DVR providers combined. Our successful employment programs combine ongoing case management approaches to address health and logistical employment barriers with individualized job development, placement, on-the-job training and post-placement services designed to increase employment opportunities and improve job retention rates. Connect to Work does all of these things. We believe that it will add a currently missing component to reentry for all offenders who are leaving DDOC facilities and returning to the community.

Scope of Services

Mental Health Services

Mental health services including assessment, treatment planning, case management, psychiatry, individual and group treatment, and psychiatric close observation/suicide prevention will be provided for all offenders who need them, including, but not limited to, those with serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, depression, PTSD); adjustment difficulties; aggressive behaviors; suicidal/homicidal ideation; dementia; and other cognitive disabilities and impairments e.g., Asperger's disorder, ADHD, etc. Mental health services will be delivered by four (4) interdisciplinary teams serving several facilities, divided geographically and by size. Each team will include a Mental Health Director with at least one Clinical Supervisor and at least one psychiatrist. The Mental Health Directors will supervised by the overall Clinical Director for the proposed integrated program of services.

Each mental health team will be a self-contained clinical team representing the disciplines of psychiatry, psychology, psychiatric nursing (at the prescriber level), social work, mental health counseling, and mental health/activity technicians. These teams will

- Assume responsibility for directly providing assessment, treatment, support, observation, and rehabilitation services to all offenders in the team's assigned location(s) who need any or all of these services
- Make minimal referrals to outside service providers, providing the vast majority of services directly and at the facility
- Provide longitudinal, time-unlimited services with continuity of caregivers over time
- Emphasize individualization of services to meet individual needs
- Promote core values of service excellence, hopefulness, courtesy, helpfulness and respect
- Collaborate with offenders and their support systems to establish goals and to work together to develop a treatment plan of effective ongoing interventions and discharge/transition strategies.

The major goals for the proposed teams include the achievement of several outcome measures:

- They will help each offender to develop a plan to lessen or eliminate debilitating symptoms, minimize or prevent recurrent acute episodes of illness, and promote recovery from mental illness
- They will help each participant to identify meaningful roles that s/he will undertake in the community post-release such as employment, family life, and parenting
- They will reduce hospitalization and lessen or eliminate the use of emergency room visits, thus reducing expenses and poor outcomes
- They will reduce harm from co-occurring addictive and/or medical conditions
- They will improve family relationships and reduce the burden of care on family members.

Table 3 below depicts the proposed mental health treatment teams, by location. Team 1 will serve level 4 and 5 facilities in Northern New Castle County—Baylor, Webb, Hazel Plant Women's

Treatment Center, and Plummer Center. Team 2 will serve Howard R. Young in Wilmington. Team 3 will serve southern New Castle and Kent Counties including Vaughn, Morris and Central Violation of Probation. Team 4 will serve Sussex County including SCI, SCCC and the Boot Camp. Table 4 below depicts the proposed staffing by type of position.

Table3: Proposed Staffing by Location and Team

Team #	Position Type	Number of FTEs
One—BWCI, WTC, Webb, Plummer	Mental Health Director	1.00 FTE
One—BWCI, WTC, Webb, Plummer	Clinical Supervisor	1.00 FTE
One—BWCI, WTC, Webb, Plummer	Administrative Assistant	1.00 FTE
One—BWCI, WTC, Webb, Plummer	Psychiatrist	1.00 FTE
One—BWCI, WTC, Webb, Plummer	Psychiatric Nurse Practitioner	1.00 FTE
One—BWCI, WTC, Webb, Plummer	Clinicians (LPC, LMFT, LCSW)	5.00 FTE
One—BWCI, WTC, Webb, Plummer	Psychologist	0.50 FTE
One—BWCI, WTC, Webb, Plummer	Observers (Psych Techs)	12.00 FTE
One—BWCI, WTC, Webb, Plummer	PRN Observers/Clinicians/Clerks	3.00 FTE
Team One Total FTE		**25.50 FTE**
Two—Howard R. Young	Mental Health Director	1.00 FTE
Two—Howard R. Young	Clinical Supervisor	1.00 FTE
Two—Howard R. Young	Administrative Assistant	1.00 FTE
Two—Howard R. Young	Psychiatrist	1.50 FTE
Two—Howard R. Young	Psychiatric Nurse Practitioner	1.00 FTE
Two—Howard R. Young	Clinicians (LPC, LMFT, LCSW)	6.00 FTE
Two—Howard R. Young	Psychologist	1.00 FTE
Two—Howard R. Young	Observers (Psych Techs)	8.00 FTE
Two—Howard R. Young	PRN Observers/Clinicians/Clerks	3.00 FTE
Team Two Total FTE		**23.50 FTE**
Three—Vaughn, Morris, CVOP	Mental Health Director	1.00 FTE
Three—Vaughn, Morris, CVOP	Clinical Supervisor	2.00 FTE
Three—Vaughn, Morris, CVOP	Administrative Assistant	1.00 FTE
Three—Vaughn, Morris, CVOP	Psychiatrist	1.50 FTE
Three—Vaughn, Morris, CVOP	Psychiatric Nurse Practitioner	1.50 FTE
Three—Vaughn, Morris, CVOP	Clinicians (LPC, LMFT, LCSW)	10.00 FTE
Three—Vaughn, Morris, CVOP	Psychologist	1.00 FTE
Three—Vaughn, Morris, CVOP	Activity Technicians	3.00 FTE
Three—Vaughn, Morris, CVOP	Observers (Psych Techs)	8.00 FTE
Three—Vaughn, Morris, CVOP	PRN Observers/Clinicians/Clerks	4.00 FTE
Team Three Total FTE		**33.00 FTE**
Four—SCI/SCCC	Mental Health Director	1.00 FTE
Four—SCI/SCCC	Clinical Supervisor	1.00 FTE
Four—SCI/SCCC	Administrative Assistant	1.00 FTE
Four—SCI/SCCC	Psychiatrist	1.00 FTE
Four—SCI/SCCC	Psychiatric Nurse Practitioner	1.00 FTE
Four—SCI/SCCC	Clinicians (LPC, LMFT, LCSW)	7.00 FTE
Four—SCI/SCCC	Psychologist	0.25 PRN
Four—SCI/SCCC	Observers (Psych Techs)	8.00 FTE
Four—SCI/SCCC	PRN Observers/Clinicians/Clerks	3.00 FTE
Team Four Total FTE		**23.25 FTE**

Table 4: Types and Number of Mental Health Positions

Position Type	FTEs	Comment
Mental Health Director	4.00	
Psychiatrists	5.00	
Psychiatric Nurse Practitioners	4.50	
Clinical Supervisors	5.00	
Clinicians (LPC, LCSW, LMFT)	28.00	Mix of full and part time
Psychologists (Psy.D., Ph.D)	2.75	One is PRN
Activity Technicians	3.00	
Observers/Psychiatric Technicians	36.00	Mix of full and part time
Administrative Assistant	4.00	
Clerks/PRN Observers	13.00	Depending on need
Employment Specialists (at VOP and work release centers only)	2.00	Not in contract—paid from a separate funding source
Total	**107.25**	

Program Administrator and Clinical Director

If we are awarded a contract, it is our intention to hire John R. (Jack) McDonough as the overall program administrator. McDonough will retire in 2012 after serving 25 years with the United States Probation and Pre-Trial Services Office for the District of Delaware, where he worked as a probation office, senior probation office, deputy chief, and where he currently serves as chief. While he has been the chief, the office has reduced recidivism by 58% according to an evaluation conducted by the University of Delaware by implementing evidence-based practices, including a nationally recognized work force development project. We believe that Jack McDonough has the right combination of security and programming background to bridge the gap between the treatment providers who will work for us and the DDOC security staff and produce the most effective program possible. Of critical importance is the Administrator's ability to interface not only with the mental health staff, but with the DDOC security staff, the employees of the medical care provider, and the DDOC Mental Health Administrator. The Program Administrator will be charged with ensuring that the program is carried out as proposed, and that it meets the goals and standards of care articulated in the Continuous Quality Improvement Plan. A copy of his resume is contained in Appendix A.

In addition to the Program Administrator, we will hire an overall Clinical Director, a licensed co-occurring credentialed clinician, who will be responsible for the implementation of the mental health, substance abuse, and sex offender programs across disciplines and facilities, supervising the four mental health directors who lead each team. S/he will ensure that all clinicians and other mental health/substance abuse workers have onsite clinical supervision and access to the necessary supports, clinically and administratively, to provide timely and effective care as described in this proposal.

Other Staff Qualifications

The proposed mental health component will employ 5 psychiatrists who will be either a Medical Doctor (MD) or a Doctor of Osteopathy (DO) and who will be board-eligible or board-certified in psychiatry and licensed to practice medicine in Delaware. Each site will have a Mental Health Director who will act as the leader of the treatment team assigned to the site. The Mental Health Director will have at least a Master's degree, will be licensed in Delaware as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW), and will have clinical and administrative experience providing services to offenders in the prison setting. Psychiatric nurse practitioners will have at least a Master's degree from a program specializing in psychiatric nursing and will be board-certified as clinical nurse specialists in psychiatry. Psychologists will be at the Ph.D. or Psy.D. level and will be licensed to practice psychology in Delaware. Clinical supervisors and clinicians will be Master's prepared and licensed in Delaware. Observers will have at least a high school diploma and the right combination of training and experience that prepares them to carry out the functions of the position. All employees will have DOC clearance. Connections is negotiating with licensed professionals who occupy these positions with the current provider. Many of them have expressed a willingness to continue with us if we are the successful bidder.

Mental Health Assessments

The mental health program staff will conduct assessments, including evaluations of competency, upon the request of the warden or his/her designee, DDOC treatment staff, the medical services vendor, and/or as ordered by the court. Properly implemented, the process of completing the initial assessment promotes the development of a therapeutic relationship and provides a beginning understanding of the offender's immediate needs. The initial assessment consists of brief summaries of the person's perception (and any referral source's explanation) of the events and circumstances resulting in his/her referral; availability of social supports; history of mental health, substance abuse, gambling, and medical conditions; perception of personal strengths, needs and immediate priorities; and the recommendations for developing the initial treatment plan.

The initial assessment will be completed within 24 hours of referral from intake. Emergent assessments will also be completed within 24 hours. Assessments that are made by the DDOC personnel, the Medical Services Vendor, or the substance abuse/sex offender treatment teams that are considered by the referral source to be non-emergent, will be completed within seven (7) days. Pre-parole and other requested assessments will be performed by the date specified on the request. Mental health clinicians will be available for evaluation and triage at Sick Call (5 days per week for non-emergent issues; 7 days per week for emergencies), and around-the-clock for emergency care. Offenders who are placed in segregation will have an initial assessment within 24 hours of placement and will be followed at least three (3) times a week while they remain in that status.

Members of the clinical team undertake a series of assessment interviews with the offender. In addition to providing the information necessary to develop an effective treatment plan, the assessment process is a good opportunity for the offender and the treatment team to get to know one another. The assessment forms the basis for the development of the treatment plan and for the use of Motivational Enhancement Therapy to facilitate recovery. The assessment also

provides the data needed to populate the ASAM Patient Placement Criteria, which will determine the level of care required. Another purpose of the comprehensive assessment is to obtain a factual, complete representation of the person's beliefs about her or his illness, cultural and religious underpinnings to her or his perspective, worries and concerns, interpersonal dynamics, daily routine, symptoms, medical and psychosocial history, psychiatric diagnosis, and treatment history and response.

Connections uses a scientifically-based and systematic approach to comprehensive assessment. The purpose of the assessment is to evaluate the need for treatment, to ensure that the appropriate level of care is determined, and that the service recipient is assigned to the right level of care using ASAM Patient Placement Criteria. The primary assessment tool is the Addictions Severity Index (ASI), a well-established biopsychosocial assessment device with extensive research supporting its use. The items on the ASI have been tested on over 8,400 clients for understanding and test-retest reliability as well as concurrent, predictive, and discriminate validity among adults of both genders and most large ethnic groups. The ASI has been validated with a homeless population specifically and with persons with co-occurring disorders with less reliable, but acceptable results. Connections has used the ASI as our primary assessment instrument across all of our programs since 2001. In addition to the completion of the ASI, the assessment will also include some or all of the following, based on the presenting problems and perceived needs of the offender and the facility:

- Offender interview(s) by a licensed person (nurse, psychiatrist or mental health professional) which includes a mental status examination and the use of a standardized tool such as the Brief Psychiatric Rating Scale (BPRS) to identify psychiatric symptomatology
- History gathering from collateral sources (including security staff, medical services vendor, family, outpatient provider, etc.)
- A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the person's condition
- Identification of social, environmental, and cultural factors that may be contributing to displayed symptoms
- Psychiatric history, diagnosis, previous treatment history and response to treatment, and current mental status, including the response to previous treatment
- A record of past psychiatric medications, dose, response, side effects and adherence; an up-to-date record of all medications currently prescribed; and the name of the prescriber
- Alcohol and other drug use and gambling habits, including screening such as the Lie-Bet gambling screen
- Medical history and pre-incarceration access to primary medical care, including a general medical history that addresses factors that may affect the person's current condition (including a review of symptoms focused on conditions that may present as psychiatric symptoms, or that may cause cognitive impairment, e.g., a history of recent physical trauma, urinary tract infections, etc.)
- Social skills and social supports, including family supports
- An assessment of the person's ability and willingness to cooperate with treatment
- An assessment for trauma/abuse/neglect
- A suicide/homicide risk and plan assessment
- Input from the Medical Services Vendor

- Input from DDOC security staff
- Input from DDOC treatment staff, as applicable
- Input from substance abuse treatment staff, as applicable
- The Brøset Violence Checklist © (BVC) will be completed when circumstances suggest that it is clinically relevant or needed to ensure the safety of others in the facility. The BVC assesses confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects as either present or absent. Research has shown that an individual displaying two or more of the behaviors on the checklist is more likely to be violent in the next 24-hour period. The BVC allows the clinician to categorize individuals in terms of their risk within a milieu such as the correctional facility, classifying it as low, moderate or high. These classifications can help the security and other personnel to modify their behavior to prevent a problem and maintain safety.
- Clinicians will also use the IS PATH WARM assessment of suicide risk, by observing the offender and by collecting data from the observations of Medical Services Vendor staff and DDOC security and treatment personnel.

IS PATH WARM: SAMHSA has developed the IS PATH WARM protocol to help crisis workers and others to determine the presence of 'red flags' for suicide risk:

- **I**deation—threatened or communicated
- **S**ubstance Abuse—Excessive or increased substance abuse
- **P**urposeless—No reasons for living
- **A**nxiety—Agitation/Insomnia
- **T**rapped—Feeling there is no way out
- **H**opelessness
- **W**ithdrawing—From friends and family
- **A**nger—Uncontrolled rage, seeking revenge
- **R**ecklessness—Risky acts, unthinking
- **M**ood changes--Dramatic

IS PATH WARM is used in conjunction with the traditional methods of assessing suicidality (ideation, plan, and means) to identify increased risk for suicide requiring precautions such as segregation and observation combined with treatment.

Referral Following Receiving Screening

During the routine intake screening conducted by the Medical Services Vendor, offenders may demonstrate symptoms that require referral for assessment by the Mental Health Vendor. The referral is made by the Medical Services Vendor through entry in the Delaware Automated Correction System (DACS). During intake screening, the following conditions will be noted in DACS by the Medical Vendor:

- Impaired cognitive functioning
- Offenders identified as having special needs related to mental disorders
- Any significant signs of psychological distress or mental health disease

A referral will be made by the Medical Services Vendor to the Mental Health Vendor for further assessment (using the tools and techniques described in the Assessment section above) within 24 hours. Mental health program staff will be available around-the-clock, either in the facility or on

call, to provide immediate assessment and evaluation of any offender who is exhibiting signs of decompensation; aggressive behavior/victimization; suicidal or homicidal ideation; withdrawal from alcohol or other drugs; dementia/delirium; or other significant cognitive or emotional impairment. The results of the mental health evaluation and recommendations for treatment will be entered into the Offender Medical Record.

Each inmate referred for mental health services/assessment is assigned to a Clinical Treatment Team (CTT) consisting of his or her lead clinician/case manager, the assigned psychiatric practitioner, and other practitioners, based on the individual's needs. Following the offender's initial psychiatric interview with the team psychiatrist, the CTT meets to review the initial treatment plan and make any needed modifications. The team also meets with personnel from the other disciplines in the facility (DDOC security and treatment staff, Medical Services Vendor staff, and the substance abuse treatment teams for offenders receiving both mental health and substance abuse treatment). These teams are referred to as Interdisciplinary Treatment Teams (ITT), who are responsible for developing and updating the master treatment plan. It is essential that the mental health staff confer with all other personnel who have an opportunity to observe (such as the DDOC security staff) and participate in the treatment of (Medical Services Vendor nursing staff) mental health conditions within the offender population.

Delaware Automated Correction System

If we are awarded this contract, all personnel who are initially employed will be trained in the use of the Delaware Automated Correction System (DACS). The purpose of DACS is to provide correctional officers (COs) with a means for both recording their own observations and ensuring that offenders who are a threat to themselves or others receive immediate mental health evaluation and treatment. Mental health personnel will be required to enter information related to mental health into the system. As new personnel are hired, the Program Administrator will be responsible for ensuring that they are trained in the system and that DACS is used for its intended purposed related to mental health. Each Mental Health Program Director will review the information in DACS daily (or will assign a senior member of the mental health team who is on-duty to review the information in his/her place) and will ensure that all information contained therein is acted on appropriately and promptly for the facilities to which his/her team is assigned.

Case Management

Any offender who is identified as having current or historic psychiatric symptoms of serious mental illness, adjustment difficulties, decompensation, aggression, suicidal/homicidal ideation, dementia, and/or other significant cognitive/emotional impairment, will be assigned to a clinical team (as depicted in Table 3) for case management. This will include offenders who are in the diagnostic or therapeutic 'pipeline,' i.e., those offenders who have been referred for treatment but have pending appointments. The case management system will be designed to ensure that these offenders attend all appointments and that barriers to receiving care are actively removed via coordination of services. A case management report will be provided monthly to the Bureau Chief, detailing any system-wide barriers that made need joint discussion and resolution.

Per Table 3, mental health services will be organized by Clinical Treatment Teams (CTT). The program design continuously monitors the effectiveness of planned services in terms of achieving desired outcomes. The CTT acts as the single point of accountability for psychiatric, mental health services, and psychosocial rehabilitation services is accountable for the welfare of

offenders assigned to it for mental health services 24-hours-a-day, 7-days-a-week. Each offender receiving mental health services will be assigned to a clinician who will act in the capacity of primary case manager and therapist, assuming responsibility for individualized treatment and discharge planning.

CTTs will meet as a group at least four (4) times each week (participation maybe electronic to ensure that team members working in multiple sites have access to the information). The central organizing mechanism for scheduling staff activity is the daily team meeting. During daily meetings, the team reviews the clinical status of each assigned offender based on staff observation over the previous several days (including information received from DDOC security and other staff and information recorded in DACS). Observations are briefly noted by the staff having contact with the offender in a daily contact log. The daily contact log is reviewed each day during the daily team meeting, and serves as a continuous point of reference and communication for the team as well as a means for physicians and supervisors to quickly check staff activity against the daily schedule and to report any activity that is required in DACS. The daily contact log facilitates quick review during the daily team meeting.

The daily activity of the team members is not driven by their own calendars or plans, but by the needs of the assigned offenders as documented in their individual treatment plans and translated to a weekly schedule of interventions, and as identified and fine-tuned during frequent contact and daily team discussion. Team members get their assignments from the mental health director or clinical supervisor daily who makes the schedule using the treatment plans. When these plans are developed, a 'week at a glance' treatment calendar is completed for each offender. These treatment calendars, plus any unscheduled needs identified in the course of the daily team meeting, form the basis for the staff daily work schedule. This process ensures that assessment is continuous, treatment plans are implemented, and treatment interventions are subject to ongoing peer review. The clinical supervisor also coordinates changes in the staff schedule during the day to meet emerging needs and respond to emergencies. All team members, including the psychiatrist, attend team meetings as often as possible (no less than once per week), during which strategies are developed to address psychiatric and other concerns of participants and to proactively identify and address any problems. During these meetings, the psychiatrist and other senior clinical staff can make recommendations for mental health care as well as any needed referrals to primary or specialty medical care. Information from the Medical Services Vendor, any alcohol and drug treatment, laboratory studies and other diagnostic tests are reviewed by the psychiatrist and clinical supervisors during team meetings.

At the daily meeting, the CTT will use a method of classifying or 'staging' observation levels for offenders based on their current functioning. For example, Level 1 describes individuals who are doing well, and who will benefit from a low to moderate level of observation and interventions. Level 2 will describe participants who are having difficulties with others in the milieu and/or are experiencing symptom exacerbation, and who may require a higher level of assistance. Level 3 describes participants who are currently on Psychiatric Close Observation, in the infirmary or hospitalized. This system of 'staging' helps to prioritize the team's work, stepping up the amount of time spent with individuals at Level 2 and signaling the need for intensive contact with and ongoing communication about those who are at Level 3. The clinical supervisor gives a 'Level 2 report' to the team psychiatrist at the end of each day, typically with a plan that the team

has already developed for helping the participant to address his or her difficulties. The report also provides an opportunity for the clinical supervisor/mental health director and psychiatrist to collaborate on any plans for higher risk Level 2 participants and to strategize for the next day. The status of Level 2 participants is reviewed at the "top of the list" at the daily report in order to make sure there is ample time for discussion and fine tuning of the treatment plan for these individuals.

Each offender will have a lead clinician who has primary responsibility for managing the assessment and planning process, establishing and maintaining a therapeutic relationship, and maintaining the integrity of the clinical record. A second member of the individual treatment team serves as back-up to the lead clinician. This arrangement creates redundancy and provides a focal point on the team for overall accountability to and for the offender. Continuity of care is assured through the back-up case manager.

Monitoring of both process and outcome measures to determine the effectiveness of the team is discussed in detail in the Continuous Quality Improvement Plan in a subsequent section of this proposal. Each team and the agency's leadership committee will perform quarterly review of each team to determine

- the number of persons served who meet the clinical and administrative criteria for the services
- the extent to which the team has the capacity to provide the comprehensive, integrated services required for the number of persons who need that level of care
- recommendations which need to be made to ensure the team's ability to meet the needs of the persons assigned to it in terms of level of intensity and number and types of staff.

The attainment of symptom stability while remaining in the general population of the facility are among the most important outcomes the proposed mental health program seeks to achieve. Several core services of the model – psychiatric treatment, medication monitoring, round-the-clock observation and crisis prevention services, skills teaching, and therapy--are designed to achieve these goals.

Each team will develop an in-depth understanding of the subjective experience of symptoms and the both positive and negative environmental influences to which the population is subjected. The team will strive to understand the impact of these experiences on the person's emotional and psychological functioning, both through the initial comprehensive assessment and through the ongoing assessment that occurs by interacting with the individual over time. An important component of the model is the regular presence of a psychiatrist as a participating team member. S/he provides ongoing clinical consultation and education in management of psychiatric symptoms to other team members. The mental health director, clinical supervisor, and the psychiatrist ensure that all members of the treatment team have sufficient understanding of mental illness, medication, and each person's individual disposition and personality to be able to recognize changes in status that signal potential relapse and call for immediate intensification of attention by the team.

During each encounter, the team member forms an assessment of the person's symptom level, response to medication and other treatment, and degree of coping, and writes a clinical service note

reflecting that observation. During the daily team meeting, contacts of the previous day are reviewed and the status of each person discussed. Interdisciplinary input and the presence of supervising team clinicians increases the likelihood that change in a person's status is both noticed and correctly interpreted, with resulting fine tuning of the treatment plan and reporting to the Medical Services Vendor and DDOC personnel as needed. The continuous assessment process results in consistent symptom management and infrequent relapse. Offenders will have face-to-face access to a psychiatrist for evaluation and the team will review his or her current level of service if any of the following triggering events occur, or if s/he or any team member requests it as an emergent need, within 24 hours. Triggering events will include, but not be limited to

- suicidal or homicidal gesture or attempt
- violence or aggression towards others
- decompensation
- symptoms of alcohol or other drug withdrawal
- hospital admission
- hospital discharge
- acute symptom exacerbation
- problems reported through DACS or other means by DDOC staff, the Medical Services Vendor, a substance abuse staff member or any other person who has contact with the offender
- personal trauma or other major life event.

This review may result in change in the type or frequency of interventions being carried out. The framework for case management is established by several elements: 1) the assessment; 2) the goals and needs of the offender; 3) the stages of change/phases of treatment paradigm that is used to monitor and measure progress; 4) regular utilization review.

The treatment plan document itself is designed to capture individualized needs based on the individual's score on each dimension of the ASI as well as the ASAM Patient Placement Criteria, which describe appropriate treatment choices based on need. ASAM PPC will form the basis for establishing standards of care and for utilization review to determine the appropriate level of care.

Both the mental health and substance abuse treatment programs that are proposed will follow a stage-wise process, using a systematic combination of evidence-based counseling approaches, each of which will address mental health problems (and, if appropriate, substance abuse) concurrently. The counseling approaches are timed to the assessment of each person's readiness to change. The stage-wise model of treatment also suggests behavioral and other indicators that a person is ready to step up or down to a different level of care:

Engagement Phase: During the Engagement Phase, the primary emphasis is to orient the person to treatment and to address acute symptoms of either or both mental health and substance use conditions. Often at this early stage of treatment, the person is experiencing strong psychological cravings, symptoms of withdrawal, and/or subjective distress related to mental health symptoms, possibly including suicidal ideation. The focus of the treatment team will be on psychiatric and medical stabilization and induction into the core routines of treatment participation, including attendance at psychoeducation groups and individual motivational

enhancement sessions to establish treatment goals. Assessment interviews and individual counseling sessions will be initiated and medications titrated as needed. The counseling approach during the Engagement Phase is motivational interviewing, focused on building rapport and eliciting frank disclosure during the assessment interviews. Within the context of the proposed program, the vast majority of individuals will be able to be treated within the correctional facility. Under extreme circumstances, when the program psychiatrist and other members of the team agree that the individual cannot be maintained safely in the facility at this level, transfer to inpatient treatment will be rapidly facilitated.

Persuasion Phase: At the Persuasion Phase the individual has become more aware of and less defensive about the consequences of his or her behaviors and subjective distress from mental health symptoms has been reduced. S/he has been able to work through a functional assessment of the pros and cons, gains and consequences of substance use and other problem behaviors with the primary counselor and has otherwise completed the comprehensive assessment process. At this point, the person meets with the team in a treatment plan review meeting to revise his/her long-range goals, short-term objectives, the interventions that will be the focus of the next month, and the types and frequency of therapeutic activities s/he is expected to participate in. This is an exploratory phase, during which the focus of counseling is on the person's resolving his or her ambivalence about the changes s/he must undergo in order to reach the long-term goals.

The person will have agreed to attend group psychoeducation and/or motivational enhancement sessions twice or more often per week. Motivational enhancement sessions will include both brief didactic and media presentations on substance abuse, mental health, and life skills topics but will be mainly discussion-oriented. Attendance consistent with the treatment plan will be encouraged by staff members. Emphasis during this phase will be on developing motivation to change, particularly as it relates to adherence to medications, addressing neglected health issues, and establishing personal goals.

Active Treatment Phase: The individual who has reached the Active Treatment Phase expresses immediate intention and conviction to change her/his behavior and life circumstances that resulted in and still present themselves in treatment. S/he will be able to elect to continue to participate in persuasion groups, but also will attend cognitive behavioral treatment sessions at least weekly. Individual counseling in Active Treatment focuses on the work of change (e.g., developing impulse control and problem solving skills, identifying personal triggers and coping mechanisms, and establishing a plan for recovery and wellness). The treatment plan is more ambitious and action-oriented than during the prior stages. Short-term goals and strategies identified address developing emotional, cognitive, and interpersonal skills.

In the Active Treatment Phase, the individual's substance use and/or mental health condition is one of many targets for individual and group therapy. Others include control of psychiatric symptoms, family and other social network conflict, boredom and isolation, and anger management. The therapeutic principles of active treatment involve directly focusing on mutually identified problems and teaching skills to cope with psychological stress, carry out meaningful adult roles such as employment and parenting, and interact effectively with others. In group activities, individuals will be facilitated to both support and challenge each other rather

than to avoid imposing opinions and constructive criticism. Group topics develop more spontaneously than in the persuasion groups. In the active treatment groups the focus will be on exposing offenders to information and developing recognition of problematic patterns of behavior that they will need to change in order to avoid bad situations and to achieve their personal goals, and on learning skills to overcome acknowledged problems.

Relapse Prevention/Health Maintenance Phase: When the individual reaches the Health Maintenance Phase toward recovery, the focus will shift to providing transition services while continuing active treatment. The individual will develop an individual relapse prevention and illness management and recovery plan. When the s/he has attained sustained abstinence over a period of months and a psychological, emotional, and behavioral skill set, therapy will focus on helping him/her to develop a written plan of the broad strategies and specific techniques that s/he will use to prevent relapsing into substance abuse and other counter-productive behavior, and to manage psychiatric symptoms as s/he undertakes a gradual process of separating from residential treatment. Offenders in this phase will receive significant assistance to engage in normal activities outside of treatment including employment and adult education, in or outside of the facility, depending on their level of incarceration and other circumstances.

When the individual has sustained a health pattern of behavior related to substance abuse and psychiatric symptoms, and has neared accomplishing other major goals s/he set for the this phase, s/he will be encourage to take initiative to ensure that a transition to aftercare/maintenance services occurs seamlessly. For those persons who did not have a clinical home prior to entering, the staff will work to help them to determine which aftercare situation best suits their needs. For offenders who are nearing release, case management activities will focus on helping them to develop a good reentry plan, including the identification of ongoing mental health supports in the community.

Case Management of Delaware Psychiatric Center (DPC) Offenders

The Mental Health Services Vendor will provide daily interface between DPC and DDOC. Each offender who is at DPC will have a case manager within the mental health unit of DDOC from which the offender was admitted to DPC. Each offender's status will be monitored daily and reported to the designated DDOC personnel. There will be physician-to-physician contact daily for any offender who is admitted to a psychiatric or other hospital outside of DDOC, and information regarding that contact will be supplied to the Medical Director. A goal of the case management process for offenders who are admitted to DPC or another hospital in the community is to facilitate rapid discharge from the hospital and safe transition back into the prison system. The Mental Health Services Vendor is responsible for ensuring that all hospital discharge information accompanies the offender back into the prison and that the information is relayed to DDOC medical staff, the Medical Services Vendor, and others who need to know the information in order to provide appropriate and adequate treatment.

Mental Health Programming

Individual Counseling: Each team has multiple licensed therapists and a psychologist who are credentialed to provide individual and group counseling. Using the clinical approaches described in the Clinical Approach section of this proposal, they will provide counseling for each offender who is referred for mental health services, in segregation and in general population, as

often as indicated in the treatment plan, but no less than every 30 days. The proposed program will use a variety of counseling strategies to help participants to develop insight and motivation that leads to recovery. Cognitive Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET) will be the primary theoretical approaches because they have has been shown in the literature to be effective among offenders in both the treatment of substance use disorders and in enhancing insight and motivation for adherence to psychiatric treatment.

Lack of insight into illness and the need for treatment is one of the defining characteristics of schizophrenia spectrum disorders and other serious mental health conditions. Insight has been defined as an objectively correct estimate of the severity of illness as well as knowing about one's illness and the social consequences of it. While it is a matter of debate as to whether or not it is important for persons with serious mental illness to accept diagnostic labels, there is little debate about the role of insight into adherence to complicated and sometimes unpleasant medication regimens. Motivational Interviewing has been shown to be an effective tool for helping persons with serious mental illness to develop insight that leads to internal motivation to take medication consistently and accurately. Team members will demonstrate their willingness and ability to help participants by using MET skills from the time of assessment. These include:

- Expressing empathy for the person
- Helping the person to develop discrepancy between the his/her own goals and the results of his/her behavior (this is equally applicable to substance abuse, failure to comply with mental health treatment regimens, and to criminal behavior)
- Avoiding argumentation with the service recipient
- Rolling with any resistance raised by the offender, instead of insisting that he or she accept the therapist's interpretation of the situation
- Supporting the offender's self-efficacy and movement toward self-determination.

We use a recovery planning process that employs MET in the development of each treatment plan as follows:
Step 1: Members of the team establish the therapeutic alliance by demonstrating acceptance and understanding during the intake and assessment process and always thereafter
Step 2: The ITT helps the participant to identify his/her personal goals in life
Step 3: As part of the planning process, ITT members ask the participant to evaluate his/her current behavior as it is brought out in the assessment process by asking 'what are you doing now to work towards your goals' and 'is this approach helping to meet identified goals?'
Step 4: The participant and the ITT members brainstorm alternative behaviors—ask 'what else could you be doing to work on this goal?'
Step 5: The ITT helps the person served to choose alternative behaviors and to agree to try them for some period of time.
Step 6: When old or new behaviors don't work out, the team allows the 'naturally occurring consequences' of the behavior to happen with no punishment from them and no excuses from the person (that doesn't mean there are no consequences—the consequences just occur naturally rather than being imposed by the mental health service provider). These consequences then form the basis for a 'teachable moment' in which the team helps the person to see that the behavior led to the consequence and that the ultimate consequence was not meeting the goal. Then the process of choosing alternative behaviors can begin again.

The individual assessment and service planning process will be tied to this paradigm from the first meeting. Participants will be encouraged to use the available treatment and case management resources in the manner that works best for each of them and which is most likely to help meet their individual goals. Recovery plan reviews will be based on each person's perception of his/her own progress towards the goals established during the initial intake and engagement process. Supportive counseling on a day-to-day basis will follow the tenets of MET and will focus on assisting persons served to meet their own goals.

When Motivational Enhancement is used with persons who have schizophrenia spectrum disorders, some modifications are needed to accommodate certain negative symptoms such as anhedonia, apathy and pervasive passivity that characterize the disorders. The primary modification is in the attitude of the provider, who will accept a non-linear path towards change without becoming frustrated. The offender does not necessarily have to come to the conclusion that he/she has a disabling mental illness in order for the strategy to work. Rather, he/she has only to recognize the areas of life that are not satisfying and consider the possibility that treatment adherence might help to improve them.

MET is often coupled with psychoeducation and cognitive interventions for most effective results. One of these is an EBP--Illness Management and Recovery (IMR). IMR is an intervention that helps people with serious mental illness to develop personal coping strategies that enable recovery. It can be provided individually or in group format and can accommodate the needs of people at various stages of recovery. Sessions include education and practical suggestions in nine areas:

- Recovery strategies
- Practical facts about mental illness
- The stress-vulnerability model and treatment strategies
- Building social support
- Reducing relapse
- Using medication effectively
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system.

Mental health personnel will conduct daily IMR sessions, covering the 9 topics described in the manual for IMR. The program will be use 45 minute sessions in groups of up to 12 individuals. Groups will be closed (meaning that cohorts will participate sequentially), but there will be more than one group per week, each at a different point in the continuum, so that offenders new to the program will be able to join quickly.

Psychiatric Medication: The psychiatrist, nurse practitioner, and other ITT members use MET to increase each offender's understanding of the rationale for each medication prescribed and its desired effects and potential side effects. Because many serious mental health conditions produce symptoms that include denial of illness, disorganized thinking, and lack of understanding of symptoms and medication effects, and because the medications themselves may produce uncomfortable side effects, and have complicated regimens, medication adherence is more the exception than the rule. Each team will devote considerable energy not only to managing the

prescribing of medication, but also to achieving the active collaboration of each service recipient to achieve medication compliance (both while incarcerated and after release). Team members will use some of the same motivational enhancement techniques and stages of change theories described previously to encourage insight and adherence to medication regimens. The use of these strategies and their effectiveness has been documented in the literature.

The psychiatrists and nurse practitioners will use these techniques, evaluating each person's medication history and current symptoms extensively. The prescriber will discuss the rationale for medication recommendations and expected short and long term effects and side effects of each with the offender, assuring him or her that the doctor or the nurse team members will meet with him or her as often as needed to review the medication effects and make adjustments in dose to maximize response and minimize discomfort. Team members report on each person's comments related to medication effects as well as their observations of the person's state of being in the daily log, clinical service notes, and verbally at the daily organizational team meeting. Medications for psychiatric conditions will be prescribed, monitored and administered in accordance with the DDOC procedures. Mental Health Vendor prescribers will coordinate with the Medical Services Vendor to ensure that medication orders are communicated and that the nursing staff receive any necessary training and support to provide the following:

- management of both psychotropic and non-psychiatric medications to prevent inadvertent drug and/or drug/food interactions and to help the individual to achieve maximum benefit from each medication prescribed
- use of decision trees and algorithms by the psychiatrist in selecting and adjusting medications and dosages
- close working relationship with the pharmacy
- written medication orders on a physician's order sheet in each person's record (this will ultimately be replaced by electronic prescribing and medication administration records, but these are currently in the development phase)
- longitudinal recording of all medications, dosages, effects, and discontinuations in each person's record
- charting of medication delivery and administration
- evaluation by the psychiatrist of each person's response to medication
- ongoing monitoring by all team members of each person's response to medication in the course of their routine interactions (including observations by DDOC staff, entered into the DACS
- timeframes and procedures for laboratory work, side effects exams, screening for metabolic effects, routine medical exams, and testing for infectious diseases.

The new generation of psychotropic medications can dramatically improve social performance and, for some people, reduce symptoms more effectively than older classes of medications, but they have serious side effects including weight gain, increase in blood sugar and the development of diabetes and metabolic syndrome. It will be important for the psychiatric prescriber to report to the Medical Services Vendor the need to monitor risk factors for offenders who are taking these medications.

Another complication of psychiatric medication is the unwillingness of people to take it as prescribed. Medication adherence is poor among persons with severe and persistent mental illness as with other chronic illnesses. The most frequent explanations for lack of adherence as prescribed are:

- not recognizing the need or potential benefit
- forgetting
- unpleasant effects
- absence of positive effects.

The most difficult factor in medication non-adherence to address is denial or lack of recognition of potential benefit. If the person does not endorse his or her assessed diagnosis, the psychiatrist and other CTT members attempt to relate the taking of a medication with the reduction of a problem that the person *can* acknowledge.

Other explanations for non-adherence are more common but usually interact in complex ways varying from person to person. Therefore, medication adherence strategies must be tailored to each individual. The CTT follows a coordinated and consistent approach, blending elements of the following adherence-promoting practices based on the individual's circumstances:

- Persistent efforts to achieve the person's trust and willingness to attempt medication adherence
- Being empathic and supportive to each person who is not achieving the intended medication effects
- Responding to each person's requests to change medication regimens
- Minimizing the complexity of medication regimens and unpleasant side effects as much as possible
- Providing medication education
- Continuing in other ways to serve individuals who refuses to take medication, while attempting to gain the person's confidence in the psychiatrist's judgment of the need for medication.

Treatment Planning:

Each offender receiving mental health treatment who remains in the DDOC for more than 72 hours will be offered the opportunity to collaborate with the ITT, including representatives of the Medical Services Vendor; the Mental Health Services Vendor; DDOC Security staff for the facility; DDOC treatment and other ancillary staff, in the development of a written individualized treatment plan. The comprehensive written plan will be derived from the assessment and will emphasize the individual offender's needs, strengths, and abilities. This plan will include the offender's goals and a plan for collaboration between the offender, identified natural supports and significant others, and the members of the ITT, to achieve those goals. Initial treatment plans are completed within 30 days of identification. Offenders who need mental health services will be assigned to one of two groups: 1) those who remain in the general population or on a specialized substance abuse unit and receive mental health services as an 'outpatient;' 2) those who need structured care and are placed on a specialized mental health unit. For those offenders receiving 'outpatient' services, the treatment plan will be revised every six months unless circumstances change (described later). For those offenders in structured care, the treatment plan is revised every 90 days.

The purpose of the treatment plan is to develop a specific set of goals with each offender that directly address any problems or needs in such a way as to bring about enhanced functioning and lead to recovery. Once these goals have been identified, the plan provides a means for detailing

interventions that can be carried out by team members, the offender, and other members of his/her support system help him/her achieve the goal.

Each ITT will be responsible for maintaining interface with other service providers, such as the Medical Services Vendor and DDOC staff to ensure that interventions are carried out as expected, to evaluate their effectiveness, and to resolve any conflicts. The Mental Health Vendor psychiatrists who are assigned to the facility will attend ITT meetings. Treatment plans will be fully revised at least every 90 days, or more frequently as warranted by changes in the needs of the offender. To ensure that revisions are made as conditions change and in response to needs of the service recipient, the following regular reviews will occur:

- At the time of initial assessment, and at least every six months thereafter (or more often if a key event or emergent issue arises) each offender will meet with his/her ITT to discuss treatment issues. These meetings will be documented in written form, using an agreed upon treatment plan format.

- Mental Health Program Directors will have formal contact with the all appropriate service providers in and outside of the facility to review progress, evaluate the effectiveness of the collaboration and to resolve any conflicts that might have arisen in the course of collaboration.

Treatment plans will indicate the extent to which prior goals have been achieved. If there has been no progress toward a goal, it should either be redefined or the interventions refined to make accomplishment of the goal more likely. Initial treatment plans are required to be completed within 72 hours of admission, and are in effect for a period not to exceed 45 days. After the initial 45-day period, a comprehensive plan will be completed and revised as described above.

Suicide Prevention and Psychiatric Close Observation:

If Connections is the successful bidder, we will implement a program to prevent suicide among offenders in all facilities in keeping with DDOC Policy Number G-05 regarding Suicide Prevention. Working with the DDOC security personnel and the personnel for the Medical Services Vendor, we will ensure that all mental health and substance abuse staff are trained to detect the risk and likelihood of suicide, the risk factors among offenders, and the roles and responsibilities of each staff member in detecting risk and preventing suicide in the facilities.

There are times when the risk of suicide is most acute among individuals who are incarcerated. These include the first 24-hours of incarceration; arrival at prison (especially for individuals who are intoxicated or under the influence of intoxicating substances); segregation or isolation within the facility; the receipt of bad news or significant loss (divorce, foreclosure, death, job loss, relationship break up); and the time surrounding court proceedings at which decisions will be made about charges, sentencing, etc. In addition, certain offenders are more at risk than others: those with acute or chronic mental illness or debilitating medical condition; those who are serving a long sentence; those who held a significant position in the community prior to incarceration; individuals who feel unsafe in the facility (may include sex offenders); those with a history of suicide attempts; and individuals who are very young. Some of these factors are dynamic, i.e., they change frequently, and therefore, all inmates must be considered at risk

during certain times. Other factors are more static and may be related to the person's mental or physical health or his or her relative status in the population. These individuals should be considered at risk all of the time.

In the correctional system, the job of detecting risk and intervening or referring for intervention a person who is at risk falls to all the personnel who interact with offenders. These include, but are not limited to, the Medical Services Vendor, the Mental Health Services Vendor, and the DDOC treatment and security personnel. All of these personnel are required to work together to identify, refer, and manage offenders who manifest suicidal or self-injurious thoughts and/or behaviors.

Awareness of the dynamic and static risk factors for suicide is a first step. All personnel should be cognizant of risk factors as they develop and will be trained not only to recognize these factors, but to communicate with all personnel—Medical Services, DDOC, and other Mental Health Services personnel—about which offenders are at risk at any point in time. The Mental Health Services Vendor will be responsible for developing and ensuring that adequate treatment and follow-up, including observation, are provided to reduce the risk for all offenders throughout the entire period of incarceration.

The Mental Health Services Vendor will develop and deliver eight hours of training in suicide risk assessment and prevention followed by two hours of annual refresher training. This training will be provided to all DDOC and vendor staff and will meet the standards in the DOC approved Suicide Intervention and Prevention curricula. Documentation of the training will be maintained in each employee's personnel file. Compliance with the training requirement for the Mental Health Services Vendor will be the responsibility of the Program Administrator and will be reported quarterly to the Bureau of Correctional Healthcare Services.

Offenders who enter any facility will be screened for suicide risk factors and potential signs/symptoms of risk during screening by the Medical Services Vendor. Offenders who are determined to be at risk will be referred to the Mental Health Services Vendor for evaluation before they are placed on a housing unit. The DACS will be used to track risk. Safe cells will be maintained where offenders who are deemed to be at-risk will be housed for constant observation while an order is obtained for placement on psychiatric observation. A licensed mental health professional will evaluate the individual at-risk within 24 hours and assign a level of observation needed to keep the offender safe. The assessment will be conducted in accordance with the DDOC policy on E-05 on Mental Health Screening and Evaluation and will include at least the following:

- Mental status examination
- Offender's self-report regarding the behavior that led to the referral
- Current suicide risk factors including active vs. passive ideation; plan to commit suicide; potential lethality of the plan; recent stressors; and any motivation or goal which is driving the suicidal behavior
- History of suicidal ideation and attempts including the date(s), method used or contemplated, previous triggers or motivations for suicidal thoughts and behaviors; consequences of previous attempts
- Offender's own view of his risk for suicide

- Offender's willingness and competence to agree to a plan of safety that includes verbal commitment to not engage in self-injury and to immediately report any change in his/her ability to adhere to that plan and commitment.

If the mental health clinician assesses the offender to be in need of Psychiatric Close Observation (PCO) or, if the offender continues to engage in self-injury after being placed on Suicide Precaution, the psychiatrist or psychiatric nurse practitioner must conduct an assessment within 24-hours.

In addition to providing immediate access to evaluation services through the use of 24-hour on call clinicians, the Mental Health Service Vendor will also provide trained observers, available 24/7, who will be trained to provide observation in accordance with the level of assessment assigned by the clinician. Placement in the infirmary requires an order by a psychiatrist which will remain in force until the order is removed by the psychiatrist. Once an offender is placed on PCO at any level, s/he will remain on that level for at least 24 hours, and will be 'stepped down' in 24 hour increments until the danger has passed based on re-assessment by the psychiatric practitioner or other approved personnel as described below. A log will be kept of all offenders in each facility who are on PCO with a record of the most recent psychiatric evaluation and the plan to reassess.

As described previously, any offender who has a positive mental health screening by the Medical Services Vendor, or any offender who is observed by DDOC personnel to be at risk for self-injury, will be referred to the Mental Health Services Vendor for a complete mental health screening and evaluation. This evaluation will always include an assessment of suicide risk. The Mental Health Director will work with the site DDOC personnel to determine the appropriate housing for any offender who is determined to be a suicide risk. Housing for offenders on suicide risk will be made as 'suicide resistant' as possible by removing any and all items that could be used for self-injury.

When an offender is going to be placed on any level of PCO, the licensed clinician who gave the order for PCO must document:

- An initial Psychiatric Observation Note that includes the suicide risk assessment and treatment plan
- An order for placement on watch if the offender is ordered to be housed in the infirmary (discharge from the infirmary must be ordered by a physician)
- A PCO level sheet, which is placed on the cell door
- PCO documentation is added to the problem list
- PCO orders are added to the observation log
- The results of a comprehensive mental health exam conducted before the offender is discharged from PCO (must be conducted by the psychiatrist, psychiatric nurse practitioner or PhD level licensed psychologist)
- Any discharge from PCO status requires an interdisciplinary discussion that includes DDOC personnel as well as representatives of the Medical and Mental Health Vendor
- A post-PCO updated treatment plan
- A medical evaluation by a physician within 24-hours of PCO placement.

Psychiatric Close Observation (PCO) will be initiated for any offender who is at-risk for suicide or who is decompensating psychiatrically to the point the s/he requires surveillance and increased management. PCO is 'staged' on levels, depending on the level of risk the offender presents. PCO Level I is initiated for any offender who is actively suicidal (this includes threats of self-injury). Offenders in need of PCO Level I are placed in special cells approved by DDOC for this use. The Mental Health Service Vendor provides trained observers who maintain direct and continuous visual observation of the offender which is documented in fifteen (15) minute intervals. The observation log is kept in the offender's medical chart and is also distributed to the Watch Commander and the Mental Health Director for the site.

PCO Level II is initiated when an offender expresses suicidal ideation but does not have a potentially lethal plan with which to carry out the thought. It may also be initiated for an offender who has a recent history of self-injury or suicidal gesture/attempt and who is exhibiting behaviors that are suspicious for self-injury, even when s/he does not express or admit to ideation. PCO Level II is also used for offenders who are actively decompensating and are, therefore, at risk to harm themselves or others. Offenders on PCO Level II status are housed in a cell approved by DDOC for either Level I or II use and then are observed at intervals not to exceed 15 minutes with the same documentation requirements described for PCO Level I.

PCO Level III is initiated for an offender who does not meet the threshold for Level I or II, but who is psychiatrically unstable or has risk factors suggesting that decompensation or self-injury are likely to occur. These offenders are housed in a cell which is approved for any level of PCO, with the same observation and documentation requirements described for PCO Level II.

PCO observation at any level is required to be carried out by a trained observer. Although electronic aids such as closed circuit television monitoring are permitted as a supplement, they are not permitted as a substitute for the observations required by clinical observers. At least once per day any offender on any level of PCO will be seen and assessed by a licensed clinician (LPC, psychologist, psychiatric nurse practitioner, or psychiatrist) who will document his/her observations, actions and plans on a Psychiatric Observation Note in the offender's medical record.

Post-PCO follow-up assessments will be scheduled with licensed personnel in accordance with the assessed needs of the offender. These follow-ups will be documented on the treatment plan and recorded on the progress notes in the record. The format of the documentation will include the subjective and objective results of observation and evaluation, the assessment of the clinician as a result of the observation, and a plan forward. These assessments will be conducted in the following minimal intervals, depending on the needs and condition of the offender:

- Within 24 hours of removing the PCO order
- Within seven (7) days of removing the PCO order
- Within fourteen (14) days of removing the PCO order
- Within thirty (30) days of removing the PCO order.

Post-PCO assessments will be tracked on a log that is available at all times.

Offenders who have been sent out for emergency or inpatient psychiatric treatment following a suicide attempt will be placed in the infirmary On PCO Level I upon return until they are evaluated by a doctoral level psychologist, psychiatrist, or psychiatric nurse practitioner. Prior to this evaluation, a mental health professional will perform and record a transfer assessment, including a contact with the on-call psychiatrist or licensed psychologist to determine if additional precautions are needed. This consultation contact and its results will be documented in the offender's medical record.

The site Mental Health Director will have the responsibility for ensuring that a psychiatrist is on-call 24/7 and will communicate the contact information for that person to the Medical Services Vendor and the DDOC custodial personnel. As described previously, the Mental Health Director at each site will also maintain a central record of all offenders who are on PCO and/or suicide precautions and will have a process for providing this information to all other personnel, including the medical and security employees. Part of the ongoing assessment process for offenders on PCO will be daily communication between the mental health staff, the medical staff and the security staff in order to obtain a complete picture of the offender's behavior and needs. This communication should include information about the offender's eating and sleeping patterns, mood, communication and any other factor that is important to understanding his/her condition. Weekly interdisciplinary meetings will be conducted to discuss the status of all offenders who are on PCO status. Any transfers to x-site facilities for treatment will be coordinated among the medical and mental health staff and the Watch Commander.

Restraints will be used only as a last resort to prevent serious injury. Any restraints, chemical or otherwise, that are used to prevent an offender from injuring himself or others will be ordered by a licensed person within their scope of practice and will be documented as to need for and type of restraint used. Any restraints that are used will be used in accordance with DOC policies and NCCHC standards for emergency psychotropic medications and therapeutic restraints. Reporting of any incidents involving suicide attempt or death will follow all DDOC policies and procedures. The site Mental Health Director will be responsible for providing a written report to the designated DDOC personnel by the next business day following any attempted or completed suicide. Mental health staff will participate in the Morbidity and Mortality Review for any serious suicide attempt or completed suicide. The Mental Health Director will collaborate with the Medical Services Vendor and DDOC security staff to conduct a Critical Incident Debriefing in the event of any serious suicide attempt or completion and will ensure that any other offenders who are in need of mental health services as a result of such an event receive the services they need, documented in accordance with the policy.

Segregation

All offenders who are being transferred to segregation will have a mental health evaluation before or within one hour after the transfer and will be seen by rounds by a psychiatrist or psychiatric nurse practitioner no less than three times per week while they are in segregation.

Boot Camp and Other Clearances

The mental health services provider will complete evaluations for Boot Camp and other clearances requested by DDOC within five (5) days of the request.

Other Emergencies
All Mental Health Services personnel will be trained in crisis prevention and intervention techniques, first aid, and CPR, including the use of Automatic Electronic Defibrillators (AED), and will maintain certification in these areas as agreed between the Medical Service Vendor, the Mental Health Services Vendor and DDOC.

A Sick Call will also be provided for all offenders, allowing them direct communication with the vendor. Offenders using Sick Call will receive a professional mental health evaluation using the same tools and techniques and credentialed personnel described previously for any such evaluation. We will use the DACS Sick Call tracking and appointment system and the appropriate electronic health record to record the event.

Withdrawal from Alcohol and Other Drugs
Offenders who are undergoing withdrawal from addictive substances will be monitored in accordance with the DDOC policies. The assessment for chemical dependency is part of the mental health evaluation and assessment and is made by a licensed clinician, psychiatrist, or certified alcohol and drug counselor (CADC) using the Addictions Severity Index (ASI), a well-researched and validated assessment instrument.

The U. S. Center for Substance Abuse Treatment published Treatment Improvement Protocol 44 (TIP 44), *Substance Abuse Treatment for Adults in Criminal Justice Settings*. The TIP describes in detail the process for assessing an offender to determine the extent of co-occurring mental health and substance use conditions, including screening for acute intoxication and/or withdrawal, which may require immediate medical intervention. The TIP describes the major topics to be covered during screening and assessment including observable signs and symptoms of alcohol or drug use, signs of acute drug or alcohol intoxication and withdrawal effects, drug tolerance effects, negative consequences associated with substance abuse, the self-reported history of substance abuse, age and pattern of first substance abuse, recent patterns of use, drug(s) of choice, and motivation for using substances. During such an assessment, a full examination is made of the offender's prior involvement in treatment, both in criminal justice and non-criminal-justice settings. The assessment will address current evidence of intoxication, dependence, overdose, and withdrawal. This is particularly important for offenders who are coming into the system as detainees from the community and those in community corrections settings, as these offenders may have had a significant period of substance abuse preceding DDOC contact. Mental Health Services Vendor staff and DDOC security staff will be trained to detect signs and symptoms of substance abuse and to refer offenders who appear to be exhibiting signs of withdrawal to medical staff for treatment of acute intoxication and withdrawal, and then back to the Mental Health Services Vendor for ongoing substance abuse treatment. Once an individual is referred for detoxification, medical staff should perform a comprehensive assessment to determine the level of prior and recent use, and the level of substance abuse or dependence.

Safe withdrawal from substances such as stimulants, cocaine, hallucinogens, and inhalants can be achieved with psychological support, symptomatic treatment, and periodic reassessments by healthcare providers. Frequent clinical assessments, along with appropriate treatment

adjustments, are also important since the intensity of withdrawal cannot always be predicted accurately (Federal Bureau of Prisons 2000). Some substances, such as alcohol, sedative-hypnotics, and anxiolytics, can produce dangerous withdrawal syndromes once physiological dependence has developed. Offenders who have severe and life-threatening symptoms of intoxication or withdrawal should be placed immediately under medical supervision. The Federal Bureau of Prisons (2000) recommends that 'inmates presenting with alcohol intoxication should be presumed to have alcohol dependence until proven otherwise.' Withdrawal from opiates can also cause both physical and psychological discomfort which may require medical treatment. Any offender who is observed to be experiencing physical withdrawal symptoms will be immediately referred to the Medical Service Vendor for appropriate medical intervention.

Not all substances of abuse produce clinically significant withdrawal syndromes, but abstinence generally results in some psychological changes. Offenders should be reassessed often by the Mental Health Services Vendor because substance abuse may mask co-occurring mental disorders, such as depression, or symptoms of mental illness may disappear when the offender is not using. In some cases, withdrawal may cause symptoms of mental disorders that can be identified and treated. Diagnoses should also be made with caution and adequate explanation. When identified with a diagnosis that will follow them throughout the system or even their lifetime (if entered into the criminal justice system's computer), people sometimes feel labeled and stigmatized. This is particularly true of diagnoses related to mental disorders. Because symptoms of mental disorders are often mimicked by recent drug or alcohol use, or withdrawal from these substances, it is particularly important to defer diagnosis until an adequate assessment period is provided under conditions of abstinence.

Many incarcerated persons have mental health conditions (approximately 16-20% of offenders in State prisons) (Ditton 1999). Of all of these individuals, 49–65 percent were under the influence of drugs or alcohol at the time of their offense, and 24–38 percent had a history of alcohol dependence. Much of the literature related to co-occurring disorders in the criminal justice system has focused on the most severe mental disorders, such as schizophrenia, bipolar disorder, and major depression (Broner et al. 2002). However, less severe disorders such as anxiety disorders, PTSD, less severe depression, attention deficit disorders, and various types of personality disorders are also common among offenders with substance use and mental disorders, and can affect treatment outcomes (Broner et al. 2002). An important first step in treating offenders with co-occurring disorders is to develop a systematic approach to screen and assess for these disorders.

Screening and assessment for co-occurring disorders should occur soon after entry into involvement in the criminal justice system. Many individuals who are screened or assessed in court, community corrections, or jail settings may be under the influence of alcohol or drugs and may need to be detoxified before determining whether they have co-occurring disorders. Acute symptoms of alcohol or drug use and post-acute withdrawal symptoms can mimic mental disorders, including anxiety, bipolar disorder, depression, and schizophrenia. It is important to identify patterns of recent substance abuse and to observe mental health symptoms over time to see if they resolve as the individual detoxifies.

Structured Care

For those offenders who are mentally ill and whose condition will not permit them to remain in the general population, we will work with DDOC to manage housing that provides structured mental health care and maintains conditions that are safe for the offender. Offenders who may need structured care include those with severe and persistent mental illness, such as schizophrenia, who are positively symptomatic at baseline, and who may need to kept in the structured situation for the majority of their sentence; and offenders who are experiencing acute symptoms of mental illness related to external events or other pressures, but who are expected to transition back into the general population after a period of intensive treatment.

Substance Abuse Services

Overview:
According to CSAT TIP 44, research consistently demonstrates a strong connection between criminal activity and substance abuse (Chaiken 1986; Inciardi 1979; Johnson et al. 1985). More than 80% of State prison inmates are using alcohol or other drugs at the time of their offense; 45% percent report that they were under the influence when they committed their crime; and 21% percent indicate that they committed their offense for money to buy drugs (Office). Data from the Arrestee Drug Abuse Monitoring program indicate that in 2000, 64% of male arrestees tested positive for at least one of five illicit drugs (cocaine, opioids, marijuana, methamphetamines, and PCP). Additionally, 57% reported binge drinking in the 30 days prior to arrest, and 36 percent reported heavy drinking (Taylor et al. 2001).

Research has consistently found that involvement in substance abuse treatment reduces recidivism. The Delaware Department of Correction, with the formation of the Key and CREST programs inside its level 4 and 5 facilities, has been a leader in the development of substance abuse treatment for offenders while they are incarcerated. A significant investment has been made in these programs—including the designation of more than 1,000 beds within the institutions for use as treatment beds. Keeping the beds full by identifying offenders who need treatment and recruiting them to obtain it is a critical goal for the Mental Health Services Vendor.

Table 5 on the following page depicts the staffing planned for the management and delivery of the substance abuse programming proposed in this response. Each site has a minimum of one program director, one clinical supervisor (the largest sites have 2), and enough counselors to staff two shifts daily with a caseload size not to exceed 20 offenders. This small caseload size allows for a high level of intervention, both individually and in groups. The staffing is depicted by program name, locations and capacity.

Table 6 depicts the total staffing needs for the proposed substance abuse programming.

Table 5: Proposed Substance Abuse Staffing by Program and Location

Program	Location	# of Beds	Proposed Staffing
Key North	Howard R. Young, Wilmington	200	Program Director (1) Clinical Supervisor (2) Admin Assistant (1) Counselors (11)
Key Village	Baylor, New Castle	58	Program Director (1) Clinical Supervisor (1) Admin Assistant (1) Counselors (4)
Key South	Sussex Correctional, Georgetown	120	Program Director (1) Clinical Supervisor (1) Admin Assistant (1) Counselors (6.5)
Crest North	Webb, Wilmington	76 plus 75 aftercare	Program Director (1)

Program	Location	# of Beds	Proposed Staffing
Aftercare			Clinical Supervisor (1) Admin Assistant (1) Counselors (7.5)
Crest North Aftercare	Hazel D. Plant, New Castle	68 plus 75 aftercare	Program Director (1) Clinical Supervisor (1) Admin Assistant (1) Counselors (7)
Crest Primary	CVOP, Smyrna	200	Program Director (1) Clinical Supervisor (2) Admin Assistant (1) Counselors (11)
Crest Central Aftercare	Morris, Dover	56 plus 75 aftercare	Program Director (1) Clinical Supervisor (1) Admin Assistant (1) Counselors (6.5)
Crest South	Sussex Correctional, Georgetown	90 plus 75 aftercare	Program Director (1) Clinical Supervisor (1) Admin Assistant (1) Counselors (8.25)
6 for 1 Men	Howard R. Young, Wilmington	80	Program Director (1) Clinical Supervisor (1) Admin Assistant (1) Counselors (4)
6 for 1 Women	Baylor, New Castle	30	Program Director (1) Counselors (2)
YCOP	Howard R. Young, Wilmington	40	Program Director (1) Counselors (3)
Boot Camp	Sussex Correctional	100	Counselor (1)
DUI Programming	TBD	50	Program Director (1) Admin Assistant (.5) Counselors (2)
DUI Programming	Baylor, New Castle	20	Program Director (1) Admin Assistant (.5) Counselors (1.2)

Table 6: Substance Abuse Staffing by Position

Position Type	FTEs	Comment
Program Director	13.00	
Clinical Supervisor	12.00	
Administrative Assistant	10.00	
Substance Abuse Counselors	74.95	
Employment Specialists (at VOP and work release centers only)	2.00	Not in contract—paid from a separate funding source
Total	**111.95**	

Staff Qualifications:

If we are awarded a contract, it is our intention to hire John R. (Jack) McDonough as the overall Program Administrator. McDonough will retire in 2012 after serving 25 years with the United

States Probation and Pre-Trial Services Office for the District of Delaware, where he worked as a probation office, senior probation officer, deputy chief, and where he currently serves as chief. While he has been the chief, the office has reduced recidivism by 58% according to an evaluation conducted by the University of Delaware by implementing evidence-based practices, including a nationally recognized work force development project. We believe that Jack McDonough has the right combination of security and programming background to produce the most effective program possible. In addition to the Program Administrator, we will employ an overall Clinical Supervisor who is a licensed clinician with co-occurring credentials and experience, who is capable of providing policy and service delivery guidance to the site-level mental health and substance abuse program directors and the director of sex offender services.

The Substance Abuse Program Directors will all be Master's prepared clinicians, who hold either a Delaware license as a professional counselor (LPC or LCDP) or a Delaware certification as an alcohol and drug counselor (CADC), and will have experience providing residential substance abuse treatment to offenders. Clinical Supervisors will hold at least a bachelor's degree and a CADC in Delaware. All other counselors will be certified at the time of hire or will be eligible for CADC certification within one year. For any counselor who is not certified at the time of hire, Connections will submit justification for hiring the individual along with a plan for him/her to obtain at least a CAAC within one year. All candidates will receive DOC clearance and written DOC approval before beginning work. As with the mental health positions, it is our intention to interview all existing employees of the current vendor who are interested in continuing to work in these programs, and to hire those who are able and willing to work within the clinical and philosophical framework that we propose.

Staff Training and Supervision: Later in the proposal we will outline a specific program that we intend to implement known as the Differential Substance Abuse Treatment (DAST) model. There is a defined process for DSAT facilitators to become certified to deliver the evidence-based practice. Licensed substance abuse providers are given intensive training and mentoring prior to delivering DSAT. Following the training, they videotape sessions for clinical supervision to ensure fidelity to the manualized program and adherence to Motivational Interviewing techniques. Facilitators are re-certified annually using the same process described below. Videotaped counseling sessions will be formally reviewed by the program evaluator and our training consultant for facilitator certification. The review results in a composite score based on the following rating scales:

- Organization
- Knowledge and Practice
- Program Integrity
- Group Facilitation
- Socratic Method of Delivery
- Communication Style
- Focus on Curriculum
- Demonstrating Empathy

Collaboration with DDOC Security Staff:

If Connections is awarded a contract, we will take our lead from the DDOC regarding security in both the mental health and substance abuse treatment programs. Our employees will receive

security training from the DDOC staff. We will work with DDOC to establish an open line of communication which goes both ways—we will inform the security staff regarding treatment activities, planning, scheduling, recruitment and movement of participants, and other issues that impact offender security. We will also seek input from the security staff regarding their observations of program participants' behavior as it pertains to mental health and substance abuse treatment.

Staffing and Work Schedule for Substance Abuse Programs:

Table 7, beginning on the next page, depicts the proposed work schedule by facility.

Table 7: Proposed Substance Abuse Staff Work Schedule by Program and Location

Program	Location	Day of the Week	AM Staffing (7AM to 330 PM Monday-Friday; 8 AM to 430 PM Saturday & Sunday)	PM Staffing (12 noon to 8 PM daily)
Key North	Howard R. Young, Wilmington	Sunday	Clinical Supervisor: 1 Counselors: 2	Counselors: 2
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Counselors: 2
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 2 Counselors: 7	Program Director: 1 Counselors: 3
		Wednesday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 7	Clinical Supervisor: 1 Counselors: 3
		Thursday	Program Director: 1 Clinical Supervisor: 2 Admin Assistant: 1 Counselors: 6	Counselors: 4
		Friday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 4	Counselors: 3
		Saturday	Clinical Supervisor: 1 Counselors: 3	Counselors: 2

Program	Location	Day of the Week	AM Staffing (7AM to 330 PM Monday-Friday; 8 AM to 430 PM Saturday & Sunday)	PM Staffing (12 noon to 8 PM daily)
Key Village	Baylor, New Castle	Sunday	Counselors: 1	Counselors: 1
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 1	Counselors: 1
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Program Director: 1 Counselors: 1
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Clinical Supervisor: 1 Counselors: 1
		Thursday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 2	Counselors: 2
		Friday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Saturday	Clinical Supervisor: 1 Counselors: 1	Counselors: 1

Program	Location	Day of the Week	AM Staffing (7AM to 330 PM Monday-Friday; 8 AM to 430 PM Saturday & Sunday)	PM Staffing (12 noon to 8 PM daily)
Key South	Sussex Correctional, Georgetown	Sunday	Counselors: 1	Counselors: 1
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Counselors: 1
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 4	Program Director: 1 Counselors: 2
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 4	Clinical Supervisor: 1 Counselors: 2
		Thursday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 3	Counselors: 3
		Friday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 3	Counselors: 1
		Saturday	Counselors: 2	Counselors: 1

Program	Location	Day of the Week	AM Staffing (7AM to 330 PM Monday-Friday; 8 AM to 430 PM Saturday & Sunday)	PM Staffing (12 noon to 8 PM daily)
Crest North plus Aftercare	Webb, Wilmington	Sunday	Counselors: 1	Counselors: 1
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Counselors: 1
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 4	Program Director: 1 Counselors: 2
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 3	Clinical Supervisor: 1 Counselors: 2
		Thursday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 3	Counselors: 3
		Friday	Program Director: 1 Admin Assistant: 1 Counselors: 4	Counselors: 1
		Saturday	Clinical Supervisor: 1 Counselors: 1	Counselors: 1

Crest North plus Aftercare	Hazel D. Plant, New Castle	Sunday	Counselors: 1	Counselors: 1
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Counselors: 1
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Program Director: 1 Counselors: 3
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 3	Clinical Supervisor: 1 Counselors: 3
		Thursday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 3	Counselors: 3
		Friday	Program Director: 1 Admin Assistant: 1 Counselors: 3	Counselors: 1
		Saturday	Clinical Supervisor: 1 Counselors: 1	Counselors: 1

Crest Primary	CVOP, Smyrna	Sunday	Clinical Supervisor: 1 Counselors: 2	Counselors: 2
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Counselors: 2
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 2 Counselors: 7	Program Director: 1 Counselors: 3
		Wednesday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 7	Clinical Supervisor: 1 Counselors: 3
		Thursday	Program Director: 1 Clinical Supervisor: 2 Admin Assistant: 1 Counselors: 6	Counselors: 4
		Friday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 4	Counselors: 3
		Saturday	Clinical Supervisor: 1 Counselors: 3	Counselors: 2

Crest Central plus Aftercare	Morris, Dover	Sunday	Counselors: 2	Counselors: 1
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Counselors: 1
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 4	Program Director: 1 Counselors: 2
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 5	Clinical Supervisor: 1 Counselors: 1
		Thursday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 3	Counselors: 3
		Friday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Saturday	Counselors: 2	Counselors: 1

Crest South	Sussex Correctional, Georgetown	Sunday	Counselors: 2	Counselors: 1
		Monday	Program Director: 1 Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 2	Counselors: 1
		Tuesday	Admin Assistant: 1 Clinical Supervisor: 1 Counselors: 3	Program Director: 1 Counselors: 2
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 4	Clinical Supervisor: 1 Counselors: 2
		Thursday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 3	Counselors: 3
		Friday	Program Director: 1 Clinical Supervisor: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Saturday	Counselors: 2	Counselors: 1

6 for 1 Men	Howard R. Young, Wilmington	Sunday	Counselors: 1	Counselors: 0
		Monday	Program Director: 1 Admin Assistant: 1 Counselors: 1	Counselors: 2
		Tuesday	Admin Assistant: 1 Counselors: 3	Program Director: 1 Counselors: 1
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 2
		Thursday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 2
		Friday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Saturday	Counselors: 1	Counselors: 0
6 for 1 Women	Baylor, New Castle	Sunday	Counselors: 1	Counselors: 0
		Monday	Program Director: 1 Admin Assistant: 1 Counselors: 1	Counselors: 2
		Tuesday	Admin Assistant: 1 Counselors: 3	Program Director: 1 Counselors: 1
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 2
		Thursday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 2
		Friday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Saturday	Counselors: 1	Counselors: 0

YCOP	Howard R. Young, Wilmington	Sunday	Counselors: 1	Counselors: 0
		Monday	Program Director: 1 Admin Assistant: 1 Counselors: 1	Counselors: 1
		Tuesday	Admin Assistant: 1 Counselors: 3	Program Director: 1
		Wednesday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Thursday	Program Director: 1 Admin Assistant: 1 Counselors: 2	Counselors: 1
		Friday	Program Director: 1 Admin Assistant: 1 Counselors: 1	Counselors: 1
		Saturday	Counselors: 1	Counselors: 0
Boot Camp	Sussex Correctional	Sunday		
		Monday	Counselors: 1	
		Tuesday	Counselors: 1	
		Wednesday	Counselors: 1	
		Thursday	Counselors: 1	
		Friday	Counselors: 1	

DUI Programming	TBD	Sunday	Counselors: 1	Counselors: 0
		Monday	Program Director: 1 Counselors:	Counselors: 1
		Tuesday	Program Director: 1 Counselors: 1	Counselors: 1
		Wednesday	Program Director: 1 Counselors: 1	Counselors: 1
		Thursday	Program Director: 1 Counselors: 1	Counselors: 1
		Friday	Program Director: 1	Counselors: 1
		Saturday	Counselors: 1	Counselors: 0
DUI Programming	Baylor, New Castle	Sunday	Counselors: 1	Counselors: 0
		Monday	Program Director: 1 Counselors:	Counselors: 1
		Tuesday	Program Director: 1 Counselors: 1	Counselors: 1
		Wednesday	Program Director: 1 Counselors: 1	Counselors: 1
		Thursday	Program Director: 1 Counselors: 1	Counselors: 1
		Friday	Program Director: 1	Counselors: 1
		Saturday	Counselors: 1	Counselors: 0

Substance Abuse Treatment Target Population:

Offenders who have identified substance use conditions and between 12 and 30 months remaining on their sentences are the target population for the Key Program therapeutic communities. Preference for participation in the CREST Program is given to offenders who have completed the Key Program. Screening and assessment will be designed to identify major mental health problems or psychopathy that would interfere with involvement in substance abuse treatment (although treatment in these programs will be co-occurring enhanced, and capable of making accommodations for many co-occurring conditions). This assessment approach will help to quickly identify offenders who are not good candidates for substance abuse treatment and

prevent the assignment of offenders who would perform poorly in the Key and CREST Programs to this relatively scarce resource.

Placement will usually be determined by the following factors:

- Risk for criminal recidivism (highest risk offenders will generally be targeted)
- Level of offender needs for substance abuse treatment, i.e., a serious history of substance abuse and substance abuse related crimes and/or a history of treatment failure in less intensive settings
- Offender motivation and readiness for treatment
- Other offender characteristics including cognitive and intellectual abilities, abilities to read and write, and related abilities to communicate in individual and group settings and to withstand stress in highly intensive therapeutic communities
- Low to moderate psychopathy as measured by an agreed-upon assessment tool for reasons described in a subsequent section of this proposal.

Research indicates that treatment programs that place individuals in services according to the areas described above are likely to enhance outcomes for offenders (Andrews et al. 1990; Gendreau 1996).

Whenever possible and sentencing permits, substance abuse programming will be on a continuum. Eligible offenders who complete the Key Program will be assisted to transition to the CREST program in a Community Corrections facility. Following completion of CREST, offenders will be assigned to Aftercare in an attempt to maintain gains achieved in treatment and reduce recidivism.

Special Populations:

The substance abuse treatment programs offered will include several programs for special populations:

- 6 for 1 Programs are offered to both male and female detainees with alcohol and other drug related charges, who are held at Young or Baylor, and who voluntarily agree to participate. The program uses a type of Incentive Contingency Management, offering sentencing reduction in exchange for agreed-upon participation in treatment.
- Young Criminal Offender Program (YCOP) operates at Young and is limited to male inmates between the ages of 16 and 18 who have been adjudicated in Superior Court because of the severity of their charges. The program helps the youth who participate to make future plans that don't involve substance use, and to develop pro-social values and behaviors.
- Boot Camp is a 6-month, military-style program. Boot Camp placement requires a court order. The program integrates substance abuse treatment with military discipline, life skills, community service, and re-entry skills including employment.

Referral Process:

Referrals for the Key Program are made by DDOC classification staff based on sentencing orders, admission interviews, and substance abuse screening provided by the Mental Health Services Vendor. Referrals will be designed so that completion of the Key Program corresponds with an offender's eligibility to move to Community Corrections, allowing them to be transferred

into CREST at the time of Key Program completion. The Mental Health Service Vendor will maintain an up-to-date list of all offenders who have been court ordered or referred to substance abuse treatment by DDOC and will coordinate with DDOC to recruit, transfer, and retain offenders in the treatment beds.

The Vendor will work with the DDOC classification staff to share information regarding the assessment of risk for future criminal and/or violent behavior based on offender characteristics and environmental factors. Once criminal risk factors are identified, research indicates that structured and intensive cognitive-behavioral approaches can address offenders' 'criminogenic needs' related to their dynamic risk factors (those that are likely to change over time) (Andrews and Bonta 1998). Offenders who are at high risk for criminal recidivism require more structured and intensive treatment interventions such as those provided in the Key and CREST Programs.

Andrews and Bonta (1998) have identified several promising treatment focus areas based on dynamic risk factors:

- Developing and improving life management, problem-solving, and self-control skills
- Developing associations or relationships and bonding with pro-social and anti-criminal peers and with pro-social and anti-criminal role models
- Enhancing closer family feelings and communication
- Improving positive family structures to promote monitoring
- Managing and changing antisocial thoughts, attitudes, and feelings.

As part of the assessment and recruitment strategy, we will work to identify factors that are important to determining the need for and likelihood of success in the Key and CREST programs. According to TIP 44, these factors include:

- Criminal history, including age at first arrest, number and type of prior arrests, history of violence and aggressive behavior, history of incarceration, probation and/or parole revocations
- Age, education, marital status, employment history
- Characteristics of psychopathy, including entitlement, impulsivity, superficial interpersonal relationships, lack of empathy, sensation seeking, poorly controlled anger
- Nature of offender's family and social network (pro-social versus pro-criminal)
- Other personality disorders, including paranoia.

The point of the referral system is to identify offenders who have significant risk for substance abuse and criminal recidivism and to prioritize those individuals for placement in substance abuse treatment services. The referral system will take into consideration mental disorder symptoms and impairment and the functional ability of inmates to engage successfully in the chosen program. Consideration will also be given to each offender's motivation and readiness for treatment, the length of sentence/ incarceration, prior history in treatment, violence potential, and other related security and management issues in determining which offenders to target for priority.

If we are awarded a contract, we will develop and maintain a centralized substance abuse treatment database to organize results from screening and assessment, to coordinate the recruitment and placement process, to monitor the availability of beds at the different levels of services, and to track offender progress in treatment.

Transition Resources:

One of the most significant assets that Connections brings to this RFP is our wide range of community programs and services that will provide transition resources for offenders who are re-entering the community. We recently completed a U.S. Department of Labor reentry grant that was one of the most successful in the country. With funding from the US DOL reentry grant between 2009 and 2012, Connections developed *Connect to Work*, an economic development arm that creates new jobs through the establishment of micro-industries. These small businesses include a janitorial services business, a restaurant and catering company, and a building and grounds maintenance business which provides training and employment in green construction and pest control practices. By working with employers in the community, Connections has developed additional jobs for ex-offenders by convincing employers to hire them. Together, these efforts have *created* more than 100 new jobs and *developed* 500 more jobs. During 2011 alone, Connections placed 557 individuals with significant barriers to employment in competitive jobs. Since April 2009, Connections has placed 268 ex-offenders into employment that pays an average of $9.43/hour for an average of 25 hours per week. These placements help ex-offenders meet release requirements imposed by DOC and their immediate survival needs while they work on developing and achieving long-term employment and training goals. We are proposing to provide up to four (4) employment specialists, to be spread among the aftercare programs throughout the state, leveraged and paid for through our ongoing relationship with the Delaware Department of Labor Work Force Investment Board and Division of Vocational Rehabilitation. Through this relationship, we are able to bring evidence-based employment and training resources, including training to achieve Serosae® food service certification and pest control licensure that will help reentering prisoners to get competitive jobs that pay a living wage.

Employment Specialists will have experience providing employment support for ex-offenders and will have small enough caseloads of motivated offenders to ensure the individualized and intensive support needed to help participants achieve good outcomes. Employment Specialists will work with participants to develop both a Vocational Assessment Profile (VAP) and a Strategic Plan for Employment. Employment services will also utilize the evidence-based Individual Placement and Support model in the SAMHSA NREPP. Reentering prisoners will be assigned to Employment Specialists who will use supported employment strategies in the provision of work-related services, with emphasis on competitive employment which pays a living wage and has benefits. Strategies include 1) rapid job search; 2) preference-based employment; 3) direct assistance with job development; 4) individualized support, including on-the-job training; 5) ongoing supports. Employers and reentering offenders know they can rely on the program when problems arise or jobs end. When the employment specialist can say to an employer that s/he will be available for as long as needed, it offers a sense of security and confidence to the employer and helps to develop jobs. Ongoing supports also give ex-offenders the confidence to continue working and develop coping skills when faced with potential problems.

Reentering offenders who are not able to find a job in the general economy with targeted assistance by an employment specialist within 7 days of release will be offered a job with *Connect to Work*, a network of social enterprises that can directly employ individuals as laborers, janitors, landscapers and food service workers. At the same time that they are working in transitional jobs, participants will receive vocational assessment, job training and support services. The Vocational Assessment Profile will be used to assess individual abilities, interests and preferences; identify logistical and other barriers to employment; assess experience, economic needs and future aspirations; and consolidate the information into a Strategic Plan for Employment. The employment plan may include on-the-job or classroom training in a targeted high growth employment area identified by DOL and its Workforce Investment Board; obtaining a GED or high school diploma; and/or enhancing financial literacy and other soft skills.

Connections will provide access to training and employment opportunities in culinary arts, building and grounds care, and pest control. Connections Culinary Futures program, a culinary arts training program that provides graduates with the industry standard ServSafe® certification, will be available to all program participants who are interested in a career in food service. Connections is a provider of culinary arts, janitorial, and pest control training for the Delaware Department of Labor, and operates a catering and restaurant businesses that produces more than 2,000 meals per day for homebound people, school children and homeless individuals and families, employing 25 offenders in diverse roles including line cook, restaurant manager, delivery driver and food service utility. The janitorial services company has more than $1 million in contracts to clean state office buildings, toll plazas, road maintenance centers, court houses and National Guard facilities and buildings owned by Connections and other local businesses. Connections works with several general contractors who have LEED green building certification. The contractors hire ex-offenders in our program and provide training in green construction principles to carry out demolition and materials salvaging/recycling subcontracts.

The job development and ongoing skills training components of the program focus on several high-growth industries identified by the Delaware DOL including 1) green construction and materials recycling; 2) green landscaping and grounds care; 3) food preparation and serving workers; 4) janitors and cleaners; 5) laborers. In addition, we work with the Delaware Technical and Community College to offer certified nursing assistant training and training in customer service and retail skills, which, along with food service, are the fastest growing non-professional occupations.

The rate of educational attainment among Delaware's prisoners on average is at the 6th grade level; many returning prisoners will be in need or want to complete a high school diploma, attain a GED, or receive specialized job training. Educational assessments of each participant will be conducted at program entry/orientation. Those participants who are academically prepared to complete their high school diplomas will be directed to EdOptions Online Academy, for which Connections has already purchased licenses. EdOptions is a fully accredited high school offering an award-winning curriculum, certified teachers and high school diplomas. EdOptions is tailored to the individual's educational needs and offers flexible, customized educational solutions. Access to computers for "class-time" will be offered, and participants will be guided by Employment Specialists to complete their high school diploma online.

Some participants will need Adult Basic Education that can ultimately lead to GED preparation. Ex-offenders whose assessments indicate a more intensive need for educational attention will be referred to an adult ABE/GED provider with which Connections has a positive and effective partnership, including but not limited to West End Neighborhood House, Inc. and Delaware Technical and Community College. ABE/GED services will be offered at no-cost to ex-offenders. Referral to either Del Tech or West End is preferred because both offer continuing educational options post-GED attainment, such as national accreditations/certifications in retail customer services, CNA, pharmacy tech, medical billing and coding, Microsoft Office, Dreamweaver and Flash certifications, and technical training and certifications for HVAC, welding, electrical, and facilities maintenance, all of which are listed as a "High Growth Services" in labor market research.

Since 2009, Connections has been providing financial literacy training for individuals who participate in our employment programs. In 2011, we helped more than 200 individuals—many of them reentering offenders--to complete it. The training is based on the FDIC 'Money Smart' program and includes the eleven program modules plus a session on the Delaware Landlord Tenant Code. The Money Smart modules are:

- Bank on It--an introduction to bank services
- Borrowing Basics--an introduction to credit
- Check It Out--how to choose and keep a checking account
- Money Matters--how to keep track of your money
- Pay Yourself First--why you should save, save, save
- Financial Recovery--how to recover financially and rebuild your credit after a financial-setback
- Keep It Safe--your rights as a consumer
- To Your Credit--how your credit history will affect your credit future
- Charge It Right--how to make a credit card work for you
- Loan To Own--know what you're borrowing before you buy
- Your Own Home—what homeownership is all about.

Once Money Smart training is completed, participants are eligible to open an Individual Development Account, a matched savings account, managed by a participating nonprofit, which matches every dollar saved by the participant with as much as $2.50 up to a designated cap. Money saved and matched in an IDA can be used for higher education, to start a business or to buy a home. This program is open to everyone who completes the financial literacy training.

Connections participates in Delaware's SOAR initiative (SSI/SSDI Outreach, Access and Recovery) providing direct assistance to help homeless persons rapidly qualify for benefits through the Social Security Administration. We have submitted more than 370 applications for homeless individuals since July 1, 2008, 80% of which have been approved within 90 days. In Delaware, individuals who are eligible for SSI are automatically eligible for Medicaid. Individuals who are parents, children and single adults with incomes below 100% of poverty are also eligible for Medicaid, which greatly enhances their access to healthcare services, including behavioral healthcare. There is an on-line application process for Delaware social services benefits (ASSIST), including Medicaid, General Assistance, TANF and food stamps. The proposed program will use SOAR and ASSIST to maximize access to mainstream resources.

Currently, Connections employs several public benefit specialists who use the ASSIST program, Delaware's online application process for general assistance, food stamps and Medicaid, to make application for all public benefits. At the same time, they initiate a Social Security application, either a new application or an application to resume benefits, based on the individual's status. One of the first things they do is to help participants to obtain copies of their birth certificates and social security cards so that she could take them to the Division of Motor Vehicles and obtain state-issued identification cards (this activity is also done as part of the I-ADAPT process for those offenders who are eligible and agree to participate, and we would coordinate with I-ADAPT). The benefits specialists have learned the importance of quickly obtaining identification through their experience and participation in the nationwide network of organizations in Social Security's SOAR initiative, which was implemented as a partnership between several government agencies and nonprofit providers. Through SOAR we developed a training and delivery system to ensure that all people who are likely to interact with a homeless person and/or a person with a disability—including reentering offenders--are able to quickly assess the person's potential eligibility and assist the person to submit a strong SSI/SSDI application that will be approved within 90 days of submission. We will bring these skills to enhance our transition resources if we are the successful bidder.

In addition to our extensive employment, training, and financial assistance services program, Connections owns and/or operates more than 600 units of affordable housing, developed through federal grants and participation in the Delaware State Housing Authority's Low Income Housing Tax Credit and Neighborhood Stabilization Programs. Through the use of housing locators who have extensive knowledge of the housing market throughout the service area and a centralized housing application and waiting list process, Connections assists low income individuals and families to obtain subsidized housing within Connections' own array of housing as well as through local housing authorities and other private agencies. If we are awarded a contract to provide mental health and substance abuse services for DDOC, we will use all of the resources at our disposable—the HUD supportive housing program for homeless persons, Delaware State Housing Authority's housing development funds and programs, and other similar resources—to develop additional housing to which reentering offenders can be referred. Connections is well positioned to help each re-entering prisoner to develop a post-transfer housing plan that meets his/her needs for ongoing, affordable housing.

Connections also provides a wide range of community-based behavioral health services in virtually every population center in Delaware. Between January 1 and December 31, 2011, Connections provided 89,953 visits to 8,202 unduplicated persons in these programs, which include outpatient psychiatry; outpatient mental health and addictions counseling; medication assisted treatment for alcohol and opiate addiction; DUI treatment; and family psychoeducation and therapy. We operate clinics in Brandywine Hundred, downtown Wilmington, Newark, Smyrna, Dover, Georgetown, Seaford, and Millsboro, and inside the federally qualified health centers operated by Westside Family Healthcare and La Red. Services include bilingual counselors and are fully co-occurring enhanced. These services will be brought in-kind to the proposed contract, sustained by third-party payments, contracts with the Delaware Division of Substance Abuse and Mental Health, and philanthropic resources.

We believe that this extensive array of reentry resources and services, coupled with our demonstrated experience and success providing reentry assistance to hundreds of Delaware offenders over the last several years, uniquely qualifies us to attain the transition success that is so crucial to the proposed mental health and substance abuse treatment programs.

Program Phases:

Similar to most evidence-based substance abuse treatment, the Key/Crest programs are designed to provide treatment that is 'phased' from beginning to end, roughly matching the length of time the offender is in the programs. The theoretical underpinning for phased treatment is the realization that most people who achieve recovery do so as the result of a gradual development of resolve that leads to changing the many behaviors that perpetuate the problem. This theory was developed and expanded upon by Prochaska and DiClemente (1983) who identified that people progress through five distinct stages in the course of committing to and sustaining quitting problematic substance use, which also apply to pro-criminal behavior in many ways:

1. Pre-contemplation. The person is not intending to stop the behavior and tends to avoid thinking or talking about stopping;
2. Contemplation. The person recognizes the pros and cons (benefits and costs to him/her) of the behavior, is open to the idea or need of change, but is experiencing ambivalence and may not be conscious of the specific cause(s) of it;
3. Preparation. The person is intending to stop the behavior in the immediate future and is willing and able to actively participate in organized activities meant to help him/her stop;
4. Action. The person has accomplished a cessation or reduction of the behavior and actively participates in a plan to abstain from it;
5. Maintenance. The person has abstained from the behavior for a significant period of time. S/he experiences infrequent or non-intense urges to resume the behavior, is able to resist acting on them, and requires less frequent or intensive participation in organized activities to sustain abstinence.

Studies of this theory of change involving persons with substance conditions support the matching of stages of change with phases of treatment that address the readiness of the individual to effectively participate (Bellack and DiClemente, 1999; DiClemente et al., 2004; Zhang, 2006). Therefore, we propose a model that includes various treatment strategies timed to correspond to the individual's intention and behavior relative to cessation of substance use. Table 8 illustrates correspondence between the stages of readiness to change and the phases of treatment. The model assumes that CREST participants have moved beyond pre-contemplation and contemplation while participating in the Key Program.

Offenders will meet behavioral and treatment requirements to move from one phase of treatment to the next. These will include attending all required sessions; completing all treatment plan assignments; displaying the behavioral indicators for phase movement contained in the treatment plan; have no behavioral sanctions within two weeks of the phase movement; completing and/or adhering to all security or institutional requirements; pass a written or oral examination on the phase from which they are moving.

Table 8: Stages of Change/Phases of Treatment

Stages of Change	Phases of Treatment	Key Phase	CREST Phase
Precontemplation	Engagement	Phase 1	n/a
Contemplation	Persuasion	Phase 1	n/a
Preparation	Persuasion/Active Treatment	Phase 2	Phase 1
Action	Active Treatment	Phase 2	Phase 2
Maintenance	Relapse Management/Recovery	Phase 3	Phase 3

Studies support that matching the emphasis of treatment to the stages of change promotes positive change (DiClemente et al., 2004; Zhang, 2006). Therefore, the proposed treatment model varies in time frames and treatment strategies to correspond to the individual's intention, insight and behavior. The Phases of Treatment—engagement, persuasion, active treatment, and relapse prevention--are matched to the Stages of Change to ensure that offenders are receiving the interventions that are most likely to be effective for them based on their individual readiness. Clinical strategies to be used at each stage of change are depicted in Table 9, below:

Table 9: Clinical Strategies in Phases of Treatment

Stage of Change	**Process**	**Definition**	**Interventions**
Pre-contemplation	Consciousness Raising	Increasing information about the problem	Orientation to the treatment program; Observations; setting up cognitive dissonance between personal goals and substance use (Motivational Enhancement); psychoeducation; exploration of perceived positive and negative aspects of behavior
Contemplation	Self-reevaluation	Assessing how one feels and thinks about oneself with respect to problem behaviors	Value clarification; imagery; corrective emotional experience; challenging beliefs and expectation; identifying incompatible personal goals and competing motivations

Stage of Change	Process	Definition	Interventions
Determination/ Preparation	Self-liberation	Choosing and committing to act or believing in ability to change	Decision making skills; commitment-enhancing techniques; development of a plan for change
Action (and beyond)	Counter conditioning	Substituting alternatives for problem behaviors	Relaxation, desensitization, assertion, refusal skills, self-affirmations
	Stimulus control	Avoiding or countering stimuli that elicit problem behavior	Restructuring the environment, avoiding high-risk cues and triggers, fading techniques
	Reinforcement management	Rewarding oneself or being rewarded by others for making changes	Contingency contracts, overt and covert reinforcement, self-reward
	Helping relationships	Being open and trusting about problems with people who care	Therapeutic alliance, social support, self-help groups, homogeneous therapy groups with others at same stage
	Emotional arousal and dramatic relief	Experiencing and expressing feelings	role playing
	Environmental re-evaluation	Assessing how one's problems affect personal environment	Empathy training, role playing, recovery work
	Social liberation	Increasing alternatives to problem behaviors	Recovery skills, alternative activities

The format for providing services will be a mixture of individual and group interventions. Group interventions will occur after the initial assessment and motivational enhancement process is completed and will be homogeneous, i.e., groups will be composed of persons who are in the same stage of treatment and have similar treatment needs. The proposed program will separate persons who are in the pre-contemplation and contemplation stages of change from those in the action and maintenance stages to ensure that clinical interventions and related services are specifically keyed to those stages. Content of individual and group sessions is discussed further in a subsequent section of the proposal.

Treatment Content

Assessment: Treatment planning requires a comprehensive assessment of an offender's substance abuse history and patterns of use, including drug(s) of abuse, chronological patterns of use, specific reasons for use, consequences of use, and family history of drug and alcohol abuse. The number and type of substance-related charges as well as the presence of intoxicating substances at the time of arrest will be considered. The assessment will focus on determining the impact of use on the individual's community adjustment, his or her attitudes, and his or her associates and the extent of substance use and criminal behavior among those associates. Using the Addictions Severity Index as a tool for data collection the counselor will take an alcohol and other drug use history that inquires about the frequency, dosage, and types of drugs used as well as times at which, or settings in which, an offender uses. Assessment will be completed within 72 hours of admission to a substance abuse treatment program.

Assessment of the severity of substance use may lead to an actual diagnosis of a substance use or dependence disorder, but a diagnosis will not be required for participation in treatment. Routine use of illicit drugs without a diagnosable disorder can be a legitimate focus for treatment, since any use is illegal and may result in arrest or violations of community supervision guidelines.

It will also be important to assess the presence and impact of psychological and emotional problems that are not the direct result of substance abuse. Offenders with severe substance use disorders have relatively high rates of co-occurring depression, bipolar disorder, attention deficit disorder, PTSD and other anxiety disorders, and personality disorders. These disorders can contribute to the development of substance use problems, or the emotional disorders may develop as a consequence of the physiological effects of long-standing drug use and stressful or traumatic life events. Some offenders come to prison with mental health problems; others develop them while incarcerated.

Both the mental health and substance abuse programs we are proposing will be designed so that they can provide effective treatment for co-occurring disorders, especially those disorders that can be managed effectively with medication and counseling within the treatment setting. When co-occurring conditions are not assessed and addressed concurrently, these underlying problems can increase the likelihood of relapse. It is also hard to distinguish between the symptoms of post-acute withdrawal from substances and anxiety and depression. Substance abuse may mask an underlying mental disorder that may not become apparent until the offender is no longer using drugs or alcohol. For these reasons, it is important to repeat and update assessments regularly during the treatment process.

Many incarcerated offenders have experienced problematic early lives that have included being physical and sexual abuse, witnessing violence among family and friends, and being subjected to other traumatic events. These issues are not always identified during the assessment process, but it is important that they be reflected in the treatment plan once they are identified and then treated with interventions likely to be effective in reducing their impact. Although the anxiety and depression that is related to withdrawal from substance use will decline over the first few months of abstinence and treatment, individual suffering from post-traumatic stress may continue to have depression, nightmares, and other trauma-related symptoms throughout the course of treatment. These offenders will be referred for further mental health assessment and treatment.

Such interventions may be instrumental in preventing substance abuse relapse and allowing the offender to continue making progress within her substance abuse treatment program.

Each offender who is recruited and placed in the Key or CREST Programs or other specialized substance abuse treatment, will receive an orientation that will include an explanation of

- Services offered
- Program description
- Overall treatment requirements and guidelines
- Treatment planning processes
- Group attendance guidelines
- Offender rights and responsibilities
- Confidentiality requirements
- Introduction of staff
- Description of assessment process and purpose
- A handbook will be distributed containing essential information

Before the offender leaves the orientation session, a clinical assessment is scheduled within three days. The assessment is used for all of the purposes that have been described above, but also is conducted to engage the offender in the treatment process by helping him/her to identify personal goals; obtain information about and request consent to contact appropriate collaterals; screen for, detect, and determine the severity of mental health, substance use, and gambling conditions, including any disabilities or other factors that could impact the offender's ability to participate the program; identify strengths; identify and address cultural or linguistic needs/resources; determine readiness for change; and provide information for use in the development of a treatment plan. The proposed program will provide integrated assessment for mental health, substance use, and gambling to establish baseline symptoms and behaviors related to any and all conditions, each within the context of the other.

Connections has adopted a scientifically-based and systematic approach to comprehensive assessment. The purpose of the assessment is to determine if there is a need for treatment, to ensure that the appropriate level of care is determined, and that the client is referred to the appropriate treatment facility according to ASAM Patient Placement Criteria. The primary assessment tool is the Addictions Severity Index (ASI), a well- established biopsychosocial assessment device with extensive research supporting its use with people with substance abuse conditions described at length in the earlier section of the proposal on mental health assessments. The ASI is an interview format that covers seven areas of a client's life. It covers medical, employment/support, drug and alcohol use, legal, family history, family/social relationships and psychiatric problems. The interview is conducted by a trained counselor. The ASI will be bolstered by a clinical interview conducted by a qualified counselor who will use ASAM PPC, to determine the appropriate level of care. Every assessment will include a gambling screen using the South Oaks Gambling Screen (SOGs).

At a minimum, the assessment documentation will include:

- ASI (electronic version)
- ASAM PPC Summary
- Assessment Summary and Reason for Treatment

- Mental Health Assessment, including any information that has been obtained from mental health treatment the offender has received in DDOC
- Intake Case Conference
- Gambling Screening (SOGS or GSI if indicated)

The assessment will provide information regarding the following dimensions:

- Acute intoxication/withdrawal potential
- Biomedical conditions and/or complications
- Emotional/behavioral/cognitive conditions and/or complications
- Readiness to change
- Relapse/continued use potential
- Recovery environment.

Properly implemented, the process of completing the initial assessment promotes development of a therapeutic relationship and provides a beginning understanding of the person's goals. The initial assessment consists of brief summaries of the person's perception (and the referral source's explanation) of the events and circumstances resulting in his/her referral; availability of social supports; history of mental health and substance abuse conditions; perception of personal strengths, needs and goals; and the clinician's recommendations for developing the initial treatment plan.

In order for the treatment of the substance use condition to be effective in reducing future recidivism, and to design cognitive behavioral treatment that addresses the correct elements of thinking and behavior, it is important to assess whether criminal attitudes and behaviors predated drug and alcohol abuse and whether criminogenic personality features will impede involvement in treatment. In addition to substance use disorder severity and presence of psychopathology, pro-criminal attitudes and personality features are the most important predictors of treatment outcome. Crimes committed by drug-involved offenders may not be completely the result of drug-acquiring behavior or attributable to intoxication. Many drug-involved offenders do show reductions in criminal activity while they are abstinent and involved in treatment, as compared with periods of active substance abuse (De Leon et al. 1982; Deschenes et al. 1991). However, this is not always the case.

Many offenders begin their criminal careers before the onset of substance use, and the use of substances is part of a broader pattern of anti-social behavior that includes criminal acts. Procriminal values, procriminal associates, and psychopathy are associated with *both* substance abuse and the commission of crimes, and it can be difficult to sort out the 'cause and effect' of each. According to TIP 44,

> 'Procriminal values in adults are most often the result of the combination of early involvement with delinquent peers, the experience of parental neglect or abuse, the absence of prosocial resources and strengths (such as literacy, employability, and social skills), and exposure to an overly permissive or procriminal environment, such as an unsafe school or crime-ridden neighborhood. Examples of procriminal values include intolerance for personal distress and unwillingness to accept responsibility for behaviors that adversely affect others. Procriminal values and attitudes, coupled with a longstanding pattern of antisocial and criminal behaviors, are the key elements of psychopathy.'

The same conditions often lead to association with procriminal 'friends' often developed during incarceration or involvement in criminal justice programming, including substance abuse treatment. Procriminal values and thinking, as well as criminal associates, are rooted in normal cognitive, emotional, and social processes, such as the need for belonging and approval, the need to feel life is 'fair', and the need to feel a sense of security. Because the origin and perpetuation of these factors are based primarily on thoughts, emotions, and ways of relating that are within normal limits, they can be changed using the methods we are proposing to use as our clinical approach, such as motivational enhancement and cognitive behavioral therapy. Individuals whose criminality results primarily from procriminal attitudes and associations can learn new ways of thinking and valuing, as well as new ways of feeling and how to manage their feelings.

Psychopathy is distinguished from both procriminal values and procriminal associates in that it can be described not so much in terms of something that a person has learned as a result of circumstance, but as personality trait with biological underpinnings. i.e., something that s/he is 'born with.' Personality disorders are distinctive, longstanding, pervasive patterns of behavior, which usually begin early in life and affect almost every aspect of a person, such as thinking, feeling, perceiving, and relating to others, involving increasingly maladaptive behaviors. Research suggests that psychopathy is the result of interactions between biological differences—primarily located in the brain (Anderson et al. 1999; Laakso et al. 2001)—and the most early experiences that shape the personality, such as the experience of bonding, attachment, and concern for others (Hare 1996). Psychopathy is expressed in ways of thinking (impulsive, irresponsible, and grandiose) and feeling (without empathy and shallow) that typically result in behaviors that seriously infringe on the rights of others. The most notable characteristic of individuals with severe psychopathy (other than persistent criminality and exploitation of others) is the lack of normal attachment to and value for other people. Although they can be glib and charming, people with psychopathy have a shallow and fleeting ability to experience, express, and understand social emotions such as embarrassment, self-consciousness, shame, guilt, pity, and remorse. Their lack of empathy is usually the basis for a lack of remorse for criminal behavior and is supported by the belief that society and the victim are at fault, rather than the perpetrator, or that the damage done by one's crimes is of little consequence (Hare 1998).

The Psychopathy Checklist-Screening Version (PCL-SV) can provide an important screening mechanism for identifying offenders who exhibit this personality trait. Offenders who are low in psychopathy do well in substance abuse treatment in the criminal justice system, and the treatment has a positive impact on their future pattern of offending. Individuals high in psychopathy require more intensive in-prison and community supervision and monitoring. Treatments for individuals with high psychopathy should be limited to practical relapse prevention activities, including relapse to illegal or seriously self-defeating forms of manipulation and exploitation of others, with increased monitoring for drug use. Offenders with severe psychopathy tend to do poorly in treatments of all types, when compared to those without severe psychopathy. In fact, there is evidence that offenders with severe psychopathy who receive substance abuse treatment are actually more likely to re-offend than those with psychopathy who go untreated (Hobson et al. 2000; Reiss et al. 1999, 2000). This suggests that treatment is most likely to be effective for substance-involved offenders with low to moderate psychopathy.

As described previously, assessment of treatment readiness and stage of change are also useful in treatment planning and in matching the offender to the correct phase of treatment. For individuals in the early stages of change, placement in treatment that is too advanced and that does not address ambivalence regarding behavior change may lead to early termination from the program. For offenders who are in later stages of change, placement in services that focus primarily on early recovery issues may also lead to premature termination from treatment. Staff involved in treatment planning should be careful to assess the offender's stage of change and readiness for substance abuse treatment and to consider this information when developing treatment plan goals.

Later in the proposal, we describe the use of the Differential Substance Abuse Treatment (DSAT) model, an evidence based program that is used in the state of Maine. DSAT requires the use of a specific assessment process that allows for pre- and post-test evaluation of the program's effectiveness. The screening tools are completed (they can be done manually) and entered into a database for the purpose of program evaluation. In June of 1999 BDS/OSA requested assistance from the Center for Substance Abuse Treatment (CSAT) in the development of an automated assessment system for all inmates entering the Maine State Correctional System. CSAT/SAMHSA provided technical assistance for this project under the State Systems Technical Assistance Project. The specific technical assistance on the project was provided by JBL a Canadian consulting firm providing services to governmental organizations regarding substance abuse issues, health and social policy, and training and development.

The DSAT Substance Use Screening Assessment (SUSA) forms the entry point for offenders entering the DSAT system. The questionnaires in the SUSA were selected based on the following criteria: 1) they are brief; 2) they are relatively easy to administer and score; 3) they are easy to interpret given appropriate norms; and 4) they are widely used instruments with demonstrated validity in the research literature. The SUSA is composed of six brief questionnaires that are administered to the offender by computer (they were originally done by hand and still can be completed that way and entered later if access to computers is a problem). These questionnaires measure two primary characteristics of substance abuse problems: severity of dependence on substances and the degree to which the individual has experienced negative consequences of his/her substance use. These two primary characteristics have been shown by research to be related to risk of criminal behavior (Graves, Rogers, & Bell, 2000).

Research with correctional populations has also shown that severity of substance use problems correlates very highly with risk of future criminal behavior. The more severe the offender's substance use problems, the greater the likelihood of future criminal behavior. The SUSA directly assesses severity of substance use problems and assigns an overall risk/need severity level based on that assessment. The SUSA also contains two measures of readiness to change substance use behavior. These indicators measure the degree to which the offender recognizes the s/he has a substance use problem and is willing to take steps to alleviate that problem. To the extent that an offender is not ready to address substance use problems, there is a need to focus initial treatment more on motivation to change than on changing substance use behavior itself.

The SUSA automatically produces two reports at the end of the assessment. The offender Output Report displays information on the offender's need/risk level. The Classification Output Report contains a print out on all screening items that the offender scored in the "positive" direction.

The detailed information found in the Classification Reports assists the treatment professionals who are responsible for guiding the offender through comprehensive assessment and treatment services.

The specific questionnaires comprising the SUSA are divided into two categories: 1) those focused on alcohol-related problems and readiness to change those problems; and 2) those focused on drug-related problems and readiness to change. Below is a brief description of the questionnaires and the scoring criteria for each.

Alcohol-focused Measures:

Short Alcohol Dependence Data (SADD) – The SADD (Raistrick, Dunbar & Davidson, 1983) is a 15-item scale that is sensitive to alcohol dependence. Respondents answer items using a four-point scale (never, sometimes, often, and nearly always) to indicate the extent to which various alcohol dependence related events have happened to them. When answering the SADD, offenders are asked to refer back to the 1-year period prior to arrest to represent a "typical intake" pattern with respect to his/her alcohol use. Scores are calculated by summing client responses from 0=never to 3=nearly always.

Michigan Alcoholism Screening Test (MAST) – The MAST (Seizer, 1971) is a measure of drinking-related events that is cumulative across the respondent's life span. Responses are given various weights that are then summed to yield a score that reflects the weight of the cumulative consequences of alcohol use across the respondent's lifetime. The MAST has also been scaled to yield ranges of severity of problems with drinking (Miller & Marlatt, 1984).

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) – The SOCRATES (Miller & Tonigan, 1996) is a scale that measures readiness to change problem behaviors with respect to alcohol (i.e. the degree to which the respondent is ready to stop drinking) and to enter treatment. For the SOCRATES there are three "scales." Ambivalence (A) which taps the degree to which the respondent is unsure about the benefits of changing his/her drinking and is "on the fence" about whether or not to change his/her drinking. Recognition (R) measures the extent to which the respondent recognizes that his/her drinking is a problem that needs to be addressed. Taking Steps (T) assesses the extent to which the respondent has begun to actually make changes in drinking or drinking-related behavior. Respondents rate themselves according to a five-point scale (ranging from strongly disagree to strongly agree) on each statement. The score is calculated by summing the responses to items associated with each of the three scales.

Drug-focused Measures:

Severity of Dependence Scales (SDS) – The SDS (Gossop, Darke, Grffiths, Hando, Powis, Hall & Strang, 1995) provides an objective measure of the severity of dependence (also known as "addiction") for up to three client normative drugs, other than alcohol. The offender is first asked if s/he used drugs at all prior to incarceration/arrest. If the answer is "no," the client discontinues the questionnaire. If the answer is "yes" the offender is then asked to indicate, by a check mark, up to three drugs s/he used on a regular basis (defined as at least once a month) over the preceding year. The offender answers five questions, using a four-point scale response format, for each of the three drugs s/he identified as using most regularly prior to incarceration/arrest.

When answering the SDS questions, the offender is asked to refer back to the 1-year period prior to arrest in order to represent his/her "typical intake" pattern with respect to his/her favorite substances. Scores are obtained for up to three drugs used and is based on assigning points to each response, summing across all responses for each particular drug. Responses are coded 0-3 with Never/almost never=0, to Always/nearly always=3. Higher total scores indicate greater severity of drug dependence, hence a more significant need for treatment.

Drug Abuse Screening Test (DAST) – The DAST (Skinner, 1982) is a comparable instrument to the MAST for assessing consequences resulting from drug use that have accumulated over the respondent's lifetime. As with the MAST, respondent's answer each question either "yes" or "no." Scoring of the DAST sums across all items in the questionnaire.

Stages of Change Readiness and Treatment Eagerness Scale-Drugs (SOCRATES-D) – The SOCRATES-D is similar to the SOCRATES in that it measures readiness to change problem behaviors, with respect to drug use rather than alcohol (i.e. the degree to which the respondent is ready to stop using drugs), and readiness to enter treatment for drug abuse. The SOCRATES-D yields the same three scales as the SOCRATES: Ambivalence, Recognition, and Taking Steps, and is scored and interpreted in the same way as the SOCRATES. Norms for the CSA have been developed using a hand-administered sample of approximately 1,100 MDOC inmates who completed it in 1998 and 1999. Both male and female inmates were included in this sample that resulted in the interpretive cut-x scores the CSA produces and uses to classify offenders into levels of risk and need for substance abuse treatment.

Concerns regarding the validity and truthfulness of the data gathered by the SUSA are addressed in several ways. First, the offender must answer all items, ensuring that there is no missing information. Second, the program prevents the offender from moving back more than one questionnaire and therefore minimizes opportunities for offenders to "fudge" the data. It is most effective if the SUSA is computer administered. Research has consistently shown that computer administered assessments obtain data that are equal in accuracy to, if not more accurate, than information gathered by a human interviewer face to face. The computer also does not "prompt" particular types of answers. Research has also shown that people generally like interactions with the computer and are at least as honest as they are in a face-to-face interview with a human interviewer. All of these factors make the computer administered assessment an accurate and cost-effective way of gathering data in sensitive situations.

The SUSA ranks offenders into severity categories based on the results of the screening battery: 1) None; 2) Mild; 3) Moderate; 4) Substantial; and 5) Severe. These five categories refer (with the exception of "None") to specific dependence levels for a combined alcohol and drug measure at each level (based on physical and psychological dependence). This five level classification system will also operate effectively within the prisons to clearly identify inmates at the "Substantial" and "Severe" levels as a basis for making referrals to the Key and CREST programs (Graves, Rogers, & Bell, 2000).

Treatment Planning

As described in the section of the proposal addressing mental health treatment, it is our position that--if at all possible--all treatment planning should include the offender, the primary clinician, other members of the treatment team, and members of the DDOC security and treatment staff. This approach is supported in the literature, including CSAT TIP 44, which outlines substance treatment protocol in criminal justice settings. Treatment plans should contain a section addressing motivation for change. From the first point of intake to the final community supervision session, using the offender's own motivations to change is the most important component of the program we are proposing.

It is also important that treatment planning use a strengths-based approach as opposed to a deficit or 'problem' based approach. Strengths can be recognized and used in treatment planning without neglecting deficits or decreasing the necessary emphasis on accountability and responsibility. Offenders tend to exaggerate or minimize their strengths. By helping them to accurately identify their strengths and motivations for treatment, the strengths-based treatment plan can set the stage for changing thinking and behavior. Within the therapeutic community settings, offenders can take on roles that are consistent with their strengths and work to develop them further. Identifying and working with strengths in the treatment planning process can reduce defensiveness and create an alliance among the offender and the other members of the community and the ITT that can lead to more positive participation in the treatment process.

Each offender will be assigned a lead counselor who will have the primary responsibility for managing the assessment and treatment planning process, establishing and maintaining a therapeutic relationship with the offender, and for maintaining the integrity of the clinical record. Each participant will have a comprehensive written treatment plan, derived from the assessment and emphasizing the individual's strengths and needs. This plan will include the person's own goals and an assessment of his/her readiness for treatment.

The purpose of the treatment plan is to develop a specific set of goals with each participant that directly address any problems or needs in such a way as to bring about enhanced functioning and lead to recovery. Once these goals have been identified, the plan provides a means for detailing interventions that can be carried out by treatment team members, the person served and others (such as security officers) in the milieu to achieve the agreed upon goals.

Each ITT will be responsible for maintaining interface with DDOC staff, mental health and medical care providers to ensure that interventions are carried out as expected, to evaluate their effectiveness, and to resolve any conflicts. Treatment plans will be fully revised at least every 90 days, or more frequently as warranted by changes in the offender's circumstances.

Treatment plans will indicate the extent to which prior goals have been achieved. If there has been no progress toward a goal, it should either be redefined or the interventions refined to make accomplishment of the goal more likely. Initial master treatment plans are required to be completed within 7 days of admission, using a format that is agreed upon between the DDOC and the vendor. Table 10 depicts the usual treatment activities in each phase of treatment.

Table 10: Treatment Activities Planned at Each Stage of Treatment

Phase/Stage of Treatment	Minimum Treatment Activities	Average Duration
Pre-contemplation (engagement/assessment) (Key Phase 1)	Orientation to the program Assessment Master Treatment Planning Individual Counseling (2x week) Psychoeducation Groups (3 daily)	90 Days
Contemplation (persuasion/orientation) (Key Phase 2)	Individual Counseling (2X week) Psychoeducation Group (2 daily) CBT Groups (1 daily) UDS/Labs (as determined by DOC)	150 days
Determination/Preparation (treatment planning and active treatment) (Key Phase 2, CREST Phase 1)	Individual Counseling (2 x week) CBT and other Group Counseling (5 X week) Psychoeducation Groups (5X week) Family Session (if applicable) (1 x month) UDS/Labs (as determined by DOC) Motivational Incentives Co-occurring groups (if applicable) 2X week Life Skills Education (2 x week) Vocational assessment/ planning Self Help Meeting Preparation groups (1 x week)	60 days
Action (active treatment and rehabilitation) Key Phase 2 and 3; CREST Phase 2	Individual Counseling (4 x month) Group Counseling (CBT and individualized groups) (1 x week) Motivational Incentives Family Session (2 x month) UDS/Labs (per DOC) HIV/STD education (1 x week)	60 days

Phase/Stage of Treatment	Minimum Treatment Activities	Average Duration
	Life Skills Education (2x week) Vocational Planning (1 x week) Self Help Group preparation (1 x week) Case Management	
Recovery/Relapse Prevention Key Phase 3; CREST Phase 3	Individual Counseling (4 x month) Relapse Management/WRAP/ Health Maintenance Group (3 X week) UDS (per DOC) Family Session (2 x month) Transition Planning (daily) Self-Help Attendance (daily)	60 days

Individual Counseling

The frequency of individual counseling is determined by the offender's stage of change/phase of treatment as depicted in Table 10 above. In the beginning, the purpose of individual counseling is to help the offender to identify personal goals that are in conflict with his or her substance abusing and criminal behavior. As treatment intensifies, the sessions become more frequent, and are oriented around changing thoughts and behaviors that lead to substance abuse and criminal activity.

Individual sessions will be conducted using Motivational Enhancement Therapy (MET). MET uses a nonjudgmental platform to analyze and dissect feedback gained from client sessions to re-pattern client behavior that is the result of ambiguous and undefined thoughts. This therapy is presented in a direct and targeted manner that strives to transform undesired behaviors.

The goal of MET is to aid the client in clarifying his or her own perceptions and beliefs in order to direct him or her in a more decisive way. Most people who respond to this type of treatment have struggled for years in a mire of ambivalence and welcome the opportunity to have vision and focus in their lives. MET is commonly used for the treatment of addictions, including abuse of alcohol and other substances. MET is administered in a receptive atmosphere that allows a client to receive feedback from the therapist for the purpose of fortifying the client's resolve for transformation and to empower the client with a feeling of self-control. Rather than engaging the client's defense mechanisms through confrontational discourse, the therapist works with the client to create positive affirmations and a sense of inner willingness to facilitate change. Once that is achieved, the client becomes receptive to the process and progresses toward recovery.

Offenders who are faced with the challenge of substance abuse experience similar emotional and mental symptoms to rebellious adolescents, including resistance, narcissism, relational difficulties, and moodiness. MET has been proven to provide substantial relief from these symptoms and has been recognized as a useful tool for gaining control of these unwanted behavior patterns. MET can be applied to clients regardless of their commitment level. It has shown significant efficacy in clients who have previously demonstrated strong resistance to or weak motivation for change

Motivational Enhancement Therapy (MET) is based on the principles of motivational Interviewing (MI) originally developed by Dr. William Miller at the University of New Mexico. The MET approach is designed to mobilize the client's own resources in order to produce rapid, internally motivated change (Miller et al., 1992). The approach is based on several decades of clinical research on motivation and the stages of change model (Miller, 1991). The goal of MET is to increase problem recognition and the probability of treatment entry, continuation, and compliance (Miller,1993). The approach is also effective for helping individuals to choose life goals and to maintain behavior that is consistent with achieving them as opposed to maladaptive behavior that leads away from the achievement of goals.

Group Counseling

The proposed substance abuse treatment program will use several manualized evidence-based treatment programs to provide consistent group therapy at the scheduled intervals shown in Table 10. The amount and type of group counseling that each offender receives is based on the phase of treatment that s/he is in. In the earliest phases of treatment, group work will be largely didactic and psychoeducational, providing the training that the offenders will need to accept their need for treatment and effectively participate in cognitive behavioral therapy.

RoadMAP Toolkit: The RoadMAP Toolkit is a multimedia group counseling curriculum toolkit which was developed by the Treatment Research Institute (TRI) in Philadelphia to provide counselors with a resource that supports the use of CBT in addictions treatment. According to Brooks et.al. in an article in the *Journal of Substance Abuse Treatment*, the most frequently used methods of training counselors—continuing education seminars lasting a few hours—have proven to be ineffective. However, when these seminars are combined with ongoing coaching and feedback, their efficacy increases (2012). The RoadMAP Toolkit was developed to 'capitalize on the cognitive theory of multimedia learning' (Brooks, 2012) by providing a package of materials—videos, posters, a counselor guide, worksheets, and wallet cards, that systematically deliver the desired information to both the counselor and the participants at the same time. Through a 'Learning by Teaching' approach, the Toolkit helps counselors to develop critical skills—such as functional analysis—that are needed to effectively provide CBT. The Toolkit is ideal for the DDOC setting, where there are multiple counselors working across many sites, because it is an 'off the shelf' package, i.e., counselors can use it with fidelity after a 90 minute introduction. The curriculum can be used for offenders who are at lower levels of risk and need than those targeted for the Key Program. Because it is short, it can also be used with detainees who exhibit a need for substance abuse treatment and offenders who are not close enough for release to be eligible for Key.

In six sessions, the RoadMAP Toolkit delivers the following content:

- My addiction pattern/my alternative plan (MAP)
    - Participants behaviorally analyze or MAP past episodes of substance use (can also apply to criminal activity) What happened? Who else was there? When and Where did it happen? How did you feel? What were the effects?
    - Participants learn to recognize triggers to problem behavior
    - Participants learn to schedule and follow through with activities that do not involve substance use

- Coping with Cravings (CwC)
    - Participants learn the basic characteristics of cravings
    - Facilitator helps participants to apply five evidence-based coping skills to craving situations
- Drug Refusal Skills
    - Participants learn the characteristics of effective refusal
    - Participants and facilitator discuss effective drug refusal skills in hypothetical situations
    - Participants practice refusal skills through role play with constructive feedback
- Managing Difficult Emotions
    - Recognize and monitor emotional states that can lead to using
    - Apply coping skills learned in Session 2 to managing difficult emotions
- Seemingly Harmless Decisions
    - Recognize decisions that seem harmless but may lead to high-risk situations
    - Create an 'all-purpose coping plan' to anticipate consequences
- Making Recovery Matter
    - Discuss short- and long-term recovery goals
    - Set a goal plan for recovery in motion

The central clinical activities of the RoadMAP Tollkit are to teach participants to analyze their typical patterns of drug and alcohol use; to teach participants how to schedule their time and follow-up; to reinforce the core theme of 'recognize, avoid, and cope' with high risk situations; to mediate and facilitate group activities such as role play; to teach and discuss coping strategies for high-risk situations; and to elicit commitment from participants top apply skills and reinforce practice outside of group.

Differential Substance Abuse Treatment (DSAT)*:* The Maine Office of Substance Abuse (OSA), Maine Department of Corrections (MDOC), and the Judicial Branch worked in collaboration to target reductions in recidivism by developing a model for providing assessment and treatment of substance abusers involved in the criminal justice system. This collaboration resulted in development of the Differential Substance Abuse Treatment (DSAT) model – based on Motivational Enhancement and Cognitive-Behavioral treatment - to provide a continuum of comprehensive substance abuse services to adults in all MDOC adult correctional institutions, as well as community settings across six counties in Maine. The term "differential" refers to not only the differentiation between the specific needs of women and men in substance abuse treatment, but also to the level of substance use severity.

DSAT is the treatment model used in all the State of Maine Adult Correctional Institutions, the Maine Coastal Regional Reentry Center, and the pilot program in the County Jails under the jurisdiction of the Maine Board of Corrections, and is embedded in the therapeutic communities within the correctional setting. In women's facilities, it is augmented by the trauma-informed Seeking Safety curriculum, which is described in a subsequent section of the proposal.

DSAT personnel undergo two training sessions prior to their certification. The first training event is a 5 day Basic Training, the second is an annual 1 day "booster" event. These trainings teach participants how to deliver each of the sessions and further develop and refine skills, ensuring program integrity. Video feedback and role playing are used as a mechanism for supervision and certification as a program facilitator. Process and outcome evaluations are used to assess the functioning of the programming. The results on the CEST (Client Evaluation Self-Test) indicate that offenders who participated in the DSAT curriculum experienced a reduction in depression, hostility, and risk-taking behaviors, and an increase in social conformity, and therapeutic involvement. In 2008, the Maine Office of Substance Abuse was awarded the SAMHSA Science to Service Award for effective delivery of DSAT. The elements that were noted as most effective were DSAT's continuum of services; collaboration between Maine Department of Corrections (MDOC), the Judicial Branch and the Office of Substance Abuse; the training and certification of facilitators; and the use of quality assurance mechanisms.

Evaluation shows that DSAT can be effectively delivered through the mechanisms described (SAMHSA 2008). The DSAT curriculum engages many of the offenders in the treatment process. They report good rapport with the counselors which is an important predictor of engaging offenders in treatment programming. Fewer drug court participants (17.5%) recidivated during a 12 month post-program follow-up than a comparison group of adult offenders traditionally adjudicated (33.1%). Overall, results of the analysis on DSAT clinical pre/post treatment measures reveals many significant improvements in the attitudes, coping behaviors and confidence of participants in their ability to refrain from drug and alcohol use (Ferguson, et. Al., 2006).

The DSAT system is based on a conceptual model of criminal behavior that reserves the most intensive treatment services for offenders with the highest levels of criminal need/risk (i.e., severity of dependence on alcohol/drugs) in order to achieve the greatest impact in reducing criminal behavior. Less intensive services are reserved for those offenders with lower levels of dependence on alcohol/drugs. The community treatment phase of the DSAT Model has the dual objective of providing both transitional and treatment services that teach offenders how to cope with high-risk situations.

The DSAT Model is grounded in empirical research. It uses manually guided CBT and Motivational Interviewing to provide services that are differentiated by gender and level of acuity. The facilitators are uniformly trained and certified to deliver DSAT (in addition to their CADC certification). Manualization of the program and certification of facilitators to deliver it ensures that DSAT is consistently delivered across setting.

The overarching goal of DSAT is to reduce criminogenic thinking, thus reducing recidivism. Research demonstrates a direct relationship between the severity of a person's dependency and criminal behavior, which in turn correlates with characteristic thinking errors. The DSAT curriculum targets criminal behavior by focusing the participant's thought process on effective problem solving and decision making skills, motivating participants to consider how they arrived at their decisions to act in a criminal manner, and how preoccupation with drugs and alcohol influenced those decisions.

In addition to screening measures discussed in the assessment section of this response, a Questionnaire Battery is administered to all participants. It consists of four standardized instruments that, in general, measure the participant's outlook toward coping with situations that are high risk for use of alcohol and drugs. The entire Questionnaire Battery is fairly brief and under normal circumstances, should take no more than 20-30 minutes to complete. The four instruments are as follows:

Alcohol and Drug Refusal Self-Efficacy Questionnaire (ADRSEQ)
The ADRSEQ (R.M. Young and R.G. Knight,1989) is a 3-factor, 31-item measure that has been slightly modified from its original form to assess drinking and drug use-related self-efficacy. The three factors are drinking and drug use in situations characterized by social pressure, emotional relief, and opportunistic drinking and drug use. Four items have been added to the original version (items 25, 26, 27 and 35), to enhance its capacity to address situations pertaining to women, yielding a 3-factor, 35-item measure that is used in the women's program. The ADRSEQ can be used to follow progress in treatment, and it can also be used to plan treatment. The original instrument (alcohol only) can discriminate between problem drinkers. The instrument has been widely used in research for understanding and treatment of substance abuse problems.

Drug Avoidance Self-Efficacy Scales (DASES)
The DASES (G.W. Martin, 1992) consists of 16 items. For each item, participants are asked to imagine themselves in a particular situation and to rate their level of confidence (self-efficacy) to resist drug use in that situation. The DASES covers a broad range of levels of confidence and has been shown to be sensitive to changes in self-efficacy associated with treatment as well as to post-treatment adaptation to the natural environment following inpatient treatment. The DASES was developed for use with young drug abusers and provides a measure of treatment progress with regard to coping with risk situations. The DASES is useful as an outcome measure because it has demonstrated predictive validity; that is, scores on the scale have been shown to predict subsequent substance use behavior. Self-efficacy assessed at the completion of treatment was a significant predictor of drug use. There is also evidence supporting the general validity and reliability of the scale, although its use has been restricted to young multiple drug users.

Coping Behaviors Inventory (CBI)
The CBI (G.K. Litman, J. Stapleton, A.N. Oppenheim and M. Pelag , 1983) is a 36-item inventory that assesses the alcohol/drug user's use of coping strategies in response to an urge to drink or use drugs. The CBI was designed specifically to assess the behaviors and thoughts of substance abusers in response to external circumstances or internal mood states to prevent, avoid, or control the resumption of use. The inventory consists of 14 cognitive and 22 behavioral items. Research suggests that it is a reliable and valid measure of the frequency of use of cognitive and behavioral coping responses. Use of the CBI in outcome studies has shown the measure to be a sensitive indicator of change following addictions treatment. The scale has been applied to male and female substance users from a range of age groups including adolescents, adults, and the elderly.

Commitment Scales (CS)
The Commitment Scales (S.M. Hall, B.E. Havassy and D.A. Wasserman, 1990) are two simple 10-point scales that are designed to measure the participant's commitment to abstaining from or

changing their use of alcohol/drugs. Research suggests that the degree of commitment to a goal of abstinence is one of the most effective predictors of treatment outcome in substance users. In fact, commitment to abstinence has been found to be the single best predictor of use status after treatment, regardless of degree of treatment participation. The scale has been used with a wide range of substance using adults in treatment, including those who use alcohol, opiates, cocaine and nicotine.

Inventory of Drug-Taking Situations (IDTS)

The Inventory of Drug-Taking Situations (IDTS) is only administered at one point in the DSAT program**,** during Session #5 on risk situations, in the Intensive treatment phase. The IDTS (H. Annis, N.E. Turner, S.M. Sklar, 1997) was developed by the Addiction Research Foundation in Canada, and is similar to the 100 item Inventory of Drinking Situations (IDS; Annis, Graham, Davis, 1987). The IDTS measures risk for drug use as well as heavy drinking and therefore provides a comparison of risk situations for different substances. The IDTS is a 50-item self report questionnaire that generates individual profiles of clients drug and/or alcohol use situations over the last year. Client's rate each of the 50 situations using a four point scale of Never (1) to Almost Always (4). This instrument was originally developed for use in cognitive-behavioral programming to identifying client risk situations. The IDTS consists of two questionnaires (one for alcohol, one for other drugs) that assess a client's substance use over the same 50 risk situations. Up to three substances that are causing the client problems can be identified and assessed using the IDTS instrument. Results from each IDTS administered assist the therapist and client in identifying specific triggers for each substance. The IDTS is a well-validated assessment tool that has been used in a wide array of clinical and treatment contexts. This instrument is appropriate for use in both individual and group programs, and with clients whose substance problems range from mild to severe. Within the Community DSAT program, the IDTS is used to provide an individualized profile of a client's drug and/or alcohol use. This information is used to plan treatment, identify and address high-risk triggers for relapse, and assist in planning for aftercare.

Drug Taking Confidence Questionnaire (DTCQ)

The Drug Taking Confidence Questionnaire (DTCQ : H. Annis, S.M. Sklar, N.E. Turner, 1997) was developed by the Addiction Research Foundation in Canada. The (DTCQ) is administered twice to DSAT participants during the first and the next-to-last sessions of the Maintenance Phase of DSAT treatment (Pre & Post-Maintenance). It is a 50-item self-report questionnaire that asks client's how confident they are that they would be able to resist the urge to drink or use a specific drug in 50 specific situations. Clients rate their confidence using a 6-point scale which ranges from 0% (not at all confident) to 100% (very confident). Like the IDTS, the DTCQ can assess up to three specific substances that are identified as causing problems for the individual client. The drinking and drug-taking situations that the DTCQ assesses are based on an eight-category classification system developed by G.A. Marlatt and his associates (Marlatt, 1978, 1979; Marlatt & Gordon, 1980, 1985). The DTCQ was also developed using a previously validated measure, the Situational Confidence Questionnaire (SCQ; Annis & Graham, 1988). The SCQ also measured self-efficacy related to situation specific coping related to alcohol use, and was used in cognitive-behavioral therapy and studies of treatment outcome.

Essential components of the DSAT model include a comprehensive assessment system and a menu of treatment options at varying levels of intensity. Progression in treatment follows a sequence of phases – Substance Abuse Screening Assessment, Comprehensive Assessment, Motivational Enhancement, Pre-Treatment Groups, Intensive Treatment, and Maintenance Groups – grounded in proven Motivational and Cognitive-Behavioral practice models. Treatment options are designed to best meet the needs of offenders, whether in prison, in transition, or in the community. The internal logic of each session is designed to help develop and enhance cause-and-effect recognition, and the ability to move from abstract understanding to a practical application of each concept.

Lessons are structured to foster interactivity, and to create a balance of objectivity, focusing on each participant's own behavior and attitudes. Standards for implementing the DSAT curriculum are also detailed in a DSAT Implementation Manual and in the core DSAT Treatment Manuals.

Before DSAT delivery, participants receive uniform screening and comprehensive assessment, the results of which are entered into a database for comparison of post-test results after the offender completes the program. All participants in the first phase of treatment receive Motivational Enhancement Therapy (MET) delivered in four (4) group sessions over a two week period. These sessions are augmented by individual MET sessions with each offender in which the assessment results are reviewed and used to stimulate the development of the offender's own personal goals. During the Intensive Phase, two (2) three-hour group sessions are conducted each week using CBT; the final Skill Building phase includes 24 sessions delivered twice per week. As previously described, Cognitive Behavioral Therapy (CBT) is an empirically supported treatment that focuses on patterns of thinking that are maladaptive and the beliefs that underlie such thinking. CBT targets the individual's thinking and behavior. DSAT achieves criminal risk reduction by using 'The Need Principle' which posits that needs are predictive of criminal behavior. Needs are dynamic risk factors that can be changed through treatment. DSAT identifies a list of criminogenic needs that it seeks to impact:

- Substance Abuse
- Anti-Social Attitudes
- Anti-Social Associates
- Anti-Social personality patterns
- Lmited involvement in anti-criminal leisure or recreational activities
- Lack of employment stability
- Weak family relationship

The methods used in DSAT are based on research that indicates that change is best obtained when certain conditions have been achieved:

- Ambivalence is resolved
- Client is afforded autonomy in deciding whether or not to change
- The client makes the argument for change
- The client has reached level of self-efficacy so s/he believes s/he can make the change.

DSAT uses CBT to explain substance abuse and dependence based on several inter-related variables including social, environmental, psychological and biological factors. CBT teaches concrete cognitive and behavioral skills by modeling pro-social and anti-criminal behaviors. Participants learn to identify and change faulty and criminal thinking through small group processing of case studies. The model is repetitive: Each lesson builds on previous ones, skills are practiced and become ingrained. The skill building phase continues to enhance skills and lessons learned during the intensive phase.

A critical function of DSAT is the matching of offenders to appropriate levels of treatment. Matching is important for several reasons: 1) There is evidence that "over-treating," i.e., providing a more intensive level of treatment intervention than is warranted by problem severity may produce poorer outcomes.; 2) Matching insures that resources are allocated appropriately and that expensive, intensive interventions are not utilized with inmates who could benefit from less expensive and less intensive interventions (Rotgers & Graves, 1999).

DSAT is designed to deliver services that are different based on assessed levels of acuity. The program considers five levels of severity based on screening and assessment scores: None, Low, Moderate, Substantial, Severe. More intensive treatment services are provided for offenders with the highest risk. Less intensive services are provided for lower levels of dependence on alcohol or drugs. Those with the highest levels of severity would be treated in the Key/CREST settings. Other offenders would be offered treatment that resembles 'outpatient' treatment while remaining in the general population. Table 11 below depicts the process.

Table 11
Institutional DSAT Program
Men and Women at Levels 1-4+

- **Substance Use Screening Assessment (SUSA)** – 20-30 minute computer or paper and pencil assessment. Scored at Level 1-4, Levels 3-4 referred for CAI (or w/ staff override).
- **Comprehensive Assessment Interview** (CAI) – 3 hour individual client interview to assess appropriateness for program and level of treatment need.
    - **Level 1:** Assessed as having no AOD dependence: Preventive intervention - 5 sessions of interactive and experiential groups (2 hours/group). Client-centered, skills acquisition psycho-educational programming with CBT foundation
    - **Level 2:** Assessed at low level of AOD dependence-10 sessions of interactive and experiential groups (2 hours/group). Client-centered, skills acquisition psycho-educational programming with CBT foundation; 3 Maintenance sessions

- **MI/MET Component**
    - **Level 2:** 1 Individual Session
    - **Level 3:** 2 Individual Sessions – Priming and Mid-Treatment 1.5 hours/session; 2-3 Group Sessions 1.5 hours each group

    - **Level 4/4+:** 2 Individual Sessions – Priming and Mid-Treatment 1.5 hours/session; 3-5 Group Sessions 1.5 hours each group

- **Intensive Treatment: Closed Groups**
    - **Level 3:** 15 Groups-3 hours/group
    - **Level 4/4+:** 26 Groups-3 hours/group

- **Maintenance Groups: Open and can be repeated/continued**
    - **Level 3:** 5 Groups-2 hours/group
    - **Level 4/4+:** 6-10 Groups-2 hours/group

Offenders enter one of the four levels of institutional programming based on a match between criminal need and risk identified through the screening and assessment procedures. The Therapeutic Community is classified as a Level V intervention. In addition, cognitive-behavioral interventions are offered at each of the five levels of institutional interventions. The cognitive-behavioral interventions are developed according to a conceptual model of criminal behavior and are based on program components that have research evidence of treatment effectiveness.

The DSAT Model operates according to a "continuum of treatment" that extends from institutional to community treatment. The offender first comes into contact with the DSAT Model at intake when screening and comprehensive assessments are conducted to determine the nature and severity of the substance abuse problem. At this stage, substance abuse treatment staff employ the procedures of client-treatment matching to ensure that the inmate's need level is matched to appropriate level of differential treatment (ranging from levels I to V). Offenders with low levels of need/risk are referred to lower intensity interventions (e.g., education) while those with high levels of need/risk are referred to higher intensity interventions. The community treatment phase of the DSAT Model has the dual objective of providing both transitional and treatment services that teach inmates how to cope with high-risk situations that are often experienced upon release from prison. Offenders are given the opportunity to fully learn and practice cognitive and behavioral coping skills that suit their individual needs. The focus is on relapse prevention and management as a basis for reducing the inmate's risk of reoffending and resuming substance abusing behaviors.

The cognitive-behavioral model makes use of principles that originated with learning theory, and social and experimental psychology (including classical conditioning, operant conditioning, and social modeling). These principles help to explain how an individual learns a maladaptive behavior, such as alcohol and other drug dependence. This theory is communicated to inmates on a concrete level and in a simple manner. the inmate expectation and initial use of substances are designed to increase positive rewards in their environment and to decrease negative consequences. The scientific term for this phenomenon is positive and negative reinforcement. Several examples can be used to illustrate how positive reinforcement (e.g.,acceptance, increased sociability, and relaxation) and negative reinforcement (e.g., reductions in shyness, stress, and anxiety) impact on an inmate's substance use behavior (Rotgers and Graves, 1999).

Researchers and clinicians have also found that antecedents (e.g., people, places, times, events) act as "triggers" that lead individuals to the initial use of a substance. The five most common

high-risk situations associated with a relapse include: negative emotional states, social pressure, interpersonal conflict, positive emotional states, and cravings (Marlatt and Gordon, 1985). Once an offender is aware of their high-risk situations, they are taught coping strategies so they can learn to either avoid or directly deal with risky situations (e.g., the use of drink/drug refusal skills to deal with peer pressure to use).

The theory that behavior is learned has direct implications for treating offenders. The model suggests that individuals are responsible for changing their own behavior. A treatment approach that targets offender motivation while at the same time teaching cognitive and behavioral coping skills encourages and help offenders to take control of their maladaptive behaviors (through relapse prevention and management planning) in favor of pro-social and anti-criminal behavior. This conceptual model recognizes that the offender's substance abuse behavior is usually closely linked to their criminal behavior. As such, the model simultaneously targets the offender's substance abuse and criminal behavior patterns.

DSAT Group Content: Table 12 below depicts the objectives and the curriculum for Level 4 DSAT programming, designed to be delivered in a TC setting within the prison.

Table 12
Men's Institutional Program
Differential Substance Abuse Treatment (DSAT)

SUMMARY OF GOALS AND OBJECTIVES
Level 4

Intended Audience for Level 4 (Key Program)
Male offenders who:

- Are currently incarcerated but due for release within 1-2 years
- Have been assessed as having a substantial level of dependence on drugs and/or alcohol
- Meet the criteria for a Level 4 intervention based on the results from the Comprehensive Assessment.

Broad Objectives of Motivational Enhancement Therapy Component

- Express concern regarding substance use
- Consolidate commitment to behavior change
- Increase motivation for treatment and ongoing behavior change.

Objectives by MET Session: (5 sessions)

- Explore pros/cons of use and alternative for changing behavior.
- Explore the short and long-term consequences of behavior change to motivate clients.
- Mock trial as basis for motivating clients to change their behavior.
- Exploring ambivalence and to examine reasons to not use alcohol/drugs in high-risk situations.
- Explore pros/cons of treatment as a basis for behavior change.

Broad Objectives of the Intensive Phase – Level 4 CBT

- To motivate offenders to examine the impact their substance using behaviors have had on their lives and the lives of those around them.
    - To deliver treatment services in a manner that encourages the offender to learn a wide range of cognitive and behavioral coping skills.
    - To increase the probability that positive changes are made during the Intensive Phase of treatment in the areas of attitudes, knowledge, cognitive and behavioral gains.
    - To establish a foundation or repertoire of skills that offenders can practice on a daily basis to improve their abilities to cope with high-risk situations leading to slips/relapses

  and criminal action.

Objectives by Intensive Phase Session: (26 sessions)

- Program introduction; review of terms.
- What the participant gets from her drug/alcohol use.
- Why people use; how some people become addicted
- Each participant establishes her own goals for the duration of the program.
- Each participant learns what situations are most likely to trigger abuse for him.
- How constructive thinking can help participants alter their use patterns.
- Learning to re-think in a more constructive fashion.
- Dealing with other people by using a problem-solving model.
- More application of the problem-solving model, and effective ways to give and receive feedback.
- Applying effective listening and self-expression skills.
- Learning different communication approaches for different situations.
- Recognizing and managing anger.
- Coping with a range of other difficult emotions.
- How to manage and prevent self-defeating thoughts.
- Understanding and practicing assertiveness.
- Focusing on techniques for refusing in the face of peer pressure.
- Support groups available to participants.
- Looking for work.
- Coping with different work environments.
- How to achieve a balanced lifestyle.
- Pursuing substance-free leisure.
- Identifying the relationship between substance abuse and crime, and the impact on participants' lives.
- Dealing with cravings, using constructive self-talk.
- How to manage a slip and prevent a relapse.
- Setting goals for the future in various life areas.
- Identifying individual personal supports; concluding the intensive phase of the program.

Level 4 Maintenance Phase

- Provide graduates of the Intensive Phase with a supportive group to encourage continued behavioral change efforts and to meet new challenges that will arise during the maintenance period.
- Increase the probability that the positive changes in attitudes, knowledge, cognitive and behavioral skills, and behavioral intentions made through treatment will be maintained.

Objectives by Maintenance Phase Session: (6 sessions)

- Focus on the relationship between values and decision-making, and thus reduces the stress of decision-making.
- Identifies key resources for helping offenders manage slips and prevent relapses.
- Focuses on how to interact with intimates to build close relationships and reduce stresses that could trigger substance abuse.
- Learn a critical skill for interacting with others, and thus reducing stress that could trigger substance abuse.
- Builds an understanding of the stages participants will go through as they make life changes.
- Learning a series of relaxation exercises participants can call upon to reduce stress.

Broad Objective of the Community Treatment Program for DSAT Graduates – Level 4 (CREST program content)

- Refresh offenders on concepts and skills covered during institutional programming.
- Position those concepts and skills within the community, and thus ease the transition from the institution to the community.
- Motivate the offenders to examine how their substance using behaviors have impacted on their lives and the lives of those around them.
- Deliver treatment services in a manner that encourages the offender to learn a wide range cognitive and behavioral coping skills.
- Increase the probability that positive changes are made during the intensive phase of treatment in areas of attitudes, knowledge, cognitive and behavioral gains.
- Establish a foundation or repertoire of skills that offenders can practice on a daily basis to improve their abilities to cope with high-risk situations leading to slips/relapses and criminal action.

Objectives by Session (10 sessions)

- Program introduction, review of basic terms.
- What did I get from my drug/alcohol use?
- Why people use; How some people become addicted.
- Each participant establishes his own goals for the duration of the program.
- Each participant learns what situations are most likely to trigger abuse for him.
- Thinking skills
- Dealing with other people.
- Support groups available, and options if no organized support group meets a participant's needs.

- How to deal with pressure to (to use) from others.
- Understanding how and why relapses happen, and using that to prevent relapses.

The exhibit below shows a sample session from the Intensive Phase of treatment:

Exhibit 1: Sample DSAT Intensive Treatment Session

SESSION 6
RISK SITUATIONS, PART 2
& COPING BY THINKING, PART 1
OVERVIEW

PURPOSE To increase participants understanding of personal triggers and how they influence their decisions to use substances. To increase participants' understanding of the role their thinking plays in influencing their emotions and actions.

OBJECTIVES Participants will:
● Complete personal Triggers – Actions – Consequences chains
● Recognize how the T-A-C can help them understand their own behavior and identify how they can change their behavior
● Understand that thinking influences emotions and actions
● Understand changing their thinking can lead to them changing their behavior
● Understand that both negative and positive emotions can represent risk situations
● Understand productive and destructive thinking
● Understand the five steps to changing thinking

SPECIAL NOTES For Segment 3.2, The facilitator should have red and black pens for participants.

MATERIALS Worksheet 6-1: My Triggers-Action-Consequences
Handout 6-2: Changing My TAC
Worksheet 6-3: Range of Emotions
Handout 6-4: Productive Versus Destructive Thinking Patterns
Handout 6-5: My Thoughts That Trigger Destructive Behavior
Worksheet 6-6: 5 Steps to Re-Thinking
OPTIONAL: Daily Feedback Form

Treatment for Women--Seeking Safety: Although there are core elements present in both the women's and men's DSAT program, there are key differences between the two curriculums. This is done because the context for male and female substance abusing offenders differs, including familial/social background and experience, learning styles, and criminal and substance abuse history. Research shows a higher incidence of social and environmental factors in females

such as sexual abuse (childhood and adult), and abuse in intimate relationships (although these factors are also significantly indicative of probable substance abuse and criminogenic behaviors in males as well as females). Other high risk factors include substance use, abstinence, and relapse linked to partner or spouse (for men, being married is a factor that helps reduce relapse, while with women, it increases it); poverty; lack of education; unemployment or sporadic employment. For females particularly significant risk factors include child care responsibilities and consequent concerns related to parenting skills as well as concerns related to child custody; concern about personal safety, including transportation, housing, and access to services; arrests for prostitution; and stigmatization for substance use. There are biological/physiological and psychological differences between males and females as well, including more rapid onset of addiction and tolerance in females, substance use behaviors that manifest themselves in severe levels of addiction, presence of multiple drug use with evidence of self-medication, and health consequences to reproductive function, nutritional deficits, mental and emotional impairment, mood disorders, and psychiatric disorders (in particular, depression).

Seeking Safety was developed at Harvard Medical School/McLean Hospital by Dr. Lisa M. Najavits with a grant from the National Institute on Drug Abuse in 1992. In the Seeking Safety manual, Dr. Najavits outlines 25 cognitive, behavioral, and interpersonal topics that can be conducted in any order. These are detailed in the substance abuse treatment section of this response. Seeking Safety can be conducted in group or individual format and has been demonstrated to be effective for women and men. It is not necessary to use all of the topics to obtain some success. It has been proven effective in clinical trials in a wide variety of outpatient, inpatient, and residential settings for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

- **Introduction to Treatment/Case Management**
- **Safety (combination)**
  Safety is described as the first stage of healing from both PTSD and substance abuse, and the key focus of this treatment. A list of over 80 Safe Coping Skills is provided, and participants explore what safety means to them.
- **PTSD: Taking Back Your Power (cognitive)**
  Four handouts are offered: (a) “What is PTSD?”; (b) “The Link Between PTSD and Substance Abuse”; (c) “Using Compassion to Take Back Your Power”; and (d) “Long-Term PTSD Problems”. The goal is to provide information.
- **Detaching from Emotional Pain: Grounding (behavioral)**
  A powerful strategy, “grounding”, is offered to help participants detach from emotional pain. Three types of grounding are presented (mental, physical, and soothing), with an experiential exercise to demonstrate the techniques. The goal is to shift attention toward the external world, away from negative feelings.
- **When Substances Control You (cognitive)**
  Eight handouts are provided, which can be combined or used separately: (a) “Do You Have a Substance Abuse Problem?” (b) “How Substance Abuse Prevents Healing From PTSD”; (c) “Choose a Way to Give Up Substances”; (d) “Climbing Mount Recovery”, an imaginative exercise to prepare for giving up substances; (e) “Mixed Feelings”; (f) “Self-Understanding of Substance Use”; (g) “Self-Help Groups”; and (h) “Substance Abuse And PTSD: Common Questions”.

- **Asking for Help (interpersonal)**
  Both PTSD and substance abuse lead to problems in asking for help. This topic encourages participants to become aware of their need for help and provides guidance on how to obtain it.
- **Taking Good Care of Yourself (behavioral)**
  Participants are guided to explore how well they take care of themselves, using a questionnaire listing specific behaviors (e.g., "Do you get regular medical check-ups?"). They are asked to take immediate action to improve at least one self-care problem.
- **Compassion (cognitive)**
  This topic encourages the use of compassion when trying to overcome problems. Compassion is the opposite of "beating oneself up", a common tendency for people with PTSD and substance abuse.
- **Red and Green Flags (behavioral)**
  Participants are guided to explore the up-and-down nature of recovery in both PTSD and substance abuse through discussion of "red and green flags" (signs of danger and safety). A Safety Plan is developed to identify what to do in situations of mild, moderate, and severe relapse danger.
- **Honesty (interpersonal)**
  Participants are encouraged to explore the role of honesty in recovery and to role-play specific situations. Related issues include: What is the cost of dishonesty? When is it safe to be honest? What if the other person doesn't accept honesty?
- **Recovery Thinking (cognitive)**
  Thoughts associated with PTSD and substance abuse are contrasted with healthier "recovery thinking". Participants are guided to change their thinking using rethinking tools such as List Your Options, Create a New Story, Make a Decision, and Imagine. The power of rethinking is demonstrated through think-aloud and rethinking exercises.
- **Integrating the Split Self (cognitive)**
  Splitting is identified as a major psychic defense in both PTSD and substance abuse. Participants are guided to notice splits (e.g., different sides of the self, ambivalence, denial) and to strive for integration as a means to overcome these.
- **Commitment (behavioral)**
  Making and keeping promises, both to self and others, are explored. Creative strategies for keeping commitments, and feelings that can get in the way, are described.
- **Creating Meaning (cognitive)**
  Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as Deprivation Reasoning, Actions Speak Louder Than Words, and Time Warp. Meanings that are harmful versus healing in recovery are contrasted.
- **Community Resources (interpersonal)**
  A list of community non-profit resources is offered to aid participants' recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help participants take a consumer approach in evaluating treatments.

- **Setting Boundaries in Relationships (interpersonal)**
  Boundary problems are described as either too much closeness (difficulty saying "no" in relationships) or too much distance (difficulty saying "yes" in relationships). Ways to set healthy boundaries are explored, and domestic violence information is provided.
- **Discovery (cognitive)**
  Discovery is offered as a tool to reduce the cognitive rigidity common to PTSD and substance abuse (called "staying stuck"). Discovery is a way to stay open to experiences and new knowledge, using strategies such as Ask Others, Try It and See, Predict, and Act "As If". Suggestions for coping with negative feedback are provided.
- **Getting Others to Support Your Recovery (interpersonal)**
  Participants are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as well as a letter they can give to others to promote understanding of their PTSD and substance abuse.
- **Coping with Triggers (behavioral)**
  Participants are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change who you are with, what you are doing, and where you are (similar to "change people, places, and things" in AA).
- **Respecting Your Time (behavioral)**
  Time is explored as a major resource in recovery. Participants may have lost years to their disorders, but they can still make the future better than the past. They are asked to fill in schedule blanks to explore issues such as: Do they use their time well? Is recovery their highest priority? Balancing structure versus spontaneity; work versus play; and time alone versus in relationships are also addressed.
- **Healthy Relationships (interpersonal)**
  Healthy and unhealthy relationship beliefs are contrasted. For example, the unhealthy belief "Bad relationships are all I can get" is contrasted with the healthy belief "Creating good relationships is a skill to learn." Participants are guided to notice how PTSD and substance abuse can lead to unhealthy relationships.
- **Self-Nurturing (behavioral)**
  Safe self-nurturing is distinguished from unsafe self-nurturing (e.g., substances and other "cheap thrills"). Participants are asked to create a gift to the self by increasing safe self-nurturing and decreasing unsafe self-nurturing. Pleasure is explored as a complex issue in PTSD/substance abuse.
- **Healing from Anger (interpersonal)**
  Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (a danger when acted out against self or others). Guidelines for working with both types of anger are offered.
- **The Life Choices Game (combination)**
  As part of termination, patients are invited to play a game as a way to review the material covered in the treatment. Patients pull from a box slips of paper that list challenging life events (e.g., "You find out your partner is having an affair"). They respond with how they would cope, using game rules that focus on constructive coping.

- **Termination**
  Participants express their feelings about the ending of treatment, discuss what they liked and disliked about it, and finalize aftercare plans. From: Najavits, L.M. (2002). Seeking Safety: A New Psychotherapy for Posttraumatic Stress Disorder and Substance Abuse. In Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders (Eds. P. Ouimette & P. Brown). Washington, DC: American Psychological Association.

The key principles of Seeking Safety are:

- **Safety** as the overarching goal (helping participants attain safety in their relationships, thinking, behavior, and emotions)**.** The program will focus on establishing a sense of safety among participants which will in turn promote a sense of interdependence with others, which is a pro-social stance. All aspects of programming will assess and address safety to assure that individuals (staff and participants) are neither traumatized nor re-traumatized inadvertently. Using a trauma-informed curriculum will lend great capacity to the program.

- **Integrated treatment** (working on both PTSD and other mental health conditions and substance abuse at the same time)

- **A focus on ideals** to counteract the loss of ideals in both PTSD and substance abuse

- **Four content areas**: cognitive, behavioral, interpersonal, case management

- **Attention to clinician processes** (helping clinicians work on countertransference, self-care, and other issues described below)
  - Trustworthiness--Clear professional boundaries are necessary for the counselors and other service providers in order to promote trust and safety among employees and service recipients. Emphasis will be placed on confidentiality and secure discussion of client issues as well as adherence to security requirements. Supervision will promote respect for the inmates and the security staff. Helping service recipients and employees to understand and respond to the developmental needs created by trauma, mental illness and substance use will reduce stress and frustration among all involved; it will also tighten professional/client boundaries. Intake and follow-up processes will focus on a full and understandable explanation of informed consent, grievance procedures, rights and responsibilities and other policy that will help individuals to be successful in the program and to feel accepted and valued. Copies of pertinent policies and handbooks will be given to the participants in hardcopy form. Signature forms will designate that participants have received and understand the above mentioned. Clarity about limitations and options for participants must be stressed in order for individuals to understand what can be offered through the program and what cannot.
  - Collaboration--The program staff will be educated to have a clear understanding of pro-social values which will be imparted to program participants. Providing staff with a clear summary and simple language to explain the concepts of pro-social values will promote integration of the

process. Groups will be offered to assist individuals in understanding the purpose of moving toward independence and assuming a meaningful role in the community. Helping inmates to look inside themselves and identify their own strengths and accomplishments and to switch from an external locus of control to an internal locus of control will reduce the need for reassurance and the anxiety that occurs when there is not enough external emotional support.

- Empowerment—Services will be delivered to provide strength-based feedback and promote self-awareness and positive reinforcement of pro-social values. Avoidance of negative statements is vital to promoting personal power and should be replaced by the use of constructive input and problem solving. Empowerment of the counselors will lead to participant empowerment. Training of staff in the more discreet areas of trauma impact and providing specific interventions to help alter the responses of traumatized participants will enhance treatment. Assuring that policies are understood and followed when providing information regarding client rights, client responsibilities and confidentiality will support client empowerment.

Benefits of Support Groups: The ability of substance abusers to re-design their environments to support recovery correlates highly with long-term success. One of the most obvious ways to do this is to participate in 12-step support groups and treatments based on 12-step philosophies which urge clients to change "people, places and things." More scientifically based approaches to recovery maintenance, such as Marlatt's relapse prevention model, attempt to promote significant lifestyle changes, including a shift in social outlets from ones that encourage or support substance use to ones that are incompatible with substance use (Rotgers & Grave, 1999).

Treatment will require that offenders complete various degrees of attendance at support groups while incarcerated and in community aftercare. For individuals who have never attended any support groups in the community, attendance of at least one meeting of a 12-step group and one meeting of an alternative group (e.g., a SMART Recovery Meeting) will be required to complete treatment. Offenders who have previously attended 12-stepgroups who are comfortable with the 12-step philosophy will be encouraged to attend meetings while incarcerated and will be assisted in re-affiliating with 12-step groups in the community.

The Treatment Research Institute (TRI) has developed the Open Doors 12-Step Facilitation Toolkit, designed to assist counselors in facilitating groups which incorporate more focused recovery content. The ***Open Doors*** Toolkit provides counselors with an easy-to-use and engaging 5-module package of activities designed to foster active engagement in 12 Step concepts, literature, meetings, and fellowship during treatment to increase the likelihood that clients will continue active engagement upon discharge. Studies have shown that active engagement in 12 Step programs during treatment (meeting attendance and engaging in 12 step suggested activities) enhances the chance of continued engagement beyond treatment. Furthermore, active engagement in 12 Step programs is associated with longer term sobriety. As many studies continue to show that relapse rates post-discharge are high, this program aims to increase post-treatment abstinence through the facilitation of active and enduring engagement in 12 Step programming.

The Toolkit content is based on 12 Step literature, audio taped interviews with 12 Step members themselves, consultation with AA/NA members, feedback from addiction counselors and 12 Step program researchers, empirically-supported materials used in Project Match to facilitate 12 Step participation, and experience with the program by supportive non-members of AA/NA. ***Open Doors*** provides clients with a multimedia toolkit experience using video content, posters, worksheets, 12 Step reading materials, and targeted activities to connect their own experiences with alcohol and drug use to the concepts and offerings within 12 Step programs such as meetings, sponsorship and Step work. Counselors are guided to motivate their clients to sample key aspects of 12 Step programming, elucidate program slogans and wisdom, and explore misconceptions and barriers to engagement. Our goal is that clients leave treatment having experienced the relevance and power of 12 Step engagement as a key resource for maintaining recovery beyond discharge. The Open Doors Curriculum covers: 1) misconceptions about 12-Step fellowships, 2) the importance of meetings, 3) spirituality and powerlessness as concepts in 12-Step, 4) misconceptions about sponsorship, and 5) building a recovery lifestyle in 12-Step fellowships. The curriculum is designed to inform clients about 12-Step so that they can make an informed choice, without coercing or forcing participation on anyone. The curriculum is thematically centered on the 12-Step wisdom saying, *"Take what you need and leave the rest."* This statement is used to exemplify how clients can engage in 12-Step meetings and fellowships without necessarily buying into every concept or 12-Step teaching.

Therapeutic Education System: A possible resource for use in Aftercare, the Therapeutic Education System (TES) was developed by HealthSim LLC as a computer-based psychosocial treatment program specifically for use with prisoners. TES was developed to increase the number of inmates who could receive treatment and to enhance the 'dosage' of treatment received without increasing the number of counselors, thus saving costs. TES is theoretically grounded in the Community Reinforcement Approach (CRA). The Community Reinforcement Approach (CRA) is a comprehensive behavioral program for treating substance-abuse problems that is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking and/or other drug use. CRA uses social, recreational, familial, and vocational reinforcers to help participants to achieve a sober lifestyle that is more rewarding than one in which the use of substances is the primary motivator. CRA uses positive reinforcement for each step, no matter how small. The computer-assisted instruction in TES is designed to provide such reinforcement to the users through experiential and interactive learning in which the participant become 'fluent' in the language or recovery. TES consists of 32 core modules in the areas of substance abuse; criminal thinking and behavior; risk reduction for HIV/AIDS and other Sexually Transmitted Infections; and psychosocial functioning such as effective problem solving and communication skills. The computer-assisted content helps counselors to pick topics for group reinforcement and provides material for follow-up. Because the intervention is delivered by the computer in exactly the same way to each offender, it has high fidelity to the EBP. It also has significant cost advantages—it is self-directed thus reducing demands on staff time; there are limited requirements for training and supervision; and the implementation is flexible and requires limited expenditures.

TES was evaluated at ten correctional sites with 513 offenders in Philadelphia, Los Angeles, Colorado and Kentucky. The offenders were identified by the DOC in their states as needing substance abuse treatment; nearing prison release; represented minimum security risks; and

voluntarily agreed to enter the study. There was a control conditions, which was the standard care usually offered in those facilities by certified counselors. The study looked at criminal activity, illegal drug use, HIV risk behavior, and re-incarceration data at baseline (in prison) and 3- and 6-months post release. During the post release period, offenders in both the TES trial and those receiving standard care showed significant improvement, including a reduction in criminal activity for the TES group form 82% at baseline to 28% 6-months post release; a reduction in illegal drug use from 76% at baseline to 24% 6-months post release; a 100% increase in numbers of days abstinent; and a 28% rate of re-incarceration within 12 months of release.

***Motivational Incentive*s**: Connections has been using a form of *Prize Incentives Contingency Management* with offenders who are mandated to treatment since 2006. This approach has been effective in enhancing treatment participation and retention and in reducing substance use of all types during treatment. The approach has been studied with adult men and women who were Black, White, Hispanic and whose race/ethnicity was not specified (Petry et. al., 2001). The approach is not documented for use inside the prison setting, but is effective in aftercare situations to keep people engaged in treatment and reward ongoing pro-social behavior. A similar approach is currently in place in the 6 For 1 programs that are operating at Young and Baylor, where pre-trial detainees attend treatment and receive one (1) day of 'good time' for every six (6) days that they attend a participate in treatment. This approach has potential for expansion into the other substance abuse treatment programs.

Relapse Prevention: Mindfulness-Based Relapse Prevention (MBRP) (Bowen, Chawla and Marlatt, 2010) is a novel treatment approach developed at the Addictive Behaviors Research Center at the University of Washington, for individuals in recovery for addictive behaviors. The program is designed to bring practices of mindful awareness to individuals suffering from addiction. MBRP practices are intended to foster increased awareness of triggers, destructive habitual patterns, and "automatic" reactions that can lead to relapse. The mindfulness practices in MBRP are designed to help participants pause, observe present experience, and bring awareness to the range of choices before each of them in the moment. Participants learn to respond in ways that serves them, rather than react in ways that are detrimental to our health and happiness and to escape from deeply ingrained and often catastrophic habits. Similar to Mindfulness-Based Cognitive Therapy for depression, MBRP is designed as an aftercare program integrating mindfulness practices and principles with cognitive-behavioral relapse prevention. MBRP is best suited to individuals who have undergone initial treatment and wish to maintain their treatment gains and develop a lifestyle that supports their well-being and recovery. The primary goals of MBRP are:

- To develop awareness of personal triggers and habitual reactions, and learn ways to create a pause in this seemingly automatic process.
- To change one's relationship to discomfort, learning to recognize challenging emotional and physical experiences and responding to them in skillful ways.
- To help participants to foster a nonjudgmental, compassionate approach toward themselves and their experiences.
- To build a lifestyle that supports both mindfulness practice and recovery.

Co-Occurring Disorders

Substance abuse populations have a much higher incidence of co-existing psychiatric disorders than do other psychiatrically disordered populations. Epidemiological studies clearly show that an average of 35% of substance abusers suffer from at least one additional psychiatric disorder (Regier et al., 1990). The concentration of individuals with co-occurring conditions in prison settings is even higher. The presence of a high percentage of dually disordered individuals, particularly ones with serious disorders such as major depression, bipolar disorder and various forms of schizophrenia, makes it imperative that screening, assessment and treatment of co-existing disorders be an accessible component of any substance abuse treatment program. Regular psychiatric screening and assessment need to be made available, and appropriate psychiatric treatments provided. Although it was once thought that substance abusers with co-existing severe mental illness could not be treated through traditional treatment programs, recent research clearly suggests otherwise.

When co-existing mental disorder is effectively managed through psychiatric care, substance abusers with these disorders are as able to benefit from treatment as those without. The proposed program will meet the criteria for Co-Occurring Enhanced Treatment as follows:

- It will have levels of services and service offerings that can treat unstable and/or disabling mental health and substance use conditions and other addictive disorders (such as gambling), alone or in combination
- It will provide accommodation for offenders who are receiving either substance abuse or mental health treatment to have access to the full range of services they need concurrently, i.e., we will ensure that offenders in all levels of substance abuse treatment have access to psychiatry and mental help treatment groups.
- The Mental Health Services Vendor staff will include professionals in psychiatry, mental health counseling and addictions treatment who are cross trained to monitor for instability or disability caused by each of the conditions being treated.
- Mental Health staff will provide voluntary mental health programs for offenders with co-occurring conditions.
- Susbtance Abuse staff will provide psychoeducational classes on mental health concerns, co-occurring disorders, treatment, and appropriate use of psychotropic meds. .
- The program will offer a range of treatment alternatives that include symptom management using motivational enhancement and cognitive behavioral approaches such as illness management and recovery and medication assisted treatment for both mental health and addictive disorders.
- The program will provide for crisis services and back-up in all treatment locations.
- The mission statement of Connections reflects a commitment to treatment of mental health and substance use conditions equally.
- Connections has dual licensure/certification to serve both persons with primary mental health conditions and persons with primary addictive disorders.
- The proposed program will use an integrated treatment plan that addresses all conditions present.
- The proposed program will routinely screens and assesses for mental health and addictive disorders and the medical record will reflect all diagnoses.

Sex Offender Programming

If we are awarded a contract, we propose to provide sex offender therapy that follows protocols which have been developed for assessment and treatment by the Office of Justice Programs in the U.S. Department of Justice. The program will meet the requirements established by the Delaware Sex Offender Management Board (SOMB) and will use evidence-based practices identified by the U.S. Department of Justice. In its publication *The Comprehensive Assessment Protocol: A Systemwide Review of Adult and Juvenile Sex Offender Management Strategies*, the DOJ outlines the steps that states and other jurisdictions should take in developing a comprehensive program to treat convicted sex offenders:

- Define eligibility criteria and any mandates (e.g., legislative, agency) for participation;
- Make available a range of prison–based sex offender treatment services that vary in intensity;
- Provide all incarcerated sex offenders with information about the available sex offender treatment services and how to access such services if they are interested;
- Delineate a formal, assessment–driven process by which individual sex offenders are matched to intensity of services based on risk level (e.g., higher risk offenders receive more intensive services);
- Prioritize access into sex offender treatment based on release dates;
- Reassess the level of interest of those individuals who are not participating in any of the available services and encourage them to engage in treatment; and
- Transition sex offenders to lower levels of care or security when they have progressed sufficiently in treatment.

A process and outcome evaluation of the program that is established will be conducted using the self-test that is available online at the Center for Sex Offender Management website. This is described in more detail in the evaluation section of the proposal.

Assessment: The term "sex offender" encompasses many different crimes and circumstances. Because adult sex offenders are such a diverse population, the Center for Sex Offender Management warns against "one size fits all" approaches to treatment. Comprehensive assessment is needed to determine what treatment is appropriate based on the risk, needs, development, and functioning of the offender.

Researchers and treatment providers in the criminal justice arena have come to view the treatment of sex offenders in much the same way as they view the treatment of substance abusers. In both cases, there are three core principles of effective correctional intervention: risk, needs, and responsivity (Andrews & Bonta, 2007; Cullen & Gendreau, 2000). When used as a framework for assessment with sex offenders, these principles address the following questions:

- Which sex offenders will benefit most from treatment and supervision interventions?
- What are the specific targets of treatment and supervision that will have the greatest impact on reducing recidivism potential among sex offenders?

- How should treatment and supervision services for sex offenders be delivered in order to ensure maximum benefit from the interventions?

Again taking a page from the treatment of offenders with substance use disorders, researchers have found that sex offenders have better outcomes when the intensity of interventions is matched based on assessed level of risk (see Andrews & Bonta, 2007). Prioritizing higher risk offenders for higher intensity services appears to have a greater impact on reducing recidivism than providing that same level of intervention to their lower risk counterparts. Additionally, there is some evidence that delivering intensive interventions to low risk offenders has limited to no impact and, in some cases, can actually result in increased rates of recidivism (see, e.g., Andrews & Bonta, 2007; Cullen & Gendreau, 2000; Gendreau, Goggin, Cullen, & Andrews, 2001).

Along with risk, consideration also must be given to 'need' in choosing which offenders to treat and what treatment to provide. The greatest impact occurs when programs and services target the changeable or 'dynamic' factors that are directly linked to recidivism (Andrews & Bonta, 2007; Cullen & Gendreau, 2000; Gendreau, 1996). Again, as in the treatment of offenders with substance use conditions, criminogenic needs are comprised of two types: stable dynamic and acute dynamic risk factors. Stable dynamic risk factors are relatively enduring but nonetheless changeable, whereas acute dynamic factors can fluctuate rapidly.

Among the stable dynamic risk factors specific to adult sex offenders are intimacy deficits, pro–offending attitudes, pervasive anger, and deviant sexual interests; examples of acute dynamic risk factors are substance abuse, sexual preoccupations, access to victims, and non–compliance with supervision (Hanson & Harris, 2000, 2001; Hanson & Morton–Bourgon, 2005). Identifying these criminogenic needs must be a key focus of assessment efforts in order for assessment and treatment to reduce recidivism and for practitioners to direct their limited resources in the most effective and efficient way. (Krisberg, 2005; Lipsey & Wilson, 1998).

Finally, assessment should take into account the potential 'responsivity' of the offenders who will receive the treatment, i.e., will the offender be able to benefit from the treatment in a way that reduces the likelihood that s/he will re-offend? To accomplish this, assessments should seek to identify specific offender characteristics that may impact their response to interventions. Learning style, motivation to change, denial, and level of functioning are key examples of these kinds of characteristics. The responsivity principle suggests that when programs and services specifically take into account these factors, better outcomes are achieved (Andrews & Bonta, 2007; Cullen & Gendreau, 2000). Again as in substance abuse treatment, the concept of matching offenders to specific services based on the content, format, modality, or "teaching approach" used, and/or the skill sets, personality attributes, or style of a specific provider, is thought to have an impact on the effectiveness of the treatment. Responsivity factors are, therefore, an important consideration in the assessment process with sex offenders.

We are proposing to use an actuarial approach to risk assessment. Trained assessors will use empirically-validated instruments to determine a total score that is associated with a broad risk category (e.g., low, moderate, high). Risk categories are linked to the known recidivism rates of groups of sex offenders who were followed at routine intervals (e.g., 5, 10, and 15 years).

Actuarial tools have been extensively validated and tested for reliability—i.e., do they predict the likelihood of recidivism, and do different assessors will reach the same conclusion about the same offender when using the tools? When they have been well-researched and tested for validity and reliability, actuarial tools provide more accurate estimates of risk than both the unstructured and empirically–guided approaches with sex offenders (Hanson & Morton–Bourgon, 2007; Quinsey, Harris, Rice, & Cormier, 2006).

Multiple actuarial risk assessment tools specific to adult sex offenders have been developed over the past decade. Sex offender–specific instruments are necessary because although there is some overlap between risk factors for sex offenders and non–sex offenders, several factors are uniquely associated with sexual recidivism (Hanson & Bussiere, 1998). It is our intention to use two actuarial tools developed for use with adult sex offenders:

- STATIC–99R (Hanson & Thornton, 1999)
- Minnesota Sex Offender Screening Tool Revised (MnSOST–R; Epperson et al., 2000).

Because the STATIC-99 takes into account only static risk factors, it is more predictive when combined with the MnSOST-R, which includes an assessment of several key dynamic variables: disciplinary issues in the correctional facility; chemical dependency and treatment for chemical dependency while in the facility; sex offender treatment while incarcerated; age at time of release.

***Intake and Referral*:** Inmates with any sexual conviction (new or old), serving time for a violation of probation, failure to register, or even an intuitional sanction can be referred. Once a referral is made, the inmate is informed of the limits of confidentiality and informed of the rules and principles of the program. Basic personal information is secured and all necessary forms are signed at this intake session.

All offenders referred for service based on the criteria described are assessed using the STATIC-99R and the MnSOST-R. Offenders who have a combined MnSOST-R and Static-99R score of twelve (12) points are referred for additional testing using the MSI-II and Abel Screening. In addition, the sex offender staff will make a referral to the mental health team providing services at the facility where each sex offender referred to treatment is housed. The mental health ITT will complete additional assessments, including a clinical interview; a mental status exam; a history of functioning, including an observational assessment of current functioning; a review of current cognitive functioning; an ASI, which assesses drug and alcohol use; social, developmental, legal and family history; vocational history; psychiatric history and current functioning. The sex offender treatment team will review these results and other items in the offender's health and DDOC records (including collateral contact/interview if possible and appropriate) and will make a determination of the offenders risk, need and potential motivation and amenability to treatment.

The sex offender treatment team will be responsible for completing a written evaluation within 30 days of the referral. The evaluation, which will be placed in the offender's medical record, will include the following minimum data: demographic information about the offender; the name and credentials of the evaluator and the source of any collateral information used; reason for the referral and assessment; the methods and tools used to conduct the assessment; the legal

account of the sex offense(s); the offender's account of the offense(s); the offenders personal, family, social, academic, vocational, substance abuse, psychiatric, medical, legal, and medical history; the offender's sexual history and sexual functioning; behavioral observations; a risk analysis; a DSM five-axis diagnosis. A written assessment summary will include the level of risk for sexual and violent re-offending; risk factors requiring management and intervention; level of denial; the need for treatment of co-occurring conditions; the need for medical/pharmacological intervention; treatment implications.

Treatment: Although sex offender treatment in correctional facilities and programs has been in existence for more than thirty years, it is not homogeneous. Early (sometimes called 'generation 1') methods were often confrontational or grounded in strict behaviorism. In more recent years, sex offender treatment has evolved in much the same way as treatment for substance abuse, moving to a cognitive–behavioral approach emphasizing relapse prevention (see Marshall & Laws, 2003). The relapse prevention model has yielded to models of treatment that take into account multiple "pathways" to offending (Hunter, 2006; Hunter, Figueredo, Malamuth, & Becker, 2003, 2004; Ward & Hudson, 1998, 2000; Ward & Siegert, 2002; Ward, Polaschek, & Beech, 2006). The model we are proposing is a 'pathways' model.

The Self-Regulation Model (SRM) is the primary methodology used for this therapy program. SRM is an evidence based program using an integrated model of treatment. Sexual offending is viewed as a maladaptive attempt to address specific emotional and environmental stressors. In response to this assumption, SRM goes beyond the "don't do it again" objective of the old Relapse Prevention model as developed for substance abuse programs and applied to sex offenders. It also steers away from cookie cutter/workbook based programs. SRM promotes a pro-social lifestyle (accountability) in all parts of an offender's life to reduce the risk of re-offense.

Whatever the model of treatment that is used, the desire and expectation that through intervention, problem sexual behaviors will be reduced and community safety will be enhanced, has remained constant. Current research suggests that, depending upon the underlying theoretical model and the specific techniques used, some forms of treatment come closer to meeting that goal than others (Aos, Miller, & Drake, 2006; Hanson et al., 2002; Reitzel & Carbonell, 2006; Walker, McGovern, Poey, & Otis, 2004). Programs that offer a continuum of care, 'phased' by the readiness of offenders to change, and using cognitive-behavioral and pathways approaches, are currently thought to be more likely to be effective.

The goal of the program is 'No More Victims.' The priority of treatment is the safety of the offender's victim (s) and the community and other potential victims. This program goal is reached by working for justice, healing, and transformation using therapeutic methods applied to the specific treatment needs of an individual offender. The community is safer if offenders are treated. The model assumes that in helping offenders reach a level of accountability by reducing denial and achieving an understanding of their potential to re-offend, they will demonstrate positive changes in attitude, thinking, behavior, character, relationships, and even core personality.

Recidivism is defined as a graduate of the program committing a new sexual offense. A program based on the same strategies as the one proposed--The Lifeline Sex Offender therapy program in the Commonwealth of Virginia--used a version of SRM beginning in 1998. Lifeline reported only six of their graduates from this program (out of 364) were arrested for a new sexual crime.

Program Phases: Every offender who is referred for sex offender treatment as described above (referrals may be based on adjudicated charges and/or behaviors observed during incarceration) is placed in a psychoeducational group for orientation and assessment. At this phase, denial is not an issue for placement. Psychoeducational groups will use the Sex Offender Awareness Program (SOAP) outlined below. SOAP is offered at the Level IV and Level V institutions.

Treatment Planning: The first phase of treatment is the assessment as described in the previous section. Following completion of the assessment, an individualized treatment plan is developed. Treatment plans will be completed within 30 days of the initial referral and will include:

- The names of individuals who will be involved in the offender's Interdisciplinary Treatment Team (ITT). The ITT will consist of the assigned counselor from the sex offender treatment team as well as other personnel based on the needs of the offender. These personnel might include substance abuse treatment staff; mental health treatment staff; the offender's psychiatrist; DDOC treatment and security staff
- Short- and long-term goals and the methodology to be used to monitor achievement of goals
- The offender's roles and responsibilities in achieving the treatment plan goals.
- Each member of the ITT's roles and responsibilities in helping the offender to achieve the treatment goals.

Treatment will be individualized in accordance with the Pathways Model (Ward & Siegert, 2002) which posits that sexual offenders have 'pathways' to offending and vulnerability factors to which treatment can be tailored for optimal effectiveness. These issues will be addressed in individual counseling sessions. For example, offenders who have intimacy and social skills deficits need training in social skills, assertiveness, reflective listening, and healthy sexuality. Offenders who have problems managing anger and other negative emotions need training in decision-making, anger/self-management, stress management, and problem solving. Offense Pathways include the following:

- Avoidant-Passive. These offenders intend to avoid sexual re-offending, but a lack of effective coping strategies and self-management skills result in their failing to take definitive action to manage their behaviors. Treatment for them involves identifying individual goals and vulnerability factors, improving coping skills, raising awareness of offense processes, and develop social and problem solving skills.
- Avoidant-Active. These offenders' desire to refrain from sexually abusive behavior is hampered by the use of ineffective strategies which actually increase their risk of offending. Treatment involves emotional regulation, raising awareness of their own offense process, teaching altered and more effective coping skills.

- Approach-Automatic. These offenders desire deviant sexual activity, but their offenses are driven more by situational factors and circumstances and impulsivity than by active planning. Treatment for them involves deconditioning of deviant arousal, emotional regulation, altering cognitive behavioral scripts, and resolving core sexual and emotional issues.
- Approach-Explicit. These offenders are motivated to offend and engage in explicit planning, including taking steps to groom victims and avoid detection. Treatment for them involves examining their view of self, intimacy and sexuality; cognitive restructuring, and external monitoring.

Offenders who would benefit from a prolonged therapy group based on the assessment results, and who are willing to admit to their crime(s), are placed into a more comprehensive group for intensive treatment (STP). Those who have protracted sentences (two or more years before release) and completed SOAP are given preference. STP will be offered at the Level V institutions. An aftercare group format (SOAR) is available to offenders who have completed STP. SOAP and STP curriculum are outlined below.

Services are provided based upon risk, need and 'responsivity' factors. New referrals will be expected to complete a psychoeducational group (SOAP) prior to admission into the more intensive therapy group called Special Treatment Program (STP). The SOAP psychoeducational and orientation group ensures that all identified offenders in need of therapy receive at least education in sex offending topics even if they are not eligible for or lack the time to complete intensive therapy.

Offenders are expected to admit their sexual offense to be eligible for STP. Incomplete admission or disagreement with some details will be accepted. However, in such instances, it will be made clear that participants are expected to work toward accepting culpability for their offense (s). Offenders must demonstrate cooperation with the therapy process to remain in STP.

Self-regulation and accountability for previous offenses are the goals of the intensive treatment program. Living with accountability is considered the highest therapeutic goal for each client. This is important as many offenders have an Axis II diagnosis of Antisocial Personality Disorder. All treatment goals will build toward living with accountability.

Offenders address their own core issues using the structure of the STP program. Specific therapeutic exercises such as autobiographies, cycle work, goal setting, re-integration to the community and victimology) will be used. All didactic methods and therapeutic interventions are directed to specific individual need. Referral for co-occurring issues such as substance abuse and mental health conditions that are observed during group treatment will be made promptly and followed up upon to promote the highest level of interdisciplinary coordination of treatment.

Offenders who have their own victimization issues "earn the right to do their victim work" after they deal with their offending issues. Therapists employ a variety of psychological methods to meet client needs (i.e. Relapse Prevention, Cognitive Behavioral Therapy, Reality Therapy, Re-parenting, Social Skill Training, Confrontation, Motivational Interviewing). The STP model is designed for the motivated client to complete therapy in less than two years. This goal for

treatment does not include participation in SOAP (psychoeducation group) or SOAR (aftercare treatment). This time goal also does not include interruptions because of violation or a suspension from treatment. A flow chart of the program is contained in Table 13.

Table 13: Sex Offender Program Outline

Step One: Referral to assessment, orientation, pyschoeducation ex Offender Awareness Program (SOAP)

SEX OFFENDER AWARENESS PROGRAM (SOAP)

Eight Session Psychoeducation Curriculum

- Relationships *
  - Four types of relationships
  - Objectification in our words and actions
  - Tactics of power and control
  - Intimacy
- Feelings/Emotions
  - The process of change (words – behaviors - attitudes)
  - Thoughts vs. feelings
  - Positive and negative feelings
  - Six primary emotions
- Handling Difficult Situations
  - Chain of choices
  - The Anger Curve
  - 4 step pre-cycle
  - Grief and trauma events
- Safety Contracts
  - The sex offender registry
  - Safety contracts (computer, church, family)
  - What to do if you see your victim
- Sex Offenses: Rape *
  - Definition of rape
  - Four types of rape
  - Myths and facts
  - 3 ways to gain access (consent, pressure, and force)
- Sex Offenses: Child Molestation & Incest
  - Pedophilia and Incest
  - Typologies (fixated and regressed)
  - Myths and facts
  - Without consent
- Sex Offenses: Hands-X Offenses
  - Exposing, peeping, stalking, groping, computer
  - Computer sex crimes
  - Paraphilias: deviance vs. inappropriate vs. appropriate behavior
  - Misuse of relationships
- Victimology
  - Definition of a victim/ why I'm not the victim

- Secondary victims (the ripple effect)
- Power and Control from a victim's point of view
- Misuse of relationships
- Reasons adults sexualize children, minors, adults
- Long term effects

* New group members accepted week 1&5

Step Two: Assessment/Evaluation

Step Three: Development of Individual Treatment Plan and Group Assignment

Step Four: Client Placement in Special Treatment Program (STP)

Step Five: Aftercare Accountability Group called SOAR

Table 14: Special Treatment Program (STP) Curriculum

Phase 1 prepares the offender to answer the first question about the crime:

- Autobiography
- Details of Offense
- Pre-cycle work (two sets of presentation)
- Setting of "My Goals for Change"

Phase 2 helps the offender understand victim impact and develop empathy

- My Primary Victims (required disclosure of all sexual victims)
- My Secondary Victims (The Ripple Effect)
- Future Impact
- Empathy Exercises (without toxic shame)

Phase 3 allows the offender to demonstrate responsibility in a relational context

- Restitution and Amends
- Safety Plans
- Reconciliation Plans (different from reunification)
- Plans for Family Reunification (when appropriate)

Phase 4 confronts sexual interests and deviant behaviors

- Sexual Autobiography
- Deviant Sexual History
- Offense Cycle Work
- Pre-planned exit strategies

Phase 5 prepares the offender for self-management in the recovery process

- Special projects assigned according to client need (impulse control)
- Accountability Letters (4 *symbolic* letters including the victim)
- Accountability Plan and Personal Safety Contract
- Accountability Partners (4 partners)
- Aftercare Planning

Sex Offender Treatment Team Staffing:

The proposed Sex Offender Treatment Team will be staffed initially with four counselors and an administrative assistant. The lead counselor will meet SOMB qualifications and will be certified to conduct the ABEL assessment. The second counselor will be a license-eligible counselor who meets SOMB qualifications. Two other counselors will have at least a bachelor's degree and will be working towards meeting SOMB certification requirements (note, Delaware currently does not have a sex offender certification process). If we are the successful bidder, it is our intention to hire Dr. James G. O'Quinn, who is a Certified Sex Offender Treatment Provider (CSOTP) in the state of Virginia. He is certified to conduct the Abel Assessment, and is also certified as a domestic violence counselor. Dr. O'Quinn has worked for MHM since October. Prior to that, he was a principal at Lifelines Counseling Associates, Inc., a specialized provider of treatment for sex offenders in the state of Virginia, for 12 years. Dr. O'Quinn is an ordained minister with a Doctor of Ministry from the United Theological Seminary in Dayton, Ohio. We would employ Dr. O'Quinn as the Sex Offender Treatment Team leader.

The staff schedule is depicted in Table 14 below.

Table 14: Sex Offender Treatment Team Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
9:00	Assessments & trainings	BWI STP group Staff A & C	SCI STP group Staff B & D	Vaughn STP group Staff A & B	Assessments & individual sessions
10:30	Assessments & trainings	BWI (24 wks) SOAP Group A & C	8/8 SCI SOAP Group B & D	Vaughn STP group A & D	Assessments & individual sessions
1:00	Assessments & trainings	8/8 Young SOAP B & C	SCI STP B & D	8/8 Vaughn SOAP B & D	Assessments & trainings
2:30	Assessments & individual sessions	Young STP group B & C	8/8 SCI SOAP B & D	8/8 Vaughn SOAP B & C	Staffing/ Supervision
3:30	Assessments & individual sessions	Young STP group B & C	Assessments & individual sessions	Assessments & individual sessions	Staffing/ Supervision
6:00		8/12 SOAP Level IV C & D	8/12 SOAP Level IV C & D	8/12 SOAP Level IV C & D	

Staff Schedule Key: A: CSOTP-Evaluator-Director; B: CSOTP-Evaluator; C: Associate CSOTP; D: Associate CSOTP

DUI Programming

In 2011, the Delaware General Assembly passed a bill to strengthen the penalties for Driving Under the Influence (DUI). Previously, a second DUI required enhanced penalties, including a period of incarceration, if it occurred within five (5) years of a first offense. The amended law extended that window to ten (10) years. The law also added a requirement for intensive DUI treatment during incarceration, including a period of abstinence from alcohol for no less than 90 consecutive days.

Driving under the influence of alcohol and other drugs is a widespread public health concern. The National Survey on Drug Use and Health reported in April, 2008, that 15.1% of drivers over the age of 18 drove under the influence of alcohol and 4.7% drove under the influence of illicit drugs (including prescription drugs used non-medically) during the year preceding the survey. In 2006, more than 30 million people over the age of 12 reported driving under the influence of alcohol at least once during the previous year. Traffic accidents involving drivers impaired by alcohol or other drugs were the single leading cause of death among persons between the ages of 3 and 33 in 2006 (International Association of Chiefs of Police), with an estimated 3,000,000 accidents involving impaired drivers annually. Although the estimate of Delaware drivers who drove under the influence of alcohol during the reported year was slightly lower than the average (13.7% versus 15.1%), the percentage of Delaware drivers who drove while under the influence of illicit drugs was slightly higher (4.8% vs. 4.7%). This statistic is of particular concern because while driving under the influence of alcohol incidents have leveled x as the result of aggressive education and sanctioning programs, driving under the influence of illicit drugs has been on the rise (Tardif & Marzuk, 1995).

Research that has been conducted regarding DUI offenders reveals that they are not a homogeneous group, but include people who do not meet the criteria for a substance use diagnosis as well as repeat offenders and people who have a history of serious substance use issues that impact not only their driving, but other areas of functioning as well. Young adults under the legal drinking age are also a concern. Research by the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that underage drinkers are more likely to drink outside of their own homes, and those underage drinkers—especially females—were eight times more likely to have had their last drink in a car than those who were of legal drinking age. Adults who drink or use illicit drugs to self-medicate undiagnosed or untreated mental health problems, such as anxiety or depression, also comprise a group of DUI offenders for whom a different approach to treatment may be required.

Connections currently provides outpatient DUI treatment for the Office of Highway Safety, Department of Homeland Security, in New Castle and Kent Counties. We have been a provider of this service since 2009, and expect to serve more than 1,000 individuals in the current year. The conceptual framework underlying our approach to treatment is multidimensional and makes the following assumptions:

- Driving under the influence of alcohol and other drugs is both a traffic safety issue that impacts the entire community and an individual alcohol and/or other drug problem. The effectiveness of interventions to sanction and prevent it must

be viewed as both safety/legal and treatment concerns. Combination interventions, which include licensing actions, court-applied sanctions and treatment/educational interventions have proven to be the most effective in reducing DUI recidivism (Wells-Parker, 2004). Incarceration combined with treatment, which is what is being developed, clearly falls in this category.

- Alcohol/drug abuse are multi-determined problems that have biological, social and psychological elements. People who enter treatment programs may have multiple needs and life issues (including DUI) that not only need attention, but provide a basis for establishing an effective therapeutic relationship. For offenders whose DUI has led to incarceration, these life issues will be further exacerbated.

- Alcohol/drug abuse are maladaptive coping behaviors that are at least partially under the voluntary control of the user. At the same time, psychoactive substances have inherent motivating properties of their own which strongly compete with other motivations (such as the desire to stop using) within each individual person (Miller and Rollnick 1991).

- Once alcohol/drug abuse becomes habituated, it causes significant changes in brain functioning that make achieving and sustaining abstinence difficult. Addiction is a disease that impacts and damages all elements of the user's existence (physical, spiritual, interpersonal, emotional, financial, legal) and results in significant changes in brain functioning that impair judgment and make achieving and sustaining abstinence difficult.

- People enter treatment for a wide variety of reasons, at various stages of abuse/dependence and at varying levels of readiness; in order to be effective, treatment interventions need to take issues of readiness and motivation into account (DiClemente & Scott 1997).

Resistance to entering treatment, noncompliance with treatment, and high rates of relapse over the long-term are serious barriers to treatment effectiveness, and strategies to address them are critical to the ultimate success of service recipients (DiClemente & Scott 1997). The proposed approach to treatment combines strategies to enhance motivation for change and to teach adaptive coping strategies. The approach is very similar to that proposed for the core substance abuse services: Motivational Enhancement Therapy and cognitive-behavioral skills training, combined with self-help groups, and abstinence.

Some research has shown that matching intervention strategies to specific traits of persons served, especially those related to underage drinking and co-occurring mental health issues, can be effective both in retaining persons in treatment and in attaining treatment success (Beutler 1997; Wells-Parker, 2004). These findings suggest that the most effective treatment is tailored to individual needs and characteristics and to the severity of the problem. Educational programs that use cognitive-behavioral skills training, aimed at improving coping and decision-making, have been more effective and avoid the potential pitfalls of referring every person to an intensive

treatment program when they either do not meet the diagnostic criteria for a current alcohol/other drug condition or do not see themselves as in need of treatment (Lapham et al., 2001).

Poor outcomes and higher rates of recidivism are frequently associated in the research with failure to engage in or complete a program of treatment and education (Nochajski, 1999). Education programs that focus on eliminating the behavior of driving while under the influence of alcohol and other drugs have been found to be effective, even for individuals who do not see themselves as having an alcohol or other drug problem. For these individuals, brief interventions focused on developing motivation to change and minimizing harmful consequences were more effective than programs that required participants to admit to having a substance use conditions or make a commitment to ongoing abstinence (Wells-Parker & Williams, 2002).

The proposed DUI treatment program will have three separate tracks (a main program and two sub-programs that provide services to clients under 21 and an alternative mental health program for clients who have both a mental health and a substance use condition). The main program provides a minimum of 16 hours of treatment using both individual and group modalities.

The core clinical counseling approaches to be used in the treatment component are derived from the work of William Miller who developed Motivational Enhancement Therapy and Prochaska and DiClemente who articulated the Stages of Change model of readiness for treatment. Motivational Enhancement Therapy is particularly suited to the DUI treatment arena because it was originally developed as a brief (2 to 4 session) intervention using the assessment process itself to draw the client further towards the 'determination' or 'preparation' stage of change, in which a commitment to treatment participation and compliance is most likely to occur.

The transtheoretical model identifies many stages of change along the way to recovery. These are accompanied by specific suggested interventions as demonstrated in the table below, adapted from DiClemente and Scott, *Stages of Change: Interactions with Treatment Compliance and Involvement*, 1997. The stages of change are based on the work of Prochaska and DiClemente (1983) who identified that people progress through five distinct stages in the course of committing to and sustaining quitting:

- Pre-contemplation. The person is not intending to stop using substances and tends to avoid thinking or talking about stopping;
- Contemplation. The person recognizes the pros and cons (benefits and costs to him/her) of substance use, is open to the idea or need of change, but is experiencing ambivalence;
- Preparation. The person is intending to stop using substances in the immediate future and willing and able to actively participate in organized activities meant to help him/her stop;
- Action. The person has accomplished a cessation or reduction in substance use and actively participates in a plan to abstain from further use;
- Maintenance. The person has abstained from using substances for a significant period of time. S/he experiences infrequent or non-intense urges to resume using, is able to resist acting on them, and requires less frequent or intensive participation in organized activities to sustain abstinence.

Most persons who enter substance abuse treatment as the result of a DUI conviction are likely to be at either the 'pre-contemplation' or 'contemplation' stage of change. They have not yet decided that they have a problem with alcohol and/or other drugs, and they are not likely to have made a commitment to stop using them. Mandated treatment works for these offenders because they are required to complete it in order to get something else they need or want—such as the return of driving privileges, the avoidance of stiffer penalties, and in the case of those who are incarcerated, release from prison. The use of Motivational Enhancement Therapy is particularly appropriate in these cases because it focuses on assisting clients to change behavior in order to attain their own goals. In Table 15, the pre-contemplation and contemplation stages of change are depicted, matched with the most promising interventions for persons incarcerated and mandated to treatment as a result of DUI conviction.

Table 15: Stages of Change

Stage of Change	Process	Definition	Interventions
Pre-contemplation	Consciousness Raising	Increasing information about the problem of alcohol and other drug consumption and driving under the influence	Motivational Enhancement; psychoeducation; exploration of perceived positive and negative consequences of substance use
Contemplation	Self-reevaluation	Assessing how one feels and thinks about oneself with respect to problem behaviors, including alcohol and other drug consumption and driving under the influence, and the incarceration that has resulted	Value clarification; imagery; corrective emotional experience; challenging beliefs and expectation; identifying incompatible personal goals and competing motivations

Referral and Assessment: Clients will be referred by the DUI treatment program by virtue of their incarceration for a second or more DUI offense. Each offender who is referred to the program will attend a one-hour orientation/assessment session with a counselor. The assigned counselor will review the arrest and referral information and will administer the Addictions Severity Index (ASI). The ASI is an assessment instrument designed to be administered as a semi-structured interview in one hour or less to individuals presenting for substance abuse treatment. The instrument gathers information about seven life domains: medical, employment/support, drug and alcohol use, legal, family history, family/social relationships, and psychiatric problems. Using a ten point scale from 0 to 9, interviewer severity ratings indicate the degree of difficulty each of the seven problem areas poses for the person served, based on historical and current information. The assessment process is used to engage the client; obtain information about and request consent to contact others who might have relevant information

regarding the client; screen for, detect and determine the severity of mental health and substance use conditions; determine the appropriate setting for care; identify strengths and potential social supports; identify and address cultural or linguistic needs/resources; determine readiness to change; and provide information for use in the development of a treatment plan. In Motivational Enhancement Therapy, assessment information is also used to help the client identify priority needs and goals that can be used to engage him/her more successfully in the treatment and change process.

Monitoring Abstinence: Arrangements will be made with the Medical Services Vendor to obtain lab work and urinalysis to ensure that the individual is not using alcohol or other drugs. This monitoring will include an initial Blood Alcohol Content evaluation as well as a NIDA-5 urine drug screen. As the program is developed, the Medical Services Vendor, DDOC Bureau Chief, and the Mental Health Services Vendor will work together to determine the best method for ensuring that all offenders who are required by the law to have 90 days of consecutive abstinence are monitored in some definitive way. The least expensive and most reliable way to achieve this would be the use of ankle bracelet monitoring for alcohol use in the prison facility.

Treatment Planning: Following the initial assessment, the counselor and client will work to develop a treatment plan within seven (7) days of admission. The treatment plan will include a diagnostic summary of problems, developed from the assessment, the individual's goals and objectives, and the services to be provided. The treatment plan will be signed by both the counselor and the client and will delineate the criteria for successful discharge. During the treatment planning process, the client will also be apprised of the requirement that s/he attend at least 6 addiction-focused support groups, such as Alcoholics Anonymous.

Treatment Interventions: In our outpatient DUI treatment program, we use a manualized treatment program—*Driving with Care: Education and Treatment of the Impaired Driving Offender* (Wanberg, Milkman & Timken, 2005). The program makes several assumptions: 1) that the impaired offender intervention must focus on the individual's moral responsibility to other members of the community; 2) that the concepts and methods of CBT are the best basis for DUI intervention, much as they are for working with offenders in other contexts described in this proposal; 3) that the prevention of relapse is the most important outcome of the treatment; 4) that the program must integrate the therapeutic and correctional intentions—the substance abuse treatment provider is playing both a sanctioning and a treatment role. The program has manuals for both the counselor and the participants, which provide content, exercises, and homework assignments for each session. The program integrates psychoeducational content about alcohol and other intoxicants, driving, and the impact of driving under the influence with CBT approaches intended to change thinking and behavior about substance use and driving while impaired. The manual contains 18 education sessions, 21 CBT sessions; and 10 extended therapy sessions. By using all 49 sessions as group interventions, integrated with individual sessions to reinforce personal goals as they relate to the content of the groups, we will be able to provide an intense and robust treatment experience inside the 90 days of incarceration.

Group sessions last approximately 1.5 hours each. The groups can be attended in any order, although in order to complete the program, each client will have to attend a total 49 1.5 hour groups and at least 13 one-hour individual sessions. The primary goal of both the individual and

group interventions is to convince all participants (emotionally and cognitively), whatever their prognosis as to alcohol/drug dependency, that responsible use of alcohol and other drugs rules out driving a car while under the influence. They should leave the program convinced that there are no exceptions to this rule, no special circumstances, and no safe level of intoxication. The group interventions will be designed to guide offenders through an examination of their own reasons for using alcohol and other drugs and to help them arrive at an informed decision about their own actual or possible dependency on psychoactive substances, especially alcohol.

Transition to Higher Level of Care: Each counselor in the DUI treatment program will be knowledgeable about the other levels of treatment that are available to offenders with substance use conditions, including detoxification, outpatient, intensive outpatient and residential treatment services, both inside and outside of the prison. The counselors and clinical supervisors will work with offender who demonstrate the need for additional care to determine the right level of care to meet that need and will make an appropriate referral.

In order for a client to be successfully discharged from the higher level of care, s/he must comply with all requirements to allow treatment providers to exchange information and must remain alcohol and other drug free for at least 12 weeks. In order to be successfully discharged from DUI treatment, the client must return to the DUI discharging agency within 60 days of completion of extended services and bring a discharge summary with prognosis and a description of the services received. At that point, the DUI treatment agency may complete the DUI At-Risk Clearance Document indicating that the client has achieved satisfactory program completion. For individuals whose sentence ends before such a process is completed, the Mental Health Services Vendor will work with a DUI or other outpatient provider in the community to ensure that the offender transfers to another treatment provider upon release.

Connections is a provider of licensed outpatient and intensive outpatient services in all three counties in Delaware. DUI offenders who are discharged at-risk may choose to continue with Connections seamlessly or go to another treatment provider. Connections will provide a list of alternative providers, licensed by Division of Substance Abuse and Mental Health. We believe that our status as a licensed provider of outpatient and intensive outpatient services for persons with or without insurance, including those with co-occurring mental health conditions, in locations throughout Delaware, uniquely positions us in those counties to provide a seamless continuum of services to meet the spectrum of needs of DUI offenders.

Appeals Process: Connections will maintain a documented appeals process and will participate in any appeals in accordance with law and policy. This will include providing any offender who is not discharged as 'satisfactory' with a letter that details specific, measurable reasons for the type of discharge given. Any offender who does not receive a satisfactory discharge will be provided with the opportunity to file an internal appeal. The results of the internal appeal will be provided at the offender's request on a form used for that purpose, with the appropriate consents to release information.

Alternative Mental Health Program: DUI offenders, who, on assessment, are determined to have a diagnosable mental health problem, such as anxiety or depression, which contributes to their use of alcohol and/or other drugs, will complete the elements of the treatment program

described above. They will also work with their counselor in individual sessions to assess the impact of the mental health issues on their use/abuse of substances by completing the Hazelden workbook, ***Coping with Dual Disorders***. This workbook provides a framework for developing a recovery plan that takes into account both the mental health and substance use conditions. If, after assessment and treatment, it is the counselor's opinion that the participant requires additional assessment and treatment for the mental health condition in order to alleviate the risk that s/he will have a repeat DUI, the client will be referred to for further evaluation and treatment by a psychiatric practitioner before being discharged as satisfactory.

Under 21 Program: Like most states, Delaware has a zero-tolerance policy regarding the use of any alcohol by a driver who is under the age of 21, and the statute delineates penalties for drinking any amount of alcohol and driving before reaching the legal drinking age. For DUI convictions (BAC of .08 or higher), persons under 21 are required to attend a DUI Treatment Program with the same minimum number of hours and discharge criteria as all DUI Treatment. Persons under 21 will participate in a specialized program for individuals in that age group who have been convicted of a DUI offense. Clinical research suggests that these individuals are in an age group that is at high risk for developing more serious substance abuse problems. Using the Hazelden Teen-Intervene program, an evidence-based brief intervention for substance-abusing adolescents, the Under 21 Treatment program will integrate the standard DUI Treatment curriculum with two special sessions aimed at enhancing decision-making and refusal skills and developing motivation to achieve abstinence.

Discharge from DUI Treatment: In order to be discharged from the DUI Treatment program with a 'satisfactory' status, the client must attend all sessions, pay the fees required, pass a content test with a score of at least 80%, and complete the program within 90 days of the initial referral. S/he he must also meet the participation requirements, present an acceptable DUI Avoidance Plan and attend at least six addiction-focused support group meetings.

Offenders who have failed to accomplish the goals and objectives of the program, even though they may have completed all of the requirements, may be discharged at-risk. The criteria for at-risk discharge include, but are not limited to:

- Failure to maintain abstinence
- Lack of meaningful group participation
- Failure to complete the treatment plan
- Failure to produce an acceptable DUI Avoidance Plan
- Failure to pass the content test with a score of 80% or higher
- An alcohol- or drug-related incident during treatment
- The presence of clinical issues that indicate the necessity of further treatment.

An at-risk discharge from the DUI Treatment Program can be resolved only by enrolling in a more in-depth treatment program and completing it satisfactorily. Any at-risk discharge will be reported to the DDOC immediately.

Special Populations

Previously in the proposal, we have addressed the needs of women, offenders with co-occurring mental health and substance use conditions, sex offenders, youth in the YCOP program, and DUI offenders. In addition, we believe that there will be at least two other populations requiring special focus: 1) older inmates; and 2) inmates with cognitive and learning disabilities, especially Attention Deficit Disorder (ADD). In this section, we describe some specialized interventions for those populations.

Older Offenders

According to the U.S. Census Bureau, the number of Americans 65+ increased by almost 158% between 1980 and 2010. It is projected that, by the year 2030, that number will increase by almost 283% from 1980. Those who are 65+ experience medical issues that younger persons do not. As a result, this age group requires the greatest amount of healthcare services. Within prisons, health-related problems are exacerbated causing difficulties for older inmates and a burden on prison budgets. According to the Delaware Criminal Justice Council report, *Aging Behind Walls*, prisons have been found to contribute to accelerated aging; in fact, the biophysical age of prisoners can be 10 to 15 years higher than their chronological age. The same report states that the annual cost to incarcerate an elderly inmate is approximately $70,000, while the cost of incarcerating a younger inmate is $30,000. In the coming years, these costs are expected to rise significantly.

There are also implications for providing behavioral healthcare for older adults. Many medications that are effective for younger people cannot be used for people over 65 because they have unintended and sometimes deadly side effects. For geriatric patients (65 and older), Beers criteria will be used in medication choice for sedation. The Beers criteria define three categories of drug use or selection that are inappropriate for elderly patients. The categories, along with some examples are:

1. Inappropriate drug choice, i.e., medications generally to be avoided in the elderly population. Examples include:
    a. Long-acting benzodiazepines, including diazepam (VALIUM), flurazepam (DALMANE), and chlordiazepoxide (LIBRIUM) which have long half-lives. This can lead to accumulation of the drug, leading to excessive sedation and an increase in the risk of falls and fractures.
    b. Meperidine (DEMEROL), which can cause confusion and its metabolites can lead to seizures.
    c. Anticholinergics and antihistamines, including diphenhydramine (BENADRYL), chlorpheniramine (CHLORTRIMETON), hydroxyzine (ATARAX, VISTARIL) and promethazine (PHENERGAN). These agents have potent anticholinergic effects and cause confusion and sedation. Diphenhydramine may be used in the lowest effective dose and only for emergency treatment of allergic reactions.
2. Excess dosage, i.e., medications at a dose or duration of therapy not to be exceeded. Examples include:

    a. Long-term use of stimulant laxatives such as bisacodyl (DULCOLAX) and cascara sagrada, which may be appropriate in the presence of opiate analgesic use, but may exacerbate bowel dysfunction.
    b. Doses for digoxin (LANOXIN) should not exceed 0.125 mg/day except when treating atrial arrhythmias. Diminished renal clearance of this medication increases the risk of toxicity.
3. Drug-disease interaction, i.e., medications to be avoided for patients with specific co-morbid conditions. Examples include:
    a. Patients with cognitive impairment receiving medications such as barbiturates, anticholinergics and muscle relaxants, which can worsen cognitive performance.
    b. Patients with a history of syncope or falls receiving medications such as short or intermediate-acting benzodiazepines and tricyclic antidepressants (amitriptyline [ELAVIL], doxepin [SINEQUAN], and imipramine [NORPRAMIN]) which may produce ataxia, impair psychomotor function, and increase falls.

The inmate population of those age 50+ in Delaware's correctional system has increased from 254 inmates in 1999 to 722 inmates in 2010, an increase of approximately 285%. In his 2011 State of the State Address, Governor Jack Markell stated:

> "[m]any inmates sentenced under the minimum mandatory provisions adopted in the 1980s are approaching their older years. The cost of their care is soaring. If we do not act, we soon will need to operate nursing homes within our prisons. We must examine who we're holding in our prisons and whether we can provide a less expensive but safe alternative."

The Delaware Center for Justice/SURJ Project for Older Prisoners (POPS) employs a Coordinator and volunteers to work with prison counselors who review an eligibility list of low-risk older offenders and designate those they think have demonstrated progress while in prison and would benefit from early release, while also making a positive contribution to their communities. POPS then researches these men's and women's backgrounds and works with DCJ reentry case managers to develop reentry plans. Sentence modification petitions are drafted by DCJ on behalf of selected candidates, and the petitions are reviewed by a Department of Correction (DOC) board, the Board of Parole and the Superior Court. If each entity approves of the petition, the inmate can obtain early release with community supervision, and strong case management and support from the reentry case managers. DCJ/SURJ remains the only organization in the state authorized to work with the Department of Correction to obtain the early release of inmates. There are now 140+ inmates on the POPS eligibility list.

Connections has extensive experience and resources to provide re-entry services for older adult prisoners who are released from prison. In Wilmington, we operate a one-stop health home where we provide primary care, mental health treatment, substance abuse treatment, assistance to obtain public benefits, housing assistance, and employment support. Many of the people we serve are chronically homeless and/or long-term institutional residents of DPC. Approximately 25% of them are over the age of 50. In Dover, we have a large clinic which provides primary

care and medical case management, psychiatry, substance abuse treatment including medication assisted treatment and DUI services, assistance to obtain public benefits and housing, and employment services. We are currently working on augmenting our clinic in Millsboro to add primary care and more case management support to our ongoing behavioral health and medication treatment services. If we are awarded a contract, we will work with DCJ to expand their case management services and to enhance the linkages for older inmates who could leave the prison setting with the right supports.

Offenders with Attention Deficit Disorder and other Cognitive Impairments

Attention Deficit Hyperactivity Disorder, or ADHD, is a neurobiological syndrome which impacts the behavior, emotional functioning, learning and cognition of affected individuals. As demonstrated by its prevalence within the prison population, the role this disorder plays in one's decision-making process is particularly relevant to issues of criminal justice. While the incidence of ADHD among the general adult population in the United States is about 4%, conservative estimates indicate that approximately 40% of prison inmates in the United States are challenged with ADHD--many of whom were never diagnosed, nor were aware of the disorder's existence.

Studies by Robert Eme and Patrick Hurley in their book, *Spinning Out of Control*, found that ADHD incidences in correctional facilities ranged from 20% to greater than 50% (2008). Russ Barkley's research of US youth, matched for socioeconomic settings and followed for 10 years, showed 20% of his control group without ADHD were arrested compared to 48% of the ADHD group. Barkley's findings also demonstrated that members of the control group were arrested on average 2.1 times, compared to 6.4 times for the ADHD group- indicating that this disorder not only impacts the likelihood of an individual having problematic encounters with the law, but also influences whether or not they will be repeat offenders (2005).

ADHD is a treatable condition. Once diagnosed, steps can be taken to reduce its interference with functioning. With appropriate treatment and support, individuals can learn to manage the behaviors related to ADHD that led to their arrests. Providing ADHD therapy to incarcerated individuals with continued support upon their release has been shown to reduce rates of recidivism. This may have been best demonstrated by the CHOICES Program of Washington State which, over the course of 20 years, consistently reduced recidivism among participants by approximately 40% (Admire, 2011). Addressing the specific needs of inmates challenged with ADHD ultimately benefits the general community in the form of lowered recidivism, safer communities, and savings to taxpayers. For this reason, it will be important to include assessment for ADHD and other cognitive disorders in the mental health component of the proposed program.

The ADHD Corrections Project, a joint effort by the Delaware Center for Justice (DCJ) and Attention Deficit Disorder Association (ADDA), is the first reentry initiative of its kind in Delaware. This program works to identify ex-offenders with previously undiagnosed and/or untreated ADHD and to incorporate appropriate treatment with their re-entry planning. In the second year of the program, DCJ has developed and begun implementing a multi-step process including informational presentations, preliminary screening sessions, full diagnostic interviews, regular group coaching sessions in the prison leading up to release, coordinated support groups

in the community following release, and a referral base facilitating additional follow-up services using our directory of local resources.

By simultaneously collecting relevant background information and tracking outcomes for ADHD program participants, DCJ is increasing understanding of the relationship between this disorder and the criminal justice system. The results of this research not only demonstrate the significant (and often overlooked) connection between ADHD and arrests and adjudications, but also provide valuable insights as to how we can better help our participants overcome the additional obstacles to successful re-entry.

Connections is an experienced provider of services to individuals with cognitive and developmental disabilities, many of whom have co-occurring mental health conditions and problem behaviors that can lead to incarceration. We will ensure that mental health evaluations include assessment for cognitive disorders and disabilities, including ADHD, and that treatment plans are tailored to address them. In addition, we will work with DCJ on their ADHD re-entry initiative to enhance re-entry planning for these individuals to address problem behaviors and ensure aftercare services that reduce the likelihood of re-offending.

Reasonable Accommodations

Connections will make reasonable accommodations for any offender who needs them because of a disability. We will provide specialized services identified in the treatment plans, both our own and those of the Medical Services Vendor, including case management to ensure the removal of any service barriers. Offenders with time-limited accommodations for temporary conditions will be re-assessed periodically.

Discharge and Re-Entry Planning

With 1 in every 22 persons in Delaware involved with the DDOC, and 28,000 offenders entering and leaving incarceration annually, discharge and re-entry planning is of critical importance to the ongoing health of Delaware and the individuals served by DDOC.

As we have discussed throughout this application, Connections is in a very good position to assist DDOC in meeting its goal of connecting offenders with community-based services that will meet their post-discharge needs. We have proposed enough staffing in both the mental health and substance abuse programs that a clinician-level staff person will act as a case manager for each identified offender who has a mental health condition and/or needs follow-up for substance abuse or sex offender treatment. We have also identified four employment specialist positions for whom we will pay with other funds to help reentering offenders prepare for employment. The case managers will have responsibility for developing referral sources in all areas of transition that the offender is concerned about, and ensuring that offenders are linked to the necessary services before they leave the Level 4 or Level 5 facility. As with all other services described throughout, the discharge planning process will be a collaboration among the offender, the Medical Services Vendor, and the Mental Health Vendor to ensure that all areas of concern are covered. This is especially important for offenders who have chronic illnesses, serious mental health conditions, infectious diseases such as HIV/AIDS, and for women who are pregnant or who have given birth while incarcerated.

In several previous sections of this proposal, we describe Connections' own resources as a re-entry provider and a statewide provider of mental health and substance abuse treatment which includes residential treatment for co-occurring conditions, DUI treatment, and medication assisted treatment. These are outlined again below:

- **Outpatient Mental Health and Medical Services**

Connections operates outpatient clinic services which are fully integrated, i.e., they offer psychiatry, mental health assessment and counseling, substance abuse assessment and treatment, medication assisted treatment for both mental health and substance use conditions, and access to primary care, all in the same location. The clinics are located in the city of Wilmington, Newark, Smyrna, Dover, Georgetown, Millsboro and Seaford. In several of these locations, we directly provide primary medical care as well. In addition, we have an ongoing MOU with Westside Family Healthcare, a federally qualified health center, where we provide reciprocal services in Wilmington, Newark, Bear, and Dover. These resources are available for referral and discharge planning.

We also have long-standing relationships with other providers—Brandywine Counseling, Horizon House, Delaware HIV Consortium, Christiana Care, La Red, NET, and Gateway—who provide similar services which can be offered to offenders preparing for discharge to ensure choice of provider. Our presence in the communities throughout Delaware and our longstanding contractual relationship with the Delaware Division of Substance Abuse and Mental Health will help to improve the discharge and re-entry planning for offenders with mental health conditions significantly.

In all cases where the release date is known, the assigned case manager for any offender known to have mental health or other special needs, will prepare a discharge plan. The case manager will work collaboratively with the offender to ensure that the areas of transition that are of concern to him/her are addressed. The plan will include the date, time, and location of all follow-up appointments that have been scheduled in the community by the case manager. The psychiatrist will note all current medications, with dosages and any other necessary information, on the discharge plan. The case manager will also assist the offender to determine his/her status relative to public benefits such as Medicaid and Medicare, and will be trained to assist the offender to make pre-release application for benefits when the discharge date is known. The psychiatrist and case manager will work with the Medical Services Vendor to ensure that a supply of medication is available and will accompany the offender when s/he leaves such that there is no gap in access to medication before the community appointment can be kept.

- **Employment and Financial Literacy Services**

Connections is a provider of Vocational Assessment, Direct Placement, On-the-Job Training, and specific training in culinary arts, pest control, and janitorial services for the Delaware Department of Labor. Connections also operates an evidence-based supported employment program (Individual Placement and Support) that has been the most successful such program in the state in placing and maintaining individuals with serious mental illness in employment. DVR has provided a commitment to us that they will assign a counselor to work with offenders who are preparing for reentry, rotating among the sites, to assist persons served to become open with DVR and to make the necessary linkages to the services they need. We will provide two employment specialists to the proposed program to be paid for through our performance-based DVR contracts.

In an attempt to ameliorate high rates of unemployment and a lack of job opportunities generally in the depressed economy, Connections has formed a subsidiary corporation, Connect to Work, an economic development company with the mission to create jobs for individuals who are hard to employ because of criminal records, disabilities and/or low rates of educational attainment. Connect to Work's primary focus is the development of small businesses in which persons served in the programs offered by Connections can obtain competitive employment. The social enterprises that are being developed by Connect to Work include 1) a janitorial service business; 2) a minor construction/landscaping business; 3) a pest control business; and 4) a catering and restaurant business. Business development has been augmented by contracts with state agencies that are 'set aside' under Delaware law and are required to be given to organizations that employ people with disabilities. We have obtained 'set aside' contracts to clean state office buildings and are in the process of being awarded contracts for temporary services. We are provide 'summer food' to day camps for school age children and homebound adults. Our food service program currently provides more than 2,000 meals per day in Wilmington and Seaford and operates a restaurant in the city of Wilmington. The employment program is coupled with a financial literacy component, offered at our locations by the Money School. Individuals who participate in financial literacy training are eligible to open an Individual Development Account (IDA), a matched savings account, similar to a 401 (K), in which the individual's contributions are matched by philanthropic sources administered by a financial institution. Funds can be used to build wealth by purchasing a home, paying for higher education or vocational training, and/or to start a business.

- **Housing**

Connections is unique among the agencies that provide community support for persons with special needs in Delaware in that it incorporates the goal of ending chronic homelessness in this population as a core mission. The provision of housing is central to Connections' mission. We are one of the largest and most diverse developers and operators of housing for individuals and families with extremely low incomes in Delaware owning and/or operating more than 600 units of housing, ranging from group homes to on-the-economy rentals with subsidies to make them affordable. Connections' supportive housing programs have been extremely successful. Delaware's statewide HUD Continuum of Care for the Homeless has brought in more than $40 million in funds since 1998, with a current average annual amount of more than $4 million. More than half of the funded projects are permanent supportive housing projects operated by Connections, housing homeless persons with substance use and mental health conditions and HIV/AIDS. Connections supportive housing for the homeless (SHP) programs with more than 300 beds, consistently rank at the top in Delaware's competitive Continuum of Care for the Homeless because of their cost effectiveness and positive outcomes. Connections has also developed significant housing for the Delaware State Housing Authority and the Delaware Department of Health and Social Services, all of it serving persons with incomes below 30% of median and special needs.

Connections also works with **Oxford House, Inc.** (OHI) to develop affordable, drug- and alcohol-free housing for persons who are recovering from substance use conditions. OHI is a publicly supported, non-profit corporation that serves as the umbrella connecting all Oxford Houses. Founded in 1975, OHI has sponsored and assisted in the development of more than 1,200 Oxford Houses in the United States. We are developing this resource for use by individuals who have completed residential substance abuse treatment and are homeless, individuals who need a place to live while they complete outpatient substance abuse treatment, and for reentering prisoners who have received substance abuse treatment while incarcerated and who need stable housing upon release.

- **Homeless Services**

Connections offers an array of prevention and intervention services for persons who are homeless in Delaware, approximately 50% of whom have a diagnosable substance use or mental health condition. We expect that our homeless services programs will both be a significant resource for reentering offenders. Connections' PATH program operates statewide, providing outreach, entitlements, housing and clinical services that help the homeless individuals and families to achieve stability. The PATH staff are experts in making linkages to mainstream resources such as General Assistance, Food Stamps, Social Security (SSI and SSDI), Medicaid/Medicare, employment, housing and treatment services. The PATH program offers full-service walk-in clinics in all three counties where homeless persons receive screening, assessment, brief treatment for mental health, substance use and primary medical conditions and referrals to ongoing treatment. Master's level licensed clinicians, psychiatric nurse practitioners, and a family physician are assigned to the walk-in clinics, which operate in rotating locations throughout the state. Connections provides regular and specialized transportation to the walk-in clinics from designated locations and coordinates with homeless shelters and other service providers in Delaware to maximize penetration of the target population. As part of the PATH

program, Connections distributes motel vouchers and security deposit assistance to help homeless people to become rapidly rehoused. PATH is funded by a formula grant from the US DHHS, which is passed through the Delaware Division of Substance Abuse and Mental Health. In Wilmington, we operate a 24/7 Homeless Café which provides an immediate place for homeless adults to take shelter throughout the winter and during weather events such as heat waves and hurricanes at other times of the year. The Café is open seven days per week year round, and provides a safe haven to receive services, take a shower, and eat a warm meal.

PATH services are augmented by a federal 'Treatment in Housing' grant—Connect to Success—a competitive award to Connections by the U.S. Center for Substance Abuse Treatment. The Connect to Success team provides in-home supportive services and field-based case management for persons who live in permanent housing programs operated by Connections, who need assertive outreach to engage in treatment, but who are not eligible for CCCP services. Connections' homeless services programs are funded by $700,000 in federal grants plus almost $600,000 annually in third-party payments and fees for service from Medicaid, Medicare and direct payment by persons served. During 2009, Connections PATH and Connect to Success programs served almost 1,500 unduplicated individuals, all of them with diagnoses of mental health and/or substance use conditions.

- **Offender Reentry**

In 2008, the Delaware Criminal Justice Council (CJC) received one of 19 President's Prisoner Re-entry Initiative (PRI) grants to serve at least 200 male and female offenders, 18 to 35 years old, within 6 months of release, returning to New Castle County. Later that same year, Connections received an employment-centered program for reentering prisoners--the US DOL funded 'sister' grant to the PRI. The projects are coordinated with the Delaware Criminal Justice Council, the Delaware Center for Justice, the Delaware Reentry Consortium and the Ministry of Caring, local organizations in Delaware that focus their efforts on assisting poor and disenfranchised Delawareans, many of them reentering offenders, to obtain access to the resources they need to achieve success. The relationships that were established during these grants, including ongoing work to with the HOPE Commission and DCJ to develop a reentry one-stop in Wilmington, will provide a wealth of resources for case managers making discharge plans. We are also proposing to sub-contract with DCJ to provide specific, targeted re-entry services through their POPS program for prisoners over the age of 65, and for prisoners with ADHD and other cognitive disabilities.

- **Women's Service**

The proposed program will follow the Guidance for States: Treatment Standards for Women with Substance Use Disorders recently issued by NASADAD and CSAT TIP 51 to develop culturally competent, tailored treatment for women who are referred to the comprehensive and integrated clinic. It is recognized throughout the literature that gender-specific treatment is more effective for women, especially when it is family-centered and makes thoughtful accommodations for children, both during incarceration and as part of the re-entry process. Women are more stigmatized by incarceration and by alcohol and other drug use and mental health conditions than men, especially related to the perception of others regarding their capacity as mothers. The fear of losing custody of their children is a major barrier for women to admitting and seeking help for behavioral health problems. Through our relationships with the Pencader

Hundred Community Center, the Boys and Girls Clubs of Delaware, and Westside Family Healthcare, we will strive to overcome these barriers by directly delivering and coordinating prenatal services and ongoing child care for older children with family-centric treatment strategies that provide positive outcomes for women and their children.

The progression of addiction, the co-occurrence of mental health problems with substance use disorders, barriers to treatment, and the impact of substance use on general health are all different for women than for men, and require interventions that are tailored to meet those special needs. As many as 70% of women who have substance use disorders have experienced physical and/or sexual abuse. Substance abusing women are more likely to report parental behavioral health problems in their histories than are their male counterparts. The continued subordination of women in many cultures, the combination of codependence and dependence that often occurs for women, and fear regarding the possible loss of their relationships with important men in their lives and/or the loss of their children are all significant barriers to treatment. There is also some evidence that the biochemical impact of most drugs is different for women than for men, and may result in much more rapid addiction. By the time women enter treatment, they may be more severely addicted than their male counterparts. Important factors in providing reentry services for for women include

- attention to basic needs and family needs (child care, food, clothing and shelter, relationship counseling, mental health treatment, primary medical and gynecological care), which will be provided through comprehensive case management;
- continuity of care givers--an ongoing relationship with a counselor with whom there is a therapeutic alliance should last throughout the treatment experience and be carried into the period of relapse prevention; if the woman returns to treatment, it is helpful to have the same treatment relationship in each occurrence;
- attention to specialized needs, especially those that relate to codependency, can be critical to successful treatment; women-only groups can help to keep women in treatment focused on their own treatment needs rather than becoming distracted by the needs of men in the group;
- attention to treating the aftermath of childhood and adult abuse and trauma as well as providing support for ACOA and other codependency issues is an important factor in the successful treatment of women.

Evaluation Plan and Continuous Quality Improvement System

Connections will evaluate the impact and the implementation of the proposed program through the ongoing use of a Continuous Quality Improvement System. The goals of this CQIS are to diagnose any program strengths and weaknesses; to formulate action plans for improving the program; to help DDOC to reduce recidivism and keep offenders moving through the system at a rate and in a manner that maintains order; to help offenders to achieve their goals for recovery from mental health and substance use conditions; to deliver services that meet the provisions of a constitutional system for offender health care; to deliver services that adhere to the NCCHC/ACA standards for Mental Health Services in Correctional Facilities, the DDOC Health Care Policies, and all other applicable law and policy; and to deliver services both efficiently and effectively with fidelity to the evidence-based practice.

Performance Measurement

The Mental Health Directors and Substance Abuse Program Directors at each site and the Sex Offender Treatment Team Director will be responsible for keeping and reporting all necessary data to ensure that the programs are achieving their stated objectives and meeting all performance improvement criteria set by DDOC policy, the vendor's policies and procedures, and the relevant NCCHC and ACA standards. The overall Clinical Director and Program Administrator will work with the Bureau Chief and the Medical Services Vendor to identify criteria that will reflect the use of generally accepted standards of care, outcomes that will reflect those standards, and methodology for measuring and reporting such. This work will include the integration of services for the purpose of meeting NCCHC/ACA standards and accreditation requirements. Connections will implement a secure web-based reporting system that provides same-day data on all pharmaceutical orders, including cost, date, prescriber, offender, facility, drug, refills needed, drug returns, and any medication errors. If we are awarded a contract, we will work with the Medical Services Vendor to develop and collect indicators measuring prescribing practices against the DDOC formulary and any other reports needed for cost auditing.

Connections is currently implementing the electronic health record known as NextGen, which has a web-based electronic prescribing tool which is accepted for Meaningful Use and has widespread use in prisons. We can work with DDOC to make this accessible, or we can use the electronic health record of the Medical Services Vendor at the election of DDOC. We have experience using the electronic health record of another provider (we currently provide services inside the federally qualified health centers where we share an electronic health record to ensure coordination of prescribing within a single system).

Longitudinal data will be collected and aggregated and will be reviewed by the management team to ensure that the goals of the program are being achieved. Because data will be collected longitudinally, barriers that may impact different stages of treatment will be easily identifiable. The durability of the interventions will also be assessed. When there are instances were goals and objectives are not being met, a plan to modify the program to obtain the stated outcome will be created. The utilization of the data to manage and modify processes and improve the delivery of services is integral to the evaluation process.

It is anticipated that during the first year, the evaluation will be used to identify problems with intake, referral, and service processes. The initial implementation requires a concerted effort by staff, management, and the program evaluator to put processes in place that will ensure that the program goals can be met. Later, the evaluation data will be analyzed to improve how services are delivered and to identify barriers to effective treatment and to determine if race, ethnicity, or any other demographic factors are contributing to differential outcomes. If disparate outcomes emerge, the program evaluator will provide the analysis of this data and consult with the management about possible ways to rectify such problems.

Documentation of program implementation, including interviews with employees, satisfaction surveys collected from service recipients, and analysis of service data will be integral to the formative evaluation process. Connections has an extensive history of implementing evidence-based interventions and is aware of unforeseen issues and barriers that can impact the implementation, including staff changes and turnover, changes in funding streams, and unforeseen needs of participants. These barriers and subsequent deviations often lead to changes that can impact how the program operates and the services received by participants. Documentation of these deviations and changes will be maintained with the qualitative data collected and considered in light of the program goals and objectives. Analysis of the service data from the electronic health record will allow the project management to identify who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost.

Aggregation of the data will allow for the formulation of any required reports. An annual report will be developed based on the data collected and will be used to consider trends, including disparate outcomes for any sub-group, and to make necessary changes to the program to enhance program delivery. Quarterly and annual reports will be provided to personnel with recommendations for possible improvements and analyzed to provide the employees with a clear understanding about how the program is working relative to the proposal. If significant changes are necessary, based on the program evaluations, requests to make those changes will be made to DDOC with a clear explanation of how changes will improve the program to achieve the stated program outcomes.

The evaluation will be conducted by William F. Northey. Ph.D., who will be contracted specifically for that purpose. One of the roles that Dr. Northey will play as the independent evaluator will be to assist the program staff to determine if the goals, objectives, and outcomes of the project are being achieved and what changes might be in order as a result of the performance assessment. Dr. Northey will provide the program management with quarterly reports summarizing the any organizational changes made (e.g., staffing, impact of personnel changes, reporting structure), barriers or challenges experienced, strategies to address identified barriers and challenges, progress made on program goals and evaluation activities. Quarterly reports will be aggregated annually and used to assess the progress of the program.

Performance assessments will be serve two purposes, examining both program outcomes and its processes. The outcome questions that will be addressed include: Is the program achieving it stated goals? Are there contextual, program, or service recipient factors that impact outcomes? Are the treatment outcomes achieved? Outcome data will analyzed by appropriate demographic

factors (e.g., race, ethnicity, gender, geographic locale, diagnosis) to determine whether there any disparities between the services and outcomes achieved. If there are disparities noted, the team will work to determine the reasons for these differences and make every attempt to rectify them. SPSS will be used to analyze if there are any statistically significant differences between the outcomes of different groups on the demographic variables.

The process questions include how well the actual implementation matches what is proposed, the changes or modifications made to the original implementation plan, the impact that any changes had on the intervention or the evaluation, and the number of people served through the program. The performance assessment will also consider the services delivered, by what service providers, in what context and at what cost to identify ways of improving the effectiveness and the efficiency of the program. Service data, service recipient surveys, audio and video recordings of sessions, fidelity monitoring tools, and observations of staff will be used to insure not only fidelity of the EBPs used, but also to the data collection processes described.

NCCHC Standards and DDOC Policies

This proposal was structured to articulate services that meet the DDOC policies and NCCHC standards for care of offenders in prison, keeping in mind that health services accreditation is granted to the facility, not to the provider. With the 2008 release of the *Standards for Mental Health Services in Correctional Facilities*, health professionals and administrators in the mental health arena can now access more specific guidance on quality mental health care services organization and delivery. These standards are the foundation of a new accreditation program originally intended for correctional facilities in which the legal authority for mental health services is separate from their other health services, but which will be applicable in this case if the Mental Health Services Vendor remains separate from the Medical Services vendor.

- Access to care, evaluation, and case management services were designed to meet essential standards J-A-01 Access to Care and J-E-02 Receiving Screening and standard J-D-05 Hospital and Specialty Care (both jail and prison standards apply because of the unified system). Inmates have a constitutional right to access to care for their significant health problems. If the level of care needed is not available at the facility, inmates are to be treated in a setting that can meet their specific health needs, such as a community hospital or ER, or a better equipped psychiatric hospital with which we will maintain transfer arrangements.
- Services related to suicide risk detection and prevention were designed to meet DDOC Policy Number G-05 and related NCCHC Standards P-G-05; P-E-02; P-E-05; P-A-10; and essential standard J-A-10/4-4373.
- Services related to withdrawal from intoxicating substances were designed to meet NCCHC essential standard J-G-06 Intoxication and Withdrawal requires that these services be provided to inmates who need them. Such services may be provided on-or x-site, depending on the severity of the clinical condition of a patient.
- Confidentiality of health records was designed to meet the federal laws contained in 42 and 45 CFR as well as NCCHC standard H-02 Confidentiality of Health Records.

As discussed in the opening section of the RFP response, Connections is currently accredited by CARF (since 1999) in multiple locations for a wide range of services. We were also continuously accredited by the Joint Commission (JCAHO) from 1999 until 2009, when, because

of the cost of maintaining two accreditations, we voluntarily elected not to seek re-accreditation. If we are the successful bidder for this contract, we will seek and obtain NCCHC/ACA accreditation using the Standards for Mental Health Services in Correctional Facilities for every facility in which we provide services for DOC. Because of our experience obtaining and maintaining accreditation, we believe that we will be able to achieve this milestone within three to six months of signing a contract.

Informed Consent

Offenders receiving mental health, substance abuse, and sex offender services will receive information about the nature, consequences, risks, and benefits of any proposed treatment or procedure, and any alternatives, and will sign a written informed consent that meets DDOC policy and uses the DDOC-required format. Any treatment refusal which is made by an offender following the receipt of informed consent will be documented in writing using DDOC-approved policies and forms.

Evaluation and Fidelity to Evidence-Based Practices

Process Measures: Process measures provide a structured method for determining fidelity to the evidence-based model, analyzing fidelity to the factors which have been proven to produce the desired outcomes. Process measures allow programs to understand whether they are providing services that are faithful to the evidence-based practice model and can therefore be viewed as 'high-fidelity services.' A process assessment can also be used to detect deficiencies in the program while at the same time providing an assessment of the program's strengths. The implementation of all services described in the proposal will be subject to a process evaluation to determine whether and with what extent of completeness the services were implemented as proposed. Specific process evaluations will be conducted to ensure fidelity to the proposed Differential Substance Abuse Treatment program (DSAT); the integrity of Motivational Interviewing; and the degree to which services meet fidelity to a measure assessing co-occurring capability.

Outcome Measures: Process measures capture the *method by which* services are provided. Outcome measures capture the *results* of those services**.** Every intervention has both immediate and long-term, measureable goals, tied to the goals that the service recipients have for themselves. These goals translate into outcomes that can be defined in ways that are specific and measureable.

It is also important to define and then monitor outcome measures that demonstrate the extent to which the project is meeting its goals. Goals for the project include:

- Reduction in adverse events including injury or death by suicide within the facilities compared to an agreed upon baseline
- Reduction in the number of offenders who are sent out of the prison for emergency care related to psychiatric events compared to an agreed upon baseline
- Improved ASI scores pre- and post-treatment for all offenders who participate in the mental health and substance abuse program components where the ASI is the baseline assessment tool

- Improved scores on the DSAT battery of pre- and post-tests for all offenders who participate in the described substance abuse interventions (described in detail below)
- Improved Static-99R and MnSOST-R scores for offenders who participate in sex offender treatment
- Reduction in recidivism among offenders completing substance abuse treatment as compared to an agreed upon baseline
- Achieving or exceeding the QA indicators included in Appendix B of the RFP.

Data will be collected and aggregated monthly and a compliance report will be generated. Areas in which the compliance goal is not being met will be further evaluated to identify the barriers for successful achievement of said goals and a remediation plan will be developed and evaluated during the next reporting period.

DSAT Evaluation—Past and Future: In 2005 an evaluation of DSAT treatment in the Maine Adult Drug Courts was completed by Taxman, Pattavina and Bouffard. The authors found the following:

- The DSAT curriculum is "a thorough and strategic approach…built on a solid curriculum—assisting the offender in achieving skills to address recovery issues…"
- That "DSAT can be effectively delivered through the mechanisms that were employed by OSA to include training the counselors, using quality assurance mechanisms…"
- That "The DSAT curriculum appears to engage many of the offenders in the treatment process – more social conformity and less risk taking behavior … clients have good rapport with the counselors…"

In 2006 Ferguson, McCole and Raio of the University of Southern Maine published results of a Process and Site-Specific Outcome Evaluation of Maine's Adult Drug Treatment Court Programs. This evaluation was a comprehensive study of the Maine Adult Drug Courts where the DSAT program was initially implemented as primary treatment for all clients in six sites across the state. An analysis of the DSAT Pre and Post Test Battery Measures in that study report the following state-wide, cross program outcomes for Maine DSAT.

Alcohol and Drug Refusal Self-Efficacy Questionnaire (ADRESQ)	Pre-Test	Post-Test	% +/Change
Social Pressure Self-Efficacy	48.5	57.6	18.76%
Emotional Relief Self-Efficacy	46.6	54.1	16.09%
Opportunistic Self-Efficacy	35.8	43.1	20.39%
Drug Avoidance Self-Efficacy Questionnaire (DASES)	68.5	88.4	29.05%
Commitment Scale (CS)	7.9	8.4	6.33%
Problem Solving Questionnaire	54.1	60.3	11.46%
Perceived Modes of Processing Inventory (PMPI)	90.9	99.4	9.35%
Coping Behaviors Inventory	65.3	46.4	28.94%

* Optimal positive outcomes should result in an increase in scores between the pre-test and the post-test, except for the Coping Behaviors Inventory (CBI) where optimal positive outcomes would result in lower scores as evidenced above.

Ferguson et.al. (2006) also noted the following outcomes:

- From inception (April 2001) to November 30, 2005 there were 540 offenders admitted to these courts and the overall completion rate in Maine was 60%, compared to a national rate of 48%
- Fewer participants recidivated (17.5%) during a 12 month post program follow-up than a comparison group of traditionally adjudicated offenders (33.1%)
- Analysis of DSAT clinical pre/post treatment measures reveal significant improvement in attitudes, coping behaviors, and confidence to refrain from alcohol/drug use
- Costs saving were significant given the small population of a state like Maine. The 4 year net correctional saving was $11,345,726.00. Additional savings associated with family and social issues (i.e. TANF, Medicaid) and loss in functional taxpaying citizens is not included in this calculation.

In a 2009 summary of Evaluations/Outcomes findings for the Maine DOC Adult Institutions includes analysis of the outcomes for implementation of DSAT in the Men's TC (called the CRA-TRA). This study included the 2009 CRA-TRA Recidivism Brief by Muskie School of Public Service which noted that by 2006, CRA-TRA Clients had recidivism rates that were 50% below the comparison cohort; and the program was rated "very satisfactory" by the Correctional Program Assessment Inventory (CPAI) tool.

The Maine DSAT Program was designed to integrate client assessment and outcome measures throughout all phases of the treatment curriculum. A summary of the screening, assessment, pre-treatment, intensive treatment, post treatment, and maintenance measures is provided in Appendix B.

All of the DSAT program measures and psychometric instruments administered during program participation are intended to serve as both tools for the ongoing assessment and treatment planning process for clients as well as measures for outcome evaluation and research on the DSAT treatment model. Starting with the Computerized Screening Assessment (an automated computer assessment tool for screening clients severity of substance abuse problems) psychometric instruments and other program measures are used to match clients to the appropriate level of DSAT services, assist in treatment planning, and assess client progress in treatment.

The Substance Use Screening Assessment or SUSA is the entry point screening for offenders entering the DSAT system. The DSATweb SUSA automatically administers the questionnaires, scores them, compares the scores to norms, and provides an interpretive print out that is used for both classification and treatment motivation purposes.

The questionnaires in DSAT were selected based on the following criteria: 1) they are brief; 2) they are relatively easy to administer and score; 3) they are easy to interpret given appropriate norms; and 4) they are widely used instruments with demonstrated validity in the research

literature. The SUSA is composed of four brief questionnaires and measure two primary characteristics of substance abuse problems: severity of dependence on substances and the degree to which the individual has experienced negative consequences of his/her substance use. These two primary characteristics have been shown by research to be related to risk of criminal behavior.

Research with correctional populations has also shown that severity of substance use problems correlates very highly with risk of future criminal behavior. The more severe the offender's substance use problems, the greater the likelihood of future criminal behavior. The SUSA directly assesses severity of substance use problems and assigns an overall risk/need severity level based on that assessment.

A DSAT Comprehensive Assessment (CA) is conducted on clients who receive a SUSA score of Moderate (3) to Substantial (4), or when the SUSA score is being questioned. The DSAT CA is a "face-to-face" assessment with a DSAT trained treatment provider to determine a final program recommendation. The purpose of the CA is to assure that a client's overall substance abuse profile is matched to the appropriate level of programming according to their criminal need/risk and substance abuse severity.

The DSAT Participant Summary is designed to provide an easy method of organizing all assessment measures that are administered over the course of the DSAT program. This includes: all in-program performance measures (i.e. psychometric tools); all problem-solving scenarios, and the facilitator rating scales. DSAT facilitators are instructed to insert information collected over the course of the delivery of the DSAT Community Treatment program directly into the DSATweb Participant Summary Booklet.

DSAT facilitators receive extensive training in the administration, scoring, and tracking of all the measures outlined below. Facilitators also receive ongoing feedback on their use of these instruments through regular clinical supervision and ongoing DSAT coaching and training.

Each individual client's score on all of the listed DSAT Program Measures are securely maintained within the DSATweb program. The DSATweb program delivers DSAT content over the web streamlining the various DSAT paper records. DSATweb provides information management for the DSAT program increasing staff efficiency and effective information gathering and dissemination. Client progress measures are consolidated and stored in DSATweb, and individual client progress summary reports are generated. Quarterly and annual analysis of system usage and aggregate client DSAT data provide for ongoing monitoring of program implementation, progress and outcome evaluation. As a repository for client treatment data DSATweb support allows for ongoing reports development as well as data access for additional research and evaluation.

Program fidelity begins with training treatment and correctional staff, supervisors, and clinicians in implementation of the DSAT Program curriculum and measures. The DSAT Certification process allows for the ongoing monitoring of program delivery based on agency, clinical supervision, and DSAT program facilitator standards. Process and implementation challenges are addressed through the creation of quarterly program advisory meetings which support and address emerging issues in service delivery.

The DSAT Facilitator certification process involves ongoing training, supervision, and taped supervision to review curriculum delivery for specific program sessions. Licensed substance abuse providers are given intensive training and mentoring prior to delivering DSAT. Video or digital taping of specified sessions is coupled with clinical supervision to ensure fidelity and adherence to the manualized program and techniques. DVD's are submitted for formal review and facilitator certification. Feedback on the specified DSAT Facilitator standards is provided by master DSAT clinicians experienced in the DSAT program.

The certification review is managed by a Master DSAT Trainer using 3 other DSAT Trainers. A composite score is determined; the rating scales include:

1. Organization
2. Knowledge and Practice
3. Program Integrity
4. Group Facilitation
5. Socratic Method of Delivery
6. Communication Style
7. Focus on Curriculum
8. Demonstrating Empathy

Facilitators who meet DSAT standards are certified for one year and each subsequent year a single DVD is submitted for continued certification, another certificate is issued. Agency level DSAT certification standards would be developed to reflect support for ongoing program support, training and supervision based on the standards used by the state of Maine.

Documentation of the Maine DSAT fidelity, certification, and licensing standards for clinicians and agencies are available for review in Appendix B.

The outline below presents all the assessment instruments that are administered over the course of delivering the DSAT program. The measures are listed according to the sequence in which they are administered over the course of DSAT program delivery.

A. Substance Use Screening Assessment
- Short Alcohol Dependence Data (SADD)
- Michigan Alcoholism Screening Test (MAST)
- Severity of Dependence Scales (SDS)
- Drug Abuse Screening Test (DAST)

B. Comprehensive Assessment
- DSAT Interview Rating Sheet
- Problem Solving Scenarios
- Pre-Treatment Rating Scale

C. Intensive Phase of the DSAT Program
- Pre-Treatment Questionnaire Battery
- Inventory of Drug-Taking Situations (IDTS) during Session #5

- Post-Intensive Questionnaire Battery
- Problem Solving Scenarios
- Post-Intensive Facilitator Ratings

C. Maintenance Phase of the DSAT Program

- Pre-Maintenance Drug Taking Confidence Questionnaire (DTCQ)
- Post-Maintenance Drug Taking Confidence Questionnaire (DTCQ)
- Post-Maintenance Questionnaire Battery
- Problem Solving Scenarios
- Post-Maintenance Facilitator Ratings

Motivational Interviewing—Fidelity and Integrity of Implementation: As part of the ongoing process of training and evaluating the effectiveness of both mental health and substance abuse clinicians, we will us the video assessment of simulated encounters (VASE). VASE is a validated group-administered method for evaluating clinician skills in motivational interviewing (Rosengren, et.al.). The video assessment of simulated encounters (VASE) consists of three videotaped vignettes of actors playing substance abusers. Each vignette is followed by eight questions asking examinees to generate written responses consistent with MI principles. Psychometric analyses of the original VASE scale evaluated: (1) scoring reliability of the 24 VASE items; (2) internal reliability of the VASE full-scale score, seven subscale scores and the three vignettes; and (3) concurrent validity with aforementioned indices of MI skill. The 18-item VASE-R scale retains its three-vignette format, and assesses overall MI skill as well as the following five MI "microskills": reflective listening, responding to resistance, summarizing, eliciting change talk and developing discrepancy.

Co-Occurring Treatment Capability: In January, 2010, Dartmouth published, in conjunction with SAMHSA, an updated description of Dual Diagnosis Enhanced (DDE) services, including a new tool, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index, a fidelity instrument for measuring addiction treatment program services for persons with co-occurring (i.e., mental health and substance use related) disorders. The DDCAT Index, which has been in development since 2003, is a fidelity scale used to ascertain adherence to and competence in the delivery of evidence-based practices related to the IDDT model when it is implemented within what was once a substance abuse only treatment program. This methodology has also been used to assess mental health programs' implementation of the Integrated Dual Disorder Treatment (IDDT), in mental health settings. Connections will use the DDCAT 90 days post program implementation and at six month intervals thereafter to ensure that persons served in the comprehensive and integrated program receive all of the services that they need regardless of their initial clinical presentation.

Medical Peer Review: Connections has an ongoing process for Medical Peer Review in our existing inpatient, residential, home healthcare, and outpatient practices, which employ seven (7) physicians and five (5) nurse practitioners. The process is carried out using the form shown in the exhibit below. If we are the successful bidder, our mental health staff and Clinical Director will participate in the DDOC process to complete the peer review and other Continuous Quality Improvement System processes that are needed to ensure that care is delivered timely and with quality that is consistent with generally accepted standards of care.

EXHIBIT 2
CONNECTIONS COMMUNITY SERVICE PROGRAMS
Physician/Nurse Practitioner Peer Review Evaluation

Evaluation for: _____

Evaluation provided by: _____

Please evaluate using the following ratings: 1 = Does not meet what is reasonably expected of someone with similar level of training, experience, and background; 2 = Meets those expectations; 3 = Exceeds those expectations

Circle your rating

1. PATIENT CARE
   Provides patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.
   1 2 3

2. MEDICAL/CLINICAL KNOWLEDGE
   Demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and the application of his/her knowledge to patient care and the education of others.
   1 2 3

3. PRACTICE-BASED LEARNING AND IMPROVEMENT
   Is able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
   1 2 3

4. INTERPERSONAL AND COMMUNICATION SKILLS
   Demonstrates interpersonal and communication skills that enable him/her to establish and maintain professional relationships with patients, families, and other members of health care teams.
   1 2 3

5. PROFESSIONALISM
   Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward his/her patients, profession and society.
   1 2 3

6. SYSTEM-BASED PRACTICE
   Demonstrates both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize care.
   1 2 3

PROFESSIONAL PRACTICE AND SANCTIONS

- To your knowledge, does this physician/nurse practitioner regularly obtain consultations when indicated?

Yes No

- To your knowledge, has the physician/nurse practitioner ever been subject to any disciplinary action, such as suspension or termination of license?
  Yes No

- To your knowledge, are there any actions in process or pending against him/her?
  Yes No

- To your knowledge, has this physician/nurse practitioner ever had his/her privileges to treat patients suspended or revoked?
  Yes No

- Has this physician/nurse practitioner been in good standing at all times while at this agency?
  Yes No
  (If no, please provide detailed explanation)

CONDUCT AND HEALTH STATUS

To your knowledge, is this physician/nurse practitioner suffering from or receiving treatment for any physical or mental disability or illness, including drug or alcohol abuse, which would impair the proper performance of his/her essential functions and responsibilities?

Yes No

(If no, please provide detailed explanation)

COMPETENCY IN PRACTICE

Based on your knowledge of the applicant's clinical practice, is he/she currently competent to perform the duties of his/her practice?

Yes No

(If yes, please provide detailed explanation)

SUMMARY

My general assessment concerning this clinician is:

(Please check one)

_____ Satisfactorily meets overall clinical competence in expected psychiatric skills.

_____ The following concerns have been identified:

_____

_____

_____

_____

_____

Signature _____ Date_____

Printed Name _____

Coordination Requirements

Delaware Automated Correction System

If we are awarded this contract, all personnel who are initially employed will be trained in the use of the Delaware Automated Correction System (DACS). The purpose of DACS is to provide correctional officers (COs) with a means for both recording their own observations and ensuring that offenders who are a threat to themselves or others receive immediate mental health evaluation and treatment. Mental health personnel will be required to enter information related to mental health into the system. As new personnel are hired, the Program Administrator will be responsible for ensuring that they are trained in the system and that DACS is used for its intended purposed related to mental health. Each Mental Health Program Director will review the information in DACS daily (or will assign a senior member of the mental health team who is on-duty to review the information in his/her place) and will ensure that all information contained therein is acted on appropriately and promptly for the facilities to which his/her team is assigned.

Sick Call and Triage

As previously described, Sick Call will be available consistent with DDOC Policy E-07. Sick Call will be available 365 days per year and will be staffed by a licensed mental health clinician who is, or has access to, a psychiatrist or psychiatric nurse practitioner who is eligible to prescribe medications. Offenders will be able to make requests for mental health services by completing health service request forms and depositing them in locked boxes kept in a designated location at each facility. Mental health staff will collect the requests daily at an agreed upon time, and will review, sign and time/date stamp them before entering into DACS. Triage will be performed to ensure that all offenders who present with urgent or emergent needs are seen and appropriately treated within 24 hours. If the request is related to medication, it will be handled by the prescriber, either directly or by verbal order to a nurse. All forms will be triaged within 24 hours, and referrals/appointments entered into DACS. Follow up on all triage (subsequent appointments, examination, treatment) will also be recorded in DACS. If the offender is not able to attend Sick Call because of custody status or disability, arrangements will be made to provide the services where the offender is housed.

Confidentiality/Exchange of Information

Connections. adheres to the provisions of 42 CFR, Part 2, pertaining to the protection of privacy of drug and alcohol patients and to 45 CFR pertaining to the privacy of personal health information (HIPAA). To preserve clients' rights to confidentiality, Connections has established certain policies and internal controls to ensure that clients' rights under the federal protections are not violated. To ensure smooth transition for individuals receiving care inside of the current level four and level five facilities, Connections will obtain qualified service agreements with the Delaware Department of Correction, the current Medical Services Vendor, and the outgoing Mental Health Services vendor that will allow for the flow of information needed to initiate and continue treatment for all offenders. Connections will also obtain consents and releases of information that are consistent with 42 CFR part 2 and 45 CFR, that will provide further protection to the individuals served, to the providers of services, and to the Delaware Department of Correction related to the release of confidential information.

If awarded, Connections Chief Operating Officer and General Counsel will develop Qualified Service Agreements and meet with each named entity above to facilitate sharing of information. Once Connections has started providing services, we will ensure the highest quality and integration of care by meeting at least weekly with the designated leadership of the Medical Services Vendor and DDOC. These meetings will serve as a forum to ensure that information sharing and coordination of care is happening without barriers.

For each individual who is court-ordered to treatment, Connections will provide progress reports as mandated by the Court and/or Delaware Department of Correction. For individuals in the 6 for 1 program that are volunteering to participate in treatment, Connections will work with them to have all proper releases and consents signed to share information with the Department of Correction, Attorney General's Office, Public Defender's Office, private defense attorneys, and other parties deemed relevant to the adjudication and sentencing of the inmates in the 6 for 1 program. The same coordination will be undertaken for individuals who are receiving treatment for Driving Under the Influence charges.

Connections will make available all documents for the inspection and quality review of the Department of Correction's Bureau of Medical Health Team. Connections will inform all individuals that their records are subject to review for quality and completeness by the DDOC.

Client information and clinical records, whether electronic or paper, will be maintained in securely, safe from fire and flood threat. Access is limited to the program staff, supervisory staff, DDOC staff and the Department of Safety and Homeland Security for DUI clients, except when an individual client requests that information be sent to others on a form that meets the requirements of 42 CFR or when the client requests a review. No information will be released without express, time limited release of information forms signed by the client.

The records rooms are kept locked at all times during and after business hours when not occupied by authorized personnel. It is the responsibility of all personnel to ensure that the records rooms remain locked. In order to complete case record documentation clinical staff will remove a client record from the records room to their respective office, and sign the record out on a form kept in the records room for that purpose. While the clinical staff is working on one or more case records, they must close the door of their office and lock it if they leave the room for any reason, even for a short period of time. No client, other guest, or unauthorized personnel will be left alone in any room where they have access to a client case record, including an electronic record. Client case records or documents containing client identifying information must never be left in a position where client identifying information could be seen or read by, guests, clients, or unauthorized staff even when authorized staff is present.

The following procedures must be followed to ensure that protected health information and alcohol and drug treatment identifying information is not exposed:

- The primary counselor must place all protected and/or identifying documentation face down on desk tops when other persons are present.
- Office doors where clinicians are working on case records must be kept closed so that records or documentation cannot be read from the hallways or other public areas.
- Protected health and/or identifying documentation shall never be left on the copy

machines, fax machines, counter tops, conference room tables, or in any other areas that may be frequented by others.

- Medical records or other documentation containing protected health and/or identifying information will not never be left in an unoccupied room or room where there are guests or clients present without authorized staff.

Client names or other information that could identify a client shall never be posted on walls, doors, or other facility posting areas either within clinicians' offices, or any areas where there may be public access. Personnel will use all possible discretion when attempting to get a client's attention in a public area. The client's first name is used and the person attempting to get the client's attention must signal the client to approach or approach the client. Personnel will speak discretely to the client and when possible move the client to a private area.

Personnel will not speak to or inquire of one client to another client even when the other client is a relative, spouse, or significant other, without a written consent from the client that is in compliance with 42-CFR Part II of the Federal register. A written consent from the client shall not be assumed as permission to speak to the party for whom the consent has been granted in a way that others may overhear any client identifying or confidential information. Personnel will not speak about a client in a place or manner that others may overhear client identifying or confidential information.

Information on authorizations to release confidential information will include:

- Specific information to be released
- To whom it is to be released
- Purpose of release
- Length of time for which the release is valid
- Client signature and date.
- A statement that the release can be revoked by the client at any time, within the confines of law and policy

Electronic records will be protected from access by unauthorized persons using the following safeguards:

- All computer screens must be protected by a screen saver that will lock the computer and go into 'screen saver' mode whenever there is no key stroke or movement of the mouse for two minutes
- The computer will be locked at the two minute mark and will not be able to be restarted unless the assigned user enters his or her password
- Passwords will be reset every two weeks automatically through the server
- Computer screens will be located so that they can be viewed only by authorized personnel

The following rules apply to the protection of client confidentiality when using electronic records:

- Client identifying information is not to be left on a computer screen. The file must be closed by the user so that information is not visible on the computer screen by an unauthorized person.

- If it is necessary to leave the computer station, files should be closed and the program exited to the extent a pass code would need to be entered to open the program.
- When leaving a computer station at the end of the work day, the computer must be shut down.
- Client confidential or client identifying information may not be transmitted by standard electronic mail.
- Client confidential or client identifying information may not be posted on any Internet sites, other than secure web-based programs that have been explicitly approved for use by the agency in writing, such as the web-based ASI assessment program, the DACS, and any electronic health records.

Healthcare Records

If we are the successful bidder, we will maintain the DDOC unified medical and mental health record in accordance with DDOC policy H-01, Health Record Format and Contents. Each offender will have his/her own record which includes medical history and problem list, complaints, progress notes, physicians' notes, and any specialized test or lab results. We will provide medical records management staff for the mental health, substance abuse, and sex offender records. We will coordinate with DDOC and the Medical Services Vendor to make the transition to the electronic health record that is chosen. We understand that the Medical Services Vendor's employees must have ready access to our medical records for the purpose of performing required services.

Mental Health and Veterans Court

Offenders receiving mental health services in DDOC facilities may have a variety of court-related issues, including involuntary commitment to outpatient treatment as well as sentences imposed through the mental health, veterans and/or drug courts or mandated as terms of probation. The Delaware Superior Court has Drug, Mental Health and Veterans Courts which expedite cases related to behavioral health issues through the Treatment Access Center (TASC). In addition the Court of Common Pleas also manages mental health and substance abuse offenses through a specialized court. Connections is one of the largest treatment agencies in Delaware to which these courts currently make referrals. As part of our ongoing responsibilities as the largest contractual provider of substance abuse and mental health services in Delaware, our physicians appear weekly to testify at civil commitment status hearings in front of the commissioner at the Delaware Psychiatric Center. Although it is our preference that individuals receive services at the lowest possible level of restriction, we recognize that some individuals require external sanctions in order to achieve adherence. We have case managers assigned to attend the Mental Health Court in Superior Court weekly and as needed in the other courts. Our case managers and clinicians regularly provide assistance and reports to the courts. In this regard, we may have more experience interacting with the diversion courts in Delaware than most prison-based healthcare providers. We will assign a liaison to the courts, who will provide at least a monthly status report on each offender (or more often if required). These reports will also be provided to TASC. We will meet monthly with TASC with both our correctional mental health and substance abuse staff and our community-based staff (we do that now), thus increasing continuity of care and the flow of information to the courts.

Testimony
We understand that a staff member may receive a court order to testify about an offender in certain cases and will do so within the limits of the law.

Medical Auditing Committee Meetings
The Program Administrator and Clinical Director will attend monthly MAC meetings as required. They will provide information for the schedule and the agenda in cooperation with other staff and the DDOC BCHS and site staff for each location.

Facilities/Inspections
Connections will ensure that the space and supplies used in the provision of services are maintained in a manner that is safe and adequate for the provision of the care proposed. The Program Administrator and Clinical Director will conduct inspections of each site at least monthly for safety and sanitation using an agreed upon form which will be submitted to DDOC, with copies to the Warden at the site. Deficiencies will be documented and a corrective action plan developed. Findings from the inspections and any corrective action plan generated as a result will be discussed at the monthly MAC meeting.

Disaster Plan
Within 30 days of starting work, we will provide a site specific disaster plan to the BCHS and each site's Warden or designee. The plan will be coordinated with those of the site and the Medical Services Vendor and will be distributed to all personnel in writing. Mental Health Services personnel will be oriented to the plan at the time of hire and at least annually thereafter. The plan will include a discussion of hazard vulnerability and conditions that could require a recall of staff in a time of extraordinary demand, use of emergency equipment, coordination with DDOC security staff in an emergency, establishment of triage areas and procedures, evacuation procedures, and stocking of emergency supplies and equipment. A mock drill of the plan will be conducted annually in cooperation with DDOC.

Telepsychiatry Expansion
Although we are not submitting a separate plan for telepsychiatry with this proposal, we believe that there is an advantage to its implementation in terms of increasing and speeding access to psychiatry for offenders, especially in remote sites to which psychiatrists have to travel. If we are the successful bidder, we would like to work with DTI and DDOC to develop a plan to use telepsychiatry that is acceptable to all parties.

DACS Entry
As previously discussed, if we are the successful bidder, we will use DACS as required to enter all mandatory information related to intake, transfer, scheduling, chronic care, specialty consultation, Sick Call, mental health appointments, and any other information that is currently required or may be required in the future. All employees who are working for us at the time of the transition, including the Program Administrator and Clinical Director, will be made available for DACS training by DDOC. Subsequently, we will accept responsibility for training new employees.

Records
We will maintain all records in accordance with applicable law, policy and regulation, including but not limited to 11 Del.C. §4322. We understand that all documents, reports, and other records, in any format, are the property of the State of Delaware and will remain as such at the end of any contract.

Dispute Resolution
Our Program Administrator will take responsibility for leading problem solving and dispute resolutions as they arise.

Coordination and Communication with DDOC
It is our intention to meet all requirements contained in the RFP and any subsequent contract regarding regular coordination and communication among the Medical Services Vendor, the DDOC BCHS and designees, the Warders of the facilities and their designees, for the purpose of ensuring that the medical needs of the offenders are met. We understand that these needs must be met within the context of security and safety.

Offender Grievances and Inquiries/Complaints
If we are awarded a contract, we will act on and respond to all complaints and inquiries. The policies and procedures for handling grievances and complaints will be tailored to mirror those of DDOC. DACS will be used to initiate and respond to all grievances. A monthly report will be made in the format specified by DDOC regarding any offender complaints and all actions taken to resolve them.

Policies and Procedures
Connections will develop policies and procedures that are consistent across facilities and that follow those of the DDOC BHCS. We will coordinate with DDOC to develop them and will submit them within 90 days of contract award. Any changes that are proposed subsequently will be submitted 30 days prior to the intended change. Policies and procedures will not be final until they are agreed to by DDOC.

Post-Critical Incident and Morbidity and Mortality Review
Connections will provide clinical participation in the DDOC Morbidity and Mortality Review Committee consistent with DDOC Policy A-10.1. We will also participate in the DDOC post-critical incident review process. The Mental Health Services vendor will be a participating member of the DDOC response team that provides critical incident debriefing.

Risk Management
Connections will use the Continuous Quality Improvement process, the critical incident, mortality and morbidity review process, and other tracking and reporting process to participate in the DDOC/Medical Services Vendor risk management process.

In addition to the DACS data entry and the Performance Measure Reporting discussed previously, we will agree to adhere to any additional reporting requirements established by DDOC, including, but not limited to:

Offender Tracking System
We will establish a tracking system for follow up/aftercare services provided to offenders in community programs post-release, as well as those provided in specialty behavioral health settings such as DPC or other psychiatric inpatient facility while the offender is incarcerated.

Progress Reports/Treatment Compliance Reports
These reports will be provided to the DDOC, the parole board, the courts, and others who have reason to request/receive them. These reports may include information about compliance with substance abuse treatment and will include an explanation of the denial of substance abuse treatment services to that is court-ordered to a person who meets the written eligibility criteria for the service and has requested to enter. A master list of all offenders receiving substance abuse services will be maintained and will include name, SBI number, type of discharge (using required categories) and enrollment in aftercare. A discharge summary will be provided within 30 days for each offender completing aftercare, including the reasons for discharge. The discharge summary will be placed in the offender's record.

Monthly Reports
Connections will provide a monthly CQIS report to the Bureau Chief which will demonstrate performance on measures related to the provision of medically necessary care which meets generally accepted standards of care and the maintenance of medical records in accordance with DDOC policy. The report will include the following:

- Number of successful completions from each program
- Number of unsuccessful completions from each program
- Average number of beds occupies daily
- Daily average of vacant beds
- Daily average of staff vacancies
- Number of grievances files by residents of substance abuse programs
- Number of Key participants who complete and transfer to CREST
- Number of Key participants who complete but return to the general population
- Number of offenders on waiting list for each level of substance abuse treatment
- Number of CREST graduates who complete and transfer to Aftercare

Weekly Reports

- Average beds occupied in each program
- Average number of vacant beds in each program
- Daily average staff vacancies by program
- Number of offenders on substance abuse program waiting lists
- All staffing vacancies

Transition Plan

Narrative

The goal of the implementation plan is to make the transition process as seamless as possible, while at the same time, fully implementing the described program model. A secondary goal is the preservation of jobs, if at all possible, for persons currently employed by the outgoing vendor if they are willing and able to provide the services described. Because Connections is currently a statewide provider of co-occurring enhanced mental health and alcohol and other drug treatment services, we have some staff capacity and site control that can be used to implement the proposed program rapidly and achieve these goals. The transition process will begin as soon as possible after award of the contract (our target date is May 24) and will be completed by July 31, 2012.

As discussed in the staffing plan, we have identified a program administrator with extensive experience working in the criminal justice system; however, he will have to give notice to his current employer after the award is made and will not be able to participate in the transition for approximately a month. We have also been in dialog with a number of employees of the existing vendor, including qualified psychiatric practitioners and the current director of sex offender services. We have come to some agreement with each of them in theory, but they all reserve the right to negotiate with whoever is the successful bidder. The remaining positions will have to be filled during the implementation period.

If DDOC agrees, we would like to offer the opportunity to interview for the open positions first to the existing MHM staff. In order to facilitate a rapid transition/implementation, we would like to conduct those interviews during the week of May 28, assuming that the award is actually made by then. We are in the process now of having our HR staff obtain clearance so that, if it is agreeable to the parties, at least some of the interviews can take place at the current work sites. If not, we will conduct them in our locations in Wilmington, Newark, Smyrna, Dover, Georgetown, and Seaford at the convenience of the MHM employees, By conducting interviews with the existing staff as quickly as possible, we can ensure that they have the first chance to accept positions before they are offered to individuals not currently employed in the existing program. We can also ensure that the remaining aspects of the transition, including the clinical reviews of existing clients, and the transition of medical records and other essential information is as disruption-free as possible.

Our hope would be that enough existing staff from the current vendor would remain so that the transition is smooth. We think this is important because we anticipate some difficulty in filling the large number (more than 200) of relatively highly skilled positions. We know that the pool of licensed and certified clinicians in Delaware is relatively small, and that it is currently difficult for licensed people from other states, especially physicians, to obtain licensure quickly in Delaware. Because of the so-called 'Bradley Laws' related to the child molestation convictions of former pediatrician Earl Bradley, there are strictures on the physician licensing process that are causing it to take between 6 and 12 months to complete. In an attempt to ameliorate this, we have identified several psychiatrists who are licensed in Delaware currently—including some from our staff—who are willing to undertake at least part-time commitments on the mental health treatment teams while we complete the transition process.

Transition Teams

It is our intention to establish two transition teams, one that will work with the clients of the existing AOD program, and one that will work with the CMHC clients. The members of the transition teams are listed below:

- **Team One—Vaughn/CVOP/Morris**

Christopher DiSanto, BA, Administrative Support (Connections)
Mark Thalheimer, LCSW, Clinical Support (Connections)
MHM clinician to be determined
DDOC staff to be determined

- **Team Two—SCI/SCCC**

Bradford Milton, MS, Administrative Support (Connections)
Jose Quinones, CADC, Clinical Support (Connections)
MHM clinician to be determined
DDOC staff to be determined

- **Team Three--Baylor/WTC/Plummer/Webb**

Catherine McKay, MC, Administrative Support (Connections)
Teresa Sharpe, MSW, ICADC, Clinical Support (Connections)
MHM clinician to be determined
DDOC staff to be determined

- **Team Four—Young**

Christopher Devaney, MSCC, Administrative Support
Brian Pasalaqua, LCSW, Clinical Support
MHM clinician to be determined
DDOC staff to be determined

During the transition period, the transition team will review the clinical case records for every person whose case is open for mental health, substance abuse or sex offender treatment and will make necessary arrangements to transfer the medical records from MHM to Connections. The clinical record reviews will be completed by June 30. The reviews will look at the following factors:

- The phase of treatment the person is currently in and the length of time left in the program (for substance abuse clients)
- The person's legal status, including any treatment mandates from Superior Court, TASC, DDOC or any civil requirements or commitments
- The degree to which the client is participating in mental health treatment relative to the need for such treatment as identified by the ASI and any subsequent psychiatric evaluation or life event
- The person's need for medications and a review of all current medications
- The person's history of suicidality or other problems requiring PCO, segregation, or structured care
- Any other potential unmet need that might be addressed by the program, including potential reentry, sex offender, and DUI treatment issues not yet addressed.

We hope to have made hiring decisions regarding the existing MHM staff by the middle of June so that June we will know which if any existing staff will be continuing with us. If an offender's primary counselor and/or psychiatric practitioner will be leaving, an appointment will be scheduled in June that will include the outgoing practitioner and the clinician(s) who will be replacing them. The clinicians who will be leaving will have the opportunity to close their relationship with each client and then, in the same session, to do a warm hand off to the new clinician. At that meeting, the offender and the receiving clinician will both have an opportunity to raise any concerns or questions. By necessity, this process will be completed in June. All persons who have received mental health or substance abuse services within the prior year, and any others who are identified by DDOC or MHM, will be scheduled for a transition meeting as described between June 1 and June 30, 2012. At that meeting, the treatment plan will be reviewed and plans made for follow-up, including ongoing medication monitoring and management services, new assessments and a treatment plan review meeting, for the next 90 days.

Offenders will be prioritized based on the above information and scheduled for face-to-face meetings during the last two weeks of June and the first two weeks of July with members of the transition team. Persons in the earliest phase of treatment will all be interviewed to explore unmet needs and provide information about new services and locations that could assist in meeting those needs. Any changes to clinician assignments will be reviewed during those meetings, with both the current clinician and the receiving clinician in attendance to answer any questions if possible.

Other clients with identified unmet needs will be prioritized for triage and will be offered enhanced services as needed. Before the end of July, every offender who has been receiving services will have been notified of the program changes and provided with a schedule for continued treatment, including appointments for medication monitoring as needed. Also by the end of July, all criminal justice agencies involved will be notified of any changes in status or contact information that is the result of the program implementation.

Implementation Schedule

PHASE ONE: PRE-OPERATIONAL 5/24/12 to 6/15/12

TASKS

- Interview existing MHM staff who are interested in potential employment in the new program
- Recruit and interview for remaining open positions
- Complete staff training
- Obtain performance bond
- Meet with MHM and DDOC to identify and prioritize cases

PHASE TWO: TRANSITION 6/15/12 to 7/31/12

TASKS

- Review clinical records at all sites and determine priority order for transition team members to meet with offenders
- Meet with each offender who is identified as having unmet needs or whose primary therapist and/or psychiatric practitioner is changing

- Schedule all identified offenders in need of additional assessment or treatment and triage for priority
- Meet with DDOC to review policy and procedure and training requirements and obtain approvals
- Write and deliver policies and procedures

PHASE THREE: OPERATIONS 7/1/12 TO 6/30/14

TASKS

- Deliver services as described
- Collect data for program evaluation as described
- Make required reports as described
- Implement all elements of the proposal
- Evaluate process and outcome measures as proposed

Table 16: Implementation Workplan

Task to be Completed	Person(s) Responsible	Start Date	End Date	Deliverable
Establish transition teams as described (existing staff)	McKay Devaney	5/3/12	5/10/12	Transition teams are recruited, trained and ready to begin
Obtain DDOC clearance for all transition team members who will need it	Devaney Evans	5/3/12	5/10/12	All transition team members and at least 3 HR staff will have obtained clearance
Interview existing MHM staff if they have an interest in continuing as employees of the new program	Matteson Arendall Clayton DiSanto Devaney McKay	5/28/12	6/8/12	Offers will be made to existing staff where there is mutual interest
Obtain performance bond	McKay Davis	Notification date	Within 5 days of notification	Performance bond in place
New Staff Recruitment and Hiring	Matteson Arendall Clayton DiSanto Devaney McDonough	5/3/12	6/15/12	Staff Roster

New Staff Training and Scheduling	Northey Rotgers Matteson Clayton Devaney DDOC	6/1/12	7/31/12	Training documentation provided to DDOC
Review of all existing clinical records and complete triage	Transition Teams	6/1/12	6/30/12	Offenders prioritized and appointments made
Interview offenders on schedule identified to complete hand-off from previous providers to receiving providers	Transition Teams	6/15/12	7/31/12	All offenders will be transitioned to receiving clinicians
Contact all collaterals of existing clients, including criminal justice contacts	Devaney DiSanto McDonough	6/15/12	6/30/12	All collaterals notified of changes
Complete policy and procedure manual with consultation from DDOC	McKay McDonough	6/15/12	7/31/12	Policy and procedure manual
Establish reporting and evaluation systems as proposed	McDonough Clayton Northey McKay	6/1/12	7/31/12	Outcome and reporting systems
Begin Service Delivery	All	7/1/12	6/30/14	Services as proposed

Human Resources Management and Training

Facility Health Unit Administration

As previously described, Connections has identified John R. (Jack) McDonough as the Program Administrator who will be responsible for the implementation and ongoing management of the proposed program. He will be responsible for corporate and administrative functions related to contract performance and will act as the liaison with the Bureau Chief. McDonough has worked for the United States Federal Probation Office in Delaware since 1988, rising through the ranks from probation officer to Chief. He is one of Delaware's most vocal and well-versed advocates for treatment and reentry services that reduce recidivism. Jack will be assisted in the management of the program by a licensed Clinical Director at the doctoral level who will provide training and supervision to our clinical employees as well as to the DDOC employees in areas including suicide prevention and responding to mental health emergencies. In addition, we will employ an administrative assistant for the management unit and six (6) medical records technicians who will assist personnel at each site to manage the recordkeeping and reporting systems and will manage the conversion of paper records to electronic once the electronic health record is selected and implemented.

Recruitment and Retention

Throughout the proposal we have depicted the total number of employees we intend to hire and retain by program area (mental health, substance abuse, sex offender treatment) and facility/ site/program. In addition, in a section below, we have included a schedule for each program and site for 30 days. With 233 total positions--107.25 mental health, 111.95 substance abuse, 5 of sex offense treatment, and 9 administrative (administrator, clinical director, administrative assistant and 6 medical records techs)—it is clear that an active recruitment and retention plan and process will be needed to fill and keep the positions filled. This is complicated by relatively new strictures on the process of licensure for healthcare workers, including physicians, recently imposed in Delaware as a result of the Bradley case. These restrictive procedures have greatly slowed down the licensure process for doctors to as long as 6-12 months. In addition, the pool of licensed and certified mental health and substance abuse clinicians in Delaware is comparatively small.

Connections has some advantages in this area in that we are a Delaware company, currently operating only in Delaware. Our Human Resources and Staff Development Department are located in Delaware with offices in Wilmington and Dover. We have a regularly updated website, which includes access to position listings and a mechanism for making application. The website also provides access to our policies, procedures, time and attendance system, and staff development system for all of our current employees. In addition, we make regular use of social media and networking to recruit for positions. We have a current contract with Career Builder, the online advertising vendor for the Wilmington News Journal and the Philadelphia Inquirer, which enables us to post almost unlimited classified ads online and to search databases of resumes that have been submitted to the site. In addition, we have an ongoing relationship with the career planning and placement services at Wilmington University, Delaware State University, Widener University, Delaware Technical and Community College, and the University of Delaware. These relationships are particularly important in recruiting licensed counselors and social workers and certified alcohol and drug counselors, because these

educational institutions produce most of the individuals who ultimately become licensed in Delaware in these disciplines. Because we currently employ a large number of physicians, nurse practitioners, counselor, social workers, and substance abuse counselors in our existing programs, we are also able to use networking to recruit for these positions. Recently, through these networking efforts, we have been able to hire two board-certified psychiatrists from Johns Hopkins University.

As part of our recruiting process for this contract, we will establish human resources kiosks at several key locations throughout Delaware which are proximate to the DDOC facilities where personnel are needed. These kiosks will include electronic access to online information about available positions, and will provide a computer for individuals to complete online applications. Once per week, human resources personnel will be available at each kiosk site to conduct interviews. The sites are listed below:

- 500 West Tenth Street, Wilmington, 19801
- 1423 Capitol Trail, Newark, 19711
- 222 N. DuPont Highway, Smyrna, 19977
- 698 Bay Road, Dover, 19901
- 21305 Berlin Road, Georgetown, 19947
- 123 Pennsylvania Avenue, Seaford , 19973

When resumes and applications are received from any source, they are posted electronically in a shared file on Connections' wide area network (WAN). The file is accessible to all hiring managers. Resumes and applications are grouped inside the file by credentials and matched to the requirements of each open position. Job descriptions are made available to hiring managers in the same fashion, again allowing them to match the credentials of the applicants with the requirements of the job. Once a hiring manager identifies a potential employee to interview, the HR department completes a prescreening process (checks of the Delaware child and adult abuse registries, primary source verification of licensure and education, and a preliminary online background check) to determine eligibility. If those checks are passed, the HR department schedules interviews at the location most convenient for the hiring manager and the candidate(s). If there is interest, a final screening includes a review of the individual's motor vehicle record, service letters to the last 5 years of employers, a urine drug screen at our contracted occupational health provider, and, if required by the position, SBI and FBI fingerprinting and criminal background check. We currently employ more than a dozen individuals who have DDOC clearance and are familiar with the process for obtaining it.

It is also our intention to apply for DDOC clearance for all of our human resources and transition team personnel no later than May 1, 2012. This will allow them to go into the facilities during the transition to talk to existing personnel about a potential integration into the new program, as well as enabling them to resolve HR issues after the transition as they arise.

All employees hired for DDOC positions will comply with DDOC and institution-specific security and clearance policies and procedures, including those related to the use of information systems and privileged information obtained in the course performing job duties.

New Employee Orientation

Connections New Employee Orientation Program is held weekly, alternating between Dover and Wilmington. Every 5th week, the orientation is held in Georgetown. Much of the content is available online and/or by telecommunication, which helps employees to complete it from wherever they are located. No employee may begin work before completing orientation, including the following required items:

1. Fire Safety: Location of fire pulls, fire alarms, fire extinguishers, and evacuation routes
2. Review of Policies and Procedures
3. Review of Security Issues (DDOC requirements)
4. Life Safety and Occurrence Reporting
5. Confidentiality and Rights of Persons Served
6. Prohibition Against Harassment
7. Risk Management
8. Infection and Exposure Control/Bloodborne Pathogens
9. CPR and First Aid
10. Drug Free Workplace
11. Crisis Prevention and Intervention (MANDT)
12. Suicide Prevention and Intervention (DDOC approved)
13. Ethical Boundaries and Contraband (DDOC and Connections)

Attendance at orientation will be documented in the employee's file by the Director of Staff Development. Written documentation of orientation will be provided to DDOC within 30 days of completion. A comprehensive list of Vendor personnel, with training subject, dates and retraining status will be provided to the BCHS and the site Warden.

The immediate supervisor or department manager is responsible for providing the new employee with a detailed orientation to the respective department, job duties, and work unit(s). The items to be covered in the orientation are:

1. Introduction to other staff members and an explanation of department/worksite organization
2. Job expectations
3. Physical layout of work area and individual work space; employee's responsibility for keeping work areas clean, safe, and orderly
4. Work hours, meal breaks, and other scheduling information
5. Telephone system and proper method of answering the telephone
6. Procedures for reporting absences and lateness
7. Any department-specific safety precautions
8. Other departmental policies, procedures, practices, and expectations.

For this contract, we are also proposing an ongoing staff training initiative, which will include training in Motivational Interviewing (28 hours); CBT (28 hours); Seeking Safety (14 hours); Differential Substance Abuse Treatment (28 hours). Training will be scheduled and conducted in a manner that does not disrupt the operation of the proposed program. This training will be conducted by Dr. Fred Rotgers, a licensed psychologist with more than three decades of

experience providing direct service, training, and consultation to prison systems. In addition, Connections uses an online staff development system—Essential Learning—which allows individual employees to be assigned training in topics which the employee and his/her supervisor identify as needed to maintain and enhance clinical and other skills. Essential Learning is used to update orientation and other information. Employees are assigned and paid to complete up to 40 additional hours of online training annually. This training is completed in off-work hours and can be accessed at the HR kiosks listed above or on any computer with access to the internet through the Connections website.

The program Clinical Director will provide basic orientation and biennial updates to DDOC officers in the recognition of altered physical or mental states as well as in suicide risk detection and prevention. If DDOC is interested, Dr. Rotgers would provide Orientation and Motivational Interviewing Training for both DDOC security officers and administrators, at DDOC's election.

Credentialing and Privileging

It is the policy of Connections Community Support Programs, Inc. (Connections) to evaluate the credentials, qualifications and competency of all employed or contracted independent practitioners. The following Practitioners fall under this policy:

- Psychiatrists
- Primary Care Physicians
- Nurse practitioners
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Certified Alcohol and Drug Counselors

Individual credentialing and privileging criteria for each type of Practitioner is based on the scope of practice which is determined by the recognized professional organization for the discipline. No new category of provider will be added until credentialing and privileging criteria for the category is developed and approved.

Practitioners may provide patient care, treatment, or services only as permitted within their scope of practice, and in keeping with all applicable rules, policies, and procedures and any formal written agreement between the Practitioner and Connections.

Employment vs. Privileges

"Privileges" are a specific scope and content of patient care services authorized for a Practitioner by a health care organization based on evaluation of the individual's credentials and performance. **"Employment"** means work or service performed by an individual for another person or entity in exchange for wages or other remuneration or under a contract of hire. *Employment is not synonymous with privileges.*

Credentialing Policy and Procedure

Credentials Verification

- In addition to all applicable Personnel policies, the following credentials verifications will be obtained for all Practitioners from the primary source or a designated equivalent source:
  - Advance practice degree;
  - Current state licensure;
  - Controlled substance license, if applicable;
  - Verification of professional liability history for the past 10 years; and
  - Verification of past employment and/or medical staff appointment and privileges for the past 10 years.
- In order to evaluate current competence and experience, peer recommendations will be solicited from 3 peers in the same professional discipline as the Practitioner, who are knowledgeable about the applicant's professional performance. This evaluation will include any effects of health status on privileges being requested.
- A criminal background check will be conducted.

Clinical Director/Medical Director Review: After completion of credentialing as noted in Section I above, the personnel file and privilege request will be reviewed by the Department Manager of the area(s) in which the Practitioner will be working. Upon the manager's positive recommendation, the file will be forwarded for final approval by the credentials committee.

Final Approval: After the opportunity for medical staff input, the application and request for privileges are processed in accordance with human resources policy and privileges are granted by the governing body.

<u>Drug Free Workplace</u>

Policy: Connections prohibits the use, sale, dispensing, or possession of illegal drugs and narcotics. The same prohibition exists concerning the consumption of alcoholic beverages on work premises. In the case of illegal drugs, this policy specifically includes off-premises use, possession or sale. Subject to the approval procedure described in paragraph 2.C. below, prescription drugs are also within the scope of this policy. Connections requires pre-employment urine drug screening for all new employees.

Procedures:

New Employees

A. Following the satisfactory completion of the applicant screening process, all individuals who have been identified for employment will be requested to obtain a urine drug screen from an authorized provider at an authorized site. All new employees will be required to execute an "Informed Consent and Release of Liability" authorizing the organization to perform the screen, to receive the results of the screen, and to disseminate the results to representatives who are immediately involved in the selection process.
B. Screening results are maintained in the employee's file and will be provided to DDOC as requested/required.

Incumbent Personnel

A. The illegal use, sale, possession or dispensing of alcohol or other drugs while on work premises or reporting to work under the influence of any of these substances will result in immediate discipline up to and including discharge.
B. A supervisor may request a drug/alcohol test when there is documented reasonable suspicion that an employee is impaired or incapable of performing assigned duties, as shown by factors including, but not limited to, avoidance of supervisors, reduced productivity, high absenteeism, or behavior inconsistent with previous performance. Screening may also be requested in the event of a motor vehicle accident occurring during work hours or when using a company vehicle. Documentation of reasonable suspicion will be provided to Human Resource and will be made available to the employee.
C. Any employee who has been directed by a physician to take a prescription drug that may adversely affect or impair performance on the job must report that circumstance to their supervisor along with acceptable medical documentation. A determination will then be made through Human Resources as to whether the effects of the drug pose a potential safety risk and/or may impair the employee's efficiency and effectiveness.
D. All supervisors should ensure that employees are aware that confidential counseling for drug or alcohol dependence problems is available through Human Resources. Referrals for treatment and arrangements for leave of absence, where appropriate, will be coordinated through Human Resources.

Testing Procedures

1. For the purpose of maintaining the quality, efficiency, and professionalism of services to its consumers and customers, all organization personnel are subject to alcohol/drug screening.
2. Testing will be conducted prior to employment and may also be conducted for reasonable suspicion as defined and explained above in 2.B., or may be conducted at random if deemed necessary by management.
3. All testing should be planned and reviewed with and approved by Human Resources. All testing will be at Connections' expense.
4. Prior to testing, the employee in question will be requested to execute an "Informed Consent and Release of Liability" authorizing Connections to proceed with the test, to receive the test results, and to disseminate those results among personnel who have a need to know including, but not limited to the CEO, Human Resources, and the employee's supervisor(s). An employee's refusal to submit to testing may result in disciplinary action and may include termination.

An employee who voluntarily admits to problems with alcohol and/or other drugs prior to drug/alcohol screen scheduling or testing will be treated as any employee requesting an accommodation, and will be offered the opportunity for treatment.

Failure to comply with the intent of this policy may be grounds for disciplinary action and may include termination. Refusals by an employee to take a drug/alcohol screen or to follow this policy may be grounds for discipline and may result in termination.

Table 17: Essential Learning Online Staff Training Curriculum

Course Code	Course Name	Training Hours	Course Description
WLB-SS	Work-Life Balance	2.5	The increasingly demanding nature of today's workplace along with the fast-pace of the digital age has resulted in a common experience: trouble maintaining balance in work and personal lives. This course gives you information on the factors that can contribute to difficulty maintaining that balance, as well as concrete techniques to get some more work- life balance.
WEL	Welcome to Essential Learning	0	Welcome to Essential Learning course. By taking this course, you will be able to navigate the system.
EP101	Emergency Preparedness	1	Especially in a corrections facility, it is important to be prepared for all types of emergencies, whether it be a natural disaster such as a fire or major storm, or a technological emergency, such as a power outage. The purpose of this course is to show you the importance of recognizing, planning and responding to an emergency situation in a corrections setting. In this brief course, you will have an opportunity to practice what you learn in interactive exercises. This will help you be more prepared should an emergency occur at your facility.
LV101	Drugs in the Workplace	1	This course describes commonly abused substances (alcohol, depressants, stimulants, opioids) in behavioral healthcare settings. It also presents strategies for promoting a drug-free workplace, effectively intervening with affected co-workers and seeking personal help.
SHWH101	Sexual Harassment and Workplace Harassment	1.5	This course provides an overview of what constitutes sexual harassment and describes how to identify illegal behavioral and the necessary steps to respond appropriately. It also describes the other types of harassment that may occur in a hospital or facility and prevention of workplace harassment.
CC101	Corporate Compliance and Ethics	1	This course discusses the concept of corporate compliance and how it benefits organizations; defines ethics, health care fraud and identifies high risk activities. It identifies and explains the elements of corporate compliance and how to report suspicious activities.
BS-TM	Time Management	2.5	The bottom line in many organizations is productivity. If you find yourself overwhelmed, working too many hours, or running behind you may have room to improve your approach to time management. This course will give you an overview of the top issues related to managing your time effectively at work. You will learn ways to streamline your daily work along with skills that can help you to get more work done in

Course Code	Course Name	Training Hours	Course Description
			less time.
CIMH	Cultural Issues in Mental Health Treatment	3	This course reviews the confluence of clinical, social, cultural, organizational and financial reasons for minority groups being underserved by the mental health and human services systems. It discusses the ethnic and racial groups that constitute underserved populations and describes their changing demographics. The course reviews five culturally-specific psychiatric syndromes or idioms of distress and discusses the epidemiology and utilization of mental health services among the major racial/ethnic groups. The course also discusses social and cultural barriers to accessing mental health and human services.
ICFS	Infection Control - Full Series	4	This course contains Infection Control Part 1, Part 2, and Bloodborne Pathogens. This series covers: Transmission of disease, hand hygiene, precautions to prevent transmission of infectious agents and biohazardous waste. Infectious diseases including Hepatitis, HIV/AIDS, Tuberculosis and MRSA are also discussed. This course is available in Spanish.
VR101	Variance Reporting	1	Variance reporting is a part of performance improvement in every healthcare facility which involves collecting and analyzing data about medical errors to assist in planning and preventing future errors. A variance is an error or unusual event that is not expected during the normal course of the day. Some examples include medication errors, adverse drug reactions, falls and healthcare worker needlestick injuries. All variances must be documented according to your facilities policies and procedures as soon as possible after the variance occurs.
DD101	Defensive Driving Training	2	This course contributed to the EL Library by CBHCare of New Jersey provides an excellent overview of good driving attitudes and behaviors. It gives the facts about driving and accidents and describes important factors in preventing collisions and recognizing conditions that could result in accidents.
FS101	Fire Safety	3	This series covers: Fire Hazards, Environmental Controls, Fire Extinguishers, Fire Procedures, Fire Alarm Procedures, and Evacuation Procedures. A Spanish version is available.
CH101	Confidentiality and	3	This course defines what information is considered confidential, it reviews the HIPAA Privacy Rule, the concept of "minimum necessary",

Course Code	Course Name	Training Hours	Course Description
	HIPAA		client rights and release of information, notice of privacy practices and best practices for privacy and security.**This course is available in Spanish.
CLR101	Client/Patient Rights	2	This course covers the six basic principles of ethical care and the function of an ethics committee, the rights and responsibilities of the client/patient and types of advance directives.
PSMI	People with Serious Mental Illness	3	This course provides a basic overview of serious mental illness in adults and children, including signs and symptoms and treatment interventions. It is intended as an introduction for direct service staff new to the field.
ABM101	Addiction: A Biopsychosocial Model	3	This course presents an overview of mind-altering drugs and the concept of instant gratification as they relate to abuse and addiction. It describes biological, psychological and social types of risk factors and how they relate to the cycle of addiction and discusses the progressive symptoms and stages of abuse and addiction.
CCSP-EMPHB	Connections Employee Handbook	0	This is a PDF version of the Connections Employee Handbook for access by all employees. Upon completion of reading the policies an exam is available so that employees may attest to reading the handbook.

Course Code	Advanced Course Name
AIDS_807	Basic Introduction to HIV/AIDS
ASC101	Age-Specific Care
OAMHI	Older Adults and Mental Health
CCA-CASRA	A Culture-Centered Approach to Recovery
CCDSP101	Cultural Competency
TB101	Therapeutic Boundaries
LI101	Legal and Ethical Issues for Mental Health Professionals
Schiz101	Understanding Schizophrenia
OMPP	Overview of Medications for Paraprofessionals
PV101	Predicting Violence and Threat Assessment
SA101-PP	Overview of Substance Abuse for Paraprofessionals in Behavioral Health Agencies
TC101	Therapeutic Communications
FAI101	Family Assessment and Intervention
PSY101	Overview of Psychopharmacology
CONMGT101	Conflict Management
EBPIMR	Illness Management and Recovery--Evidence Based Practices
OSPMI101	Overview of Severe Persistent Mental Illness
SA101	Suicide Assessment
SP101	Suicide Prevention
WRAP	WRAP One on One
CPCN101	Coordinating Primary Care Needs of People with SMI
PFCS100	Person and Family Centered Services

Course Code	Advanced Course Name
CRM101	Crisis Management
COD-PP	Co-Occurring Disorders: An Overview for Paraprofessionals
MI101	Motivational Interviewing

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position.
The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule for MH Services at Vaughn, Morris and CVOP</u> – 31 FTE x 2080 = 64,480 Hours/Year

Sunday through Saturday LEGEND: D = Day (8 am – 4 pm) E = Evening (4 pm – 12 am) M = Midnight (12 am – 8 am) 10 = 10 am to 6 pm

TITLE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Mental Health Director	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Admin. Assistant	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Clinical Supervisor 1	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D
Clinical Supervisor 2 (one day at Morris and one day at CVOP)	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X
Psychologist	X	D	D	D	D	D	X	D	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Psychiatrist	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Psychiatrist (P/T)	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X
Psych NP	X	10	10	10	10	10	X	X	10	10	10	10	10	X	X	10	10	10	10	10	X	X	10	10	10	10	10	X	X	10
Pscyh NP (one day at Morris and one day at CVOP)	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X
Counselor 1	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D
Counselor 2	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X
Counselor 3	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X
Counselor 4	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E
Counselor 5	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X
Counselor 6	X	N	N	N	N	N	X	X	N	N	N	N	N	X	X	N	N	N	N	N	X	X	N	N	N	N	N	X	X	N
Counselor 7 (Morris)	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D
Counselor 8 (SVOP)	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X
Counselor 9 (P/T)	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D
Counselor 10 (P/T)	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X
Tech #1	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X
Tech #2	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D
Tech #3	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E
Tech #4	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X
Tech #5	X	M	M	M	M	X	M	M	X	M	M	M	M	X	X	M	M	M	M	X	M	M	X	M	M	M	M	X	X	M
Tech #6	M	X	M	M	M	M	X	X	M	M	M	M	X	M	M	X	M	M	M	M	X	X	M	M	M	M	X	M	M	X
Tech #7 PT	E	E	X	X	X	E	E	E	E	X	X	X	E	E	E	E	X	X	X	E	E	E	E	X	X	X	E	E	E	E
Tech #8 PT	M	M	X	X	X	M	M	M	M	X	X	X	M	M	M	M	X	X	X	M	M	M	M	X	X	X	M	M	M	M
Clerk	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X
Clerk	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D
Activity Assistant 1	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D
Activity Assistant 2	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X
Activity Assistant 3	X	E	E	E	E	E	X	X	E	E	E	E	E	X	X	E	E	E	E	E	X	X	E	E	E	E	E	X	X	E
PRN																														
PRN																														

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule for MH Services at YOUNG</u> – Hours/Year = 64,480 – 22.2 FTE x 2080 hours = 46,176 hours/year
Sunday through Saturday LEGEND: D = Day (8 am – 4 pm) E = Evening (4 pm – 12 am) M = Midnight (12 am – 8 am) 10 = 10 am to 6 pm

TITLE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Mental Health Director	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Admin. Assistant	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Clinical Supervisor 1	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D
Psychologist (Shared with BWCI)	X	D	D	D	D	D	X	D	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Psychiatrist	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D
Psychiatrist (P/T)	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X	X	X	X	X	D	D	X
Psych NP	X	10	10	10	10	10	X	X	10	10	10	10	10	X	X	10	10	10	10	10	X	X	10	10	10	10	10	X	X	10
Counselor 1	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D
Counselor 2	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X
Counselor 3	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X
Counselor 4	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E
Counselor 5	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X
Counselor 6 (P/T)	X	N	N	N	N	N	X	X	N	N	N	N	N	X	X	N	N	N	N	N	X	X	N	N	N	N	N	X	X	N
Counselor 7 (P/T)	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D	D	D	D	X	X	D	D
Tech #1	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X
Tech #2	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D	D	D	D	X	D	D	X	D	D	D	D	X	X	D
Tech #3	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E
Tech #4	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X	E	E	E	E	X	X	E	E	E	E	X	E	E	X
Tech #5	X	M	M	M	M	X	M	M	X	M	M	M	M	X	X	M	M	M	M	X	M	M	X	M	M	M	M	X	X	M
Tech #6	M	X	M	M	M	M	X	X	M	M	M	M	X	M	M	X	M	M	M	M	X	X	M	M	M	M	X	M	M	X
Tech #7 PT	E	E	X	X	X	E	E	E	E	X	X	X	E	E	E	E	X	X	X	E	E	E	E	X	X	X	E	E	E	E
Tech #8 PT	M	M	X	X	X	M	M	M	M	X	X	X	M	M	M	M	X	X	X	M	M	M	M	X	X	X	M	M	M	M
Clerk	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X	D	D	D	X	X	X	X
PRN																														
PRN																														

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

Staffing Schedule for MH Services at SCI/SCCC – 20.8 FTE x 2080 hours = 43,264 hours/year

Sunday through Saturday LEGEND: D = Day (8 am – 4 pm) E = Evening (4 pm – 12 am) M = Midnight (12 am – 8 am) 10 = 10 am to 6 pm

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Mental Health Director	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D
Psychologist(PRN)																														
Psychiatrist	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Psych NP	x	10	10	10	10	10	x	x	10	10	10	10	10	x	x	10	10	10	10	10	x	x	10	10	10	10	10	x	x	10
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x
Counselor 4	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E
Counselor 5	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x
Counselor 6 (P/T)	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D
Counselor 7 (P/T)	x	x	X	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x
Tech #1	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Tech #2	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Tech #3	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E
Tech #4	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x
Tech #5	x	M	M	M	M	x	M	M	x	M	M	M	M	x	x	M	M	M	M	x	M	M	x	M	M	M	M	x	x	M
Tech #6	M	x	M	M	M	M	x	x	M	M	M	M	x	M	M	x	M	M	M	M	x	x	M	M	M	M	x	M	M	x
Tech #7 PT	E	E	X	x	x	E	E	E	E	x	x	x	E	E	E	E	x	X	x	E	E	E	E	x	x	x	E	E	E	E
Tech #8 PT	M	M	X	x	x	M	M	M	M	x	x	x	M	M	M	M	x	X	x	M	M	M	M	x	x	x	M	M	M	M
Clerk	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x
PRN																														
PRN																														

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

Staffing Schedule for MH Services at BWCI, WTC, Webb, Plummer – 20.7 FTE x 2080 hours = 43,056 hours/year

Sunday through Saturday LEGEND: D = Day (8 am – 4 pm) E = Evening (4 pm – 12 am) M = Midnight (12 am – 8 am) 10 = 10 am to 6 pm

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Mental Health Director	x	D	D	D	D	D	x	X	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	X	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D
Psychologist (shared with Young)	x	D	D	D	x	x	x	X	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D
Psychiatrist	x	D	D	D	D	D	x	X	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Psych NP	x	10	10	10	10	10	x	X	10	10	10	10	10	x	x	10	10	10	10	10	x	x	10	10	10	10	10	x	x	10
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	X	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	E	x	E	E	E	E	x	X	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x
Counselor 4	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E
Counselor 5 (p/t Webb)	x	D	D	D	x	x	x	X	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D
Counselor 6 (p/t Plummer)	x	x	x	D	D	D	x	X	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x
Tech #1	D	x	D	D	D	D	x	X	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Tech #2	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Tech #3	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E
Tech #4	E	x	E	E	E	E	x	X	E	E	E	E	x	E	E	x	E	E	E	E	x	x	E	E	E	E	x	E	E	x
Tech #5	x	M	M	M	M	x	M	M	x	M	M	M	M	x	x	M	M	M	M	x	M	M	x	M	M	M	M	x	x	M
Tech #6	M	x	M	M	M	M	x	X	M	M	M	M	x	M	M	x	M	M	M	M	x	x	M	M	M	M	x	M	M	x
Tech #7 PT	E	E	x	x	x	E	E	E	E	x	x	x	E	E	E	E	x	x	x	E	E	E	E	x	x	x	E	E	E	E
Tech #8 PT	M	M	x	x	x	M	M	M	M	x	x	x	M	M	M	M	x	x	x	M	M	M	M	x	x	x	M	M	M	M
Clerk	x	x	D	D	D	x	x	X	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x	D	D	D	x	x	x	x
PRN																														
PRN																														

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position.

The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule for Women's DUI Services at BWCI</u> – 2.5 FTE x 2080 hours = 5,200 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 5 pm on Sat and Sun OR 7 am – 3 pm Mon – Fri N = 12 pm – 8 pm AA works 4 hrs/day Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Program Director	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assist.	x	PM	AM	PM	AM	PM	x	x	PM	AM	PM	AM	PM	x	x	PM	AM	PM	AM	PM	x	x	PM	AM	PM	AM	PM	x	x	PM
Counselor 1	x	D	E	D	E	D	x	x	D	E	D	E	D	x	x	D	E	D	E	D	X	x	D	E	D	E	D	X	X	D

<u>Staffing Schedule for Men's DUI Services at TBD</u> – 3.5 FTE x 2080 hours = 7,280 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 5 pm on Sat and Sun OR 7 am – 3 pm Mon – Fri N = 12 pm – 8 pm AA works 4 hrs/day Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assist.	x	AM	PM	AM	PM	AM	x	x	AM	PM	AM	PM	AM	x	x	AM	PM	AM	PM	AM	x	x	AM	PM	AM	PM	AM	x	x	AM
Counselor 1	x	E	D	D	D	x	D	D	x	E	E	E	E	x	x	E	D	D	D	x	D	D	x	E	E	E	E	x	x	E
Counselor 2	D	x	E	E	E	E	x	x	E	D	D	D	x	D	D	x	E	E	E	E	x	x	E	D	D	D	x	D	D	x

<u>Staffing Schedule for Women's 6 for 1 Services at BWCI</u> – 3.0 FTE x 2080 hours = 6,240 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 1	x	E	D	D	D	x	D	D	x	E	E	E	E	x	x	E	D	D	D	x	D	D	x	E	E	E	E	x	x	E
Counselor 2	D	x	E	E	E	E	x	x	E	D	D	D	x	D	D	x	E	E	E	E	x	x	E	D	D	D	x	D	D	x

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule for Boot Camp Services at SCI</u> – 1.0 FTE x 2,080 hours = 2,080 hours/year
Sunday through Saturday LEGEND: Mon and Tues 8 am – 5 pm, Wed, Thurs, Fri 7 am – 5 pm

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Counselor 1	x	D	D	D	D	D	x	D	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D

<u>Staffing Schedule for YCOP Services at YOUNG</u> – 5.0 FTE x 2,080 hours = 10,400 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	N	x	x	N	N	N	N	N	x	x	N	N	N	N	N	x	x	N	N	N	N	N	x	x	N

<u>Staffing Schedule for Men's 6 for 1 Services at YOUNG</u> – 6.0 FTE x 2,080 hours = 12,480 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	D	x	x	N	N	N	N	N	x	x	N	N	N	N	D	x	x	N	N	N	N	N	x	x	N
Counselor 4	x	N	N	N	N	N	x	x	N	N	N	N	D	x	x	N	N	N	N	N	x	x	N	N	N	N	D	x	x	N

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule for Sex Offender Treatment Services</u> – 5.0 FTE x 2,080 hours = 10,400 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm – 8 pm

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 2	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 3	x	N	N	N	N	D	x	x	N	N	N	N	N	x	x	N	N	N	N	D	x	x	N	N	N	N	N	x	x	N

<u>Staffing Schedule CREST South & Aftercare Services at SCCI</u> – 9.0 FTE x 2,080 hours = 18,720 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 4	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x
Counselor 5	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D
Counselor 6	x	x	N	N	N	D	D	x	x	N	N	N	D	D	x	x	N	N	N	D	D	x	x	N	N	N	D	D	x	x

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule CREST Central & Aftercare Services at Morris</u> – 9.0 FTE x 2,080 hours = 18,720 hours/year

Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 4	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x
Counselor 5	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D
Counselor 6	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x

<u>Staffing Schedule CREST Primary at SVOP</u> – 14.0 FTE x 2,080 hours = 29,120 hours/year

Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D
Clinical Supervisor 2	x	D	D	D	E	D	x	x	D	D	D	E	D	x	x	D	D	D	E	D	x	x	D	D	D	E	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 4	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 5	D	X	D	D	D	D	x	x	D	D	D	D	D	x	D	x	D	D	D	D	x	x	D	D	D	D	D	x	D	x
Counselor 6	x	D	D	D	D	D	x	D	x	D	D	D	D	x	x	D	D	D	D	D	x	D	x	D	D	D	D	x	x	D
Counselor 7	N	X	N	N	N	N	x	x	N	N	D	N	x	N	N	x	N	D	N	N	x	x	N	N	D	N	x	N	N	x
Counselor 8	N	X	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x
Counselor 9	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 10	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule Key South Services at SCI</u> – 9.0 FTE x 2,080 hours = 18,720 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 4	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x
Counselor 5	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 6	x	x	D	N	N	D	D	x	x	D	N	N	D	D	x	x	D	N	N	D	D	x	x	D	N	N	D	D	x	x

<u>Staffing Schedule Key Village Services at BWCI</u> – 7.0 FTE x 2,080 hours = 14,560 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon - Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	D	E	D	D	x	x	D	D	E	D	D	x	x	D	D	E	D	D	x	x	D	D	E	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	x	N	N	X	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 4	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	X	x	N	N	N	N	x	N	N	x

Work Schedules

The RFP requires the vendor to 'propose a staff work schedule detailing the number of weeks, days and total hours anticipated annually for each position. The pages below depict 31 day schedules by program and facility as well as total staff hours for each.

<u>Staffing Schedule Key North Services at Young</u> – 14.0 FTE x 2,080 hours = 29,120 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = 12 pm to 8 pm on Sat and Sun D = 7 am – 3 pm N = 12 pm – 8 pm on Mon – Fri

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D	D	N	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	D	D	D	x	D	D	D	D	x	D	D	x	x	D	D	D	D	x	D	D	D	D	x	D	D	x	x	D
Clinical Supervisor 2	D	D	D	x	D	D	x	x	D	D	D	D	x	D	D	D	D	x	D	D	x	x	D	D	D	D	x	D	D	D
Counselor 1	x	D	D	D	D	x	D	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	D	D	D	D	x	D	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 4	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 5	x	D	D	D	D	x	D	D	X	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 6	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 7	N	x	N	D	N	N	x	x	N	N	D	N	x	N	N	x	N	D	N	N	x	x	N	N	D	N	x	N	N	x
Counselor 8	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x
Counselor 9	x	N	N	N	N	x	N	N	X	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 10	x	N	N	N	N	x	N	N	X	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N

<u>Staffing Schedule Crest North and Aftercare at WEBB</u> – 9.0 FTE x 2,080 hours = 18,720 hours/year
Sunday through Saturday LEGEND: D = Day 8 am – 4 pm N = Night 12 pm – 8 pm

Title	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
Team Leader	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Admin. Assistant	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Clinical Supervisor 1	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D	E	D	D	D	x	x	D
Counselor 1	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D
Counselor 2	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x	D	D	D	D	x	x	D	D	D	D	x	D	D	x
Counselor 3	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N
Counselor 4	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x	N	N	N	N	x	x	N	N	N	N	x	N	N	x
Counselor 5	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D	D	D	D	D	x	x	D
Counselor 6	x	x	D	N	N	D	D	x	x	D	N	N	D	D	x	x	D	N	N	D	D	x	x	D	N	N	D	D	x	x

Pricing Structure

The budget is presented in the following formats with the following assumptions:

- The DDOC BCHS RFP Appendix C format
- A salary listing for all positions separately for substance abuse programs and for mental health and sex offender treatment programs, showing hourly rates for each position
- A budget for each program by site
- A consolidated budget for all substance abuse programs and a consolidated budget for all mental health and sex offender treatment services
- Administrative overhead includes the administrative assistants and medical records technicians working at the program sites and listed in the salary budgets
- Indirect costs are calculated at 12% of the direct costs, excluding the performance bond; indirect costs include the allocated costs on a pro rata share basis of Connections' finance, human resources, corporate compliance, and senior management functions.
- We have not proposed a model in which there are incentives, but we would be willing to work with DDOC to define one.
- We have not marked up the costs. Connections is a non-profit organization and is proposing no profit.

DDOC BCHS RFP

Vendor Name: Connections Community Support Programs, Inc.

Mental Health, Substance Abuse and Sex Offender Tx

Based on 7,000 ADP

Fixed Costs	
Mid-Level Practitioners and Above	**4,827,000.00**
Line Staff	**3,677,763.00**
Performance Bond	**350,000.00**
Professional Liability/Malpractice Insurance	**99,000.00**
Other Employment Costs (benefits, tax, workers comp)	**2,553,053.00**
Subtotal	**11,506,816.00**
Management Costs	
Senior Management	**305,000.00**
Admin Overhead (admin assistants, medical records)	**584,400.00**
Office Space, Phones, Internet	**58,122.00**
Inidrect Costs	**1,437,632.00**
Subtotal	**2,385,154.00**
Variable Costs	
Staff Training & Process Evaluation	**402,000.00**
Mileage	**39,555.00**
Supplies	**56,313.00**
Recruiting	**14,207.00**
Auditing and Legal Fees	**105,096.00**
Case Management Contract DCJ for POPS/ADHD	**100,000.00**
DSAT Program Evaluation Contract	**207,000.00**
Subtotal	**924,171.00**
Mark-Up	
Profit over Costs	**-**
Annual Base Total	**14,816,141.00**
Year 1 Performance Incentive Potential	**14,816,141.00**

Cost per Offender/day **5.80**

(7,000 offenders @ 365 days)

Mental Health And Sex Offender Treatment Programs Consolidated Salaries

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Program Administrator	All	40	100,000	20	50,000	48.08
Admin. Assistant	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Admin. Assistant	Young	40	24,960	40	24,960	12.00
Admin. Assistant	SCI/SCCC	40	24,960	40	24,960	12.00
Admin. Assistant	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Medical Records	All	240	210,000	125	112,123	16.83
Admin Assistant	All	40	35,000	40	17,500	16.83
Clinical Progam Director	All	40	125,000	20	62,500	60.10
Psychiatric Nurse Practitioner	BWCI/Webb/WTC/Plummer	40	120,000	40	120,000	57.69
Psychiatric Nurse Practitioner	SCI/SCCC	40	120,000	40	120,000	57.69
Psychiatric Nurse Practitioner	Vaughn/Morris/CVOP	40	120,000	40	120,000	57.69
Psychiatric Nurse Practitioner	Vaughn/Morris/CVOP	20	60,000	20	60,000	57.69
Psychiatric Nurse Practitioner	Young	40	120,000	40	120,000	57.69
Clinical Supervisor	BWCI/Webb/WTC/Plummer	40	52,000	40	52,000	25.00
Clinical Supervisor	SCI/SCCC	40	52,000	40	52,000	25.00
Clinical Supervisor	Vaughn/Morris/CVOP	40	52,000	40	52,000	25.00
Clinical Supervisor #2	Vaughn/Morris/CVOP	40	52,000	40	52,000	25.00
Clinical Supervisor	Young	40	52,000	40	52,000	25.00

Mental Health And Sex Offender Treatment Programs Consolidated Salaries

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Clincian #1	BWCI/Webb/WTC/Plummer	40	47,000	40	47,000	22.60
Clinician #2	BWCI/Webb/WTC/Plummer	40	47,000	40	47,000	22.60
Clinician #3	BWCI/Webb/WTC/Plummer	40	47,000	40	47,000	22.60
Clinician #4	BWCI/Webb/WTC/Plummer	40	47,000	40	47,000	22.60
Clinician #5	BWCI/Webb/WTC/Plummer	40	47,000	40	47,000	22.60
Clinciain #2	SCI/SCCC	40	47,000	40	47,000	22.60
Clinician #1	SCI/SCCC	40	47,000	40	47,000	22.60
Clinician #3	SCI/SCCC	40	47,000	40	47,000	22.60
Clinician #4	SCI/SCCC	40	47,000	40	47,000	22.60
Clinician #5	SCI/SCCC	40	47,000	40	47,000	22.60
Clinician #6	SCI/SCCC	40	47,000	40	47,000	22.60
Clinician #7	SCI/SCCC	40	47,000	40	47,000	22.60
Clinciain #2	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinciain #7	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #1	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #10	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #3	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #4	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #5	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #6	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #8	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60

Mental Health And Sex Offender Treatment Programs Consolidated Salaries

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Clinician #9	Vaughn/Morris/CVOP	40	47,000	40	47,000	22.60
Clinician #2	Young	40	47,000	40	47,000	22.60
Clinician #1	Young	40	47,000	40	47,000	22.60
Clinician #3	Young	40	47,000	40	47,000	22.60
Clinician #4	Young	40	47,000	40	47,000	22.60
Clinician #5	Young	40	47,000	40	47,000	22.60
Clinician #6	Young	40	47,000	40	47,000	22.60
Mental Health Director	BWCI/Webb/WTC/Plummer	40	55,000	40	55,000	26.44
Mental Health Director	SCI/SCCC	40	55,000	40	55,000	26.44
Mental Health Director	Vaughn/Morris/CVOP	40	55,000	40	55,000	26.44
Mental Health Director	Young	40	55,000	40	55,000	26.44
PRN Observer/Clerk	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
PRN Observer/Clerk	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
PRN Observer/Clerk	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Psychiatric Technician #1	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Psychiatric Technician #10	BWCI/Webb/WTC/Plummer	20	12,480	20	12,480	12.00
Psychiatric Technician #11	BWCI/Webb/WTC/Plummer	20	12,480	20	12,480	12.00
Psychiatric Technician #12	BWCI/Webb/WTC/Plummer	20	12,480	20	12,480	12.00
Psychiatric Technician #2	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00

Mental Health And Sex Offender Treatment Programs Consolidated Salaries

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Psychiatric Technician #3	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Psychiatric Technician #4	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Psychiatric Technician #5	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Psychiatric Technician #6	BWCI/Webb/WTC/Plummer	40	24,960	40	24,960	12.00
Psychiatric Technician #7	BWCI/Webb/WTC/Plummer	20	12,480	20	12,480	12.00
Psychiatric Technician #8	BWCI/Webb/WTC/Plummer	20	12,480	20	12,480	12.00
Psychiatric Technician #9	BWCI/Webb/WTC/Plummer	20	12,480	20	12,480	12.00
PRN Observer/Clerk	SCI/SCCC	40	24,960	40	24,960	12.00
PRN Observer/Clerk	SCI/SCCC	40	24,960	40	24,960	12.00
PRN Observer/Clerk	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #1	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #2	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #3	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #4	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #5	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #6	SCI/SCCC	40	24,960	40	24,960	12.00
Psychiatric Technician #7	SCI/SCCC	20	12,480	20	12,480	12.00

Mental Health And Sex Offender Treatment Programs Consolidated Salaries

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Psychiatric Technician #8	SCI/SCCC	20	12,480	20	12,480	12.00
Activity Technician	Vaughn/Morris/CVOP	40	32,000	40	32,000	15.38
Activity Technician	Vaughn/Morris/CVOP	40	32,000	40	32,000	15.38
Activity Technician	Vaughn/Morris/CVOP	40	28,000	40	28,000	15.38
PRN Observer/Clerk	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
PRN Observer/Clerk	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
PRN Observer/Clerk	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
PRN Observer/Clerk	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #1	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #2	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #3	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #4	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #5	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #6	Vaughn/Morris/CVOP	40	24,960	40	24,960	12.00
Psychiatric Technician #7	Vaughn/Morris/CVOP	20	12,480	20	12,480	12.00
Psychiatric Technician #8	Vaughn/Morris/CVOP	20	12,480	20	12,480	12.00
PRN Observer/Clerk	Young	40	24,960	40	24,960	12.00
PRN Observer/Clerk	Young	40	24,960	40	24,960	12.00
PRN Observer/Clerk	Young	40	24,960	40	24,960	12.00
Psychiatric Technician #1	Young	40	24,960	40	24,960	12.00
Psychiatric Technician #2	Young	40	24,960	40	24,960	12.00

Mental Health And Sex Offender Treatment Programs Consolidated Salaries

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Psychiatric Technician #3	Young	40	24,960	40	24,960	12.00
Psychiatric Technician #4	Young	40	24,960	40	24,960	12.00
Psychiatric Technician #5	Young	40	24,960	40	24,960	12.00
Psychiatric Technician #6	Young	40	24,960	40	24,960	12.00
Psychiatric Technician #7	Young	20	12,480	20	12,480	12.00
Psychiatric Technician #8	Young	20	12,480	20	12,480	12.00
Psychiatrist	BWCI/Webb/WTC/Plummer	30	187,000	30	187,000	119.87
Psychiatrist	SCI/SCCC	30	187,000	30	187,000	119.87
Psychiatrist	Vaughn/Morris/CVOP	30	187,000	30	187,000	119.87
Psychiatrist	Vaughn/Morris/CVOP	30	187,000	20	187,000	119.87
Psychiatrist	Young	30	187,000	30	187,000	119.87
Psychiatrist	Young	30	187,000	30	187,000	119.87
Psychologist	BWCI/Webb/WTC/Plummer	20	40,000	20	40,000	38.46
Psychologist	SCI/SCCC	10	20,000	10	20,000	38.46
Psychologist	Vaughn/Morris/CVOP	40	80,000	40	80,000	38.46
Psychologist	Young	40	80,000	40	80,000	38.46
		4310	**5,413,120**	**4,145**	**5,185,243**	
				103.6		

Sex Offender Treatment Team

Agency Title	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary	Hourly Rate
Sex Offender Treatment Team Leader	40	$85,000	40	$85,000	40.87
Certified Sex Offender Treatment Provider	40	$55,000	40	$55,000	26.44
Associate Sex Offender Treatment Provider	40	$47,000	40	$47,000	22.60
Associate Sex Offender Treatment Provider	40	$47,000	40	$47,000	22.60
Admin Assistant	40	$24,960	40	$24,960	
	200	**$258,960**	**200**	**$258,960**	
			5		

Staffing: All Substance Abuse Programs

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Program Administrator	All	40	100,000	20	50,000	$ 48.08
Admin Assistant	All	40	35,000	40	17,500	$ 16.83
Medical Records	All	240	210,000	115	101,500	$ 16.83
Admin. Assistant	Key Village (BWCI)	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Key North (Young)	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Key South (SCI)	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Women's Crest North	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Crest Primary	40	24,960	40	24,960	$ 12.00

Staffing: All Substance Abuse Programs

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Admin. Assistant	Crest Central + Aftercare	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Crest South + Aftercare	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Men's 6 for 1	40	24,960	40	24,960	$ 12.00
Admin. Assistant	YCOP	40	24,960	40	24,960	$ 12.00
Admin. Assistant	DUI (Men's and Women's)	40	24,960	40	24,960	$ 12.00
Admin. Assistant	Men's Crest North	40	24,960	40	24,960	$ 12.00
Clinical Progam Director	All	40	125,000	20	62,500	$ 60.10
Program Director	Key Village (BWCI)	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Key Village (BWCI)	40	52,000	40	52,000	$ 25.00
Counselor #1	Key Village (BWCI)	40	32,000	40	32,000	$ 15.38
Counselor #2	Key Village (BWCI)	40	32,000	40	32,000	$ 15.38
Counselor #3	Key Village (BWCI)	40	32,000	40	32,000	$ 15.38
Counselor #4	Key Village (BWCI)	40	32,000	40	32,000	$ 15.38
Program Director	Key North (Young)	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Key North (Young)	40	52,000	40	52,000	$ 25.00
Clinical Supervisor	Key North (Young)	40	52,000	40	52,000	$ 25.00
Counselor #1	Key North (Young)	40	35,000	40	35,000	$ 16.83
Counselor #2	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #3	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #4	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #5	Key North (Young)	40	35,000	40	35,000	$ 16.82

Staffing: All Substance Abuse Programs

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Counselor #6	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #7	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #8	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #9	Key North (Young)	40	35,000	40	35,000	$ 16.82
Counselor #10	Key North (Young)	40	35,000	40	35,000	$ 16.82
Program Director	Key South (SCI)	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Key South (SCI)	40	52,000	40	52,000	$ 25.00
Clinician #1	Key South (SCI)	40	32,000	40	32,000	$ 15.38
Clinciain #2	Key South (SCI)	40	32,000	40	32,000	$ 15.38
Clinician #3	Key South (SCI)	40	32,000	40	32,000	$ 15.38
Clinician #4	Key South (SCI)	40	32,000	40	32,000	$ 15.38
Clinician #5	Key South (SCI)	40	32,000	40	32,000	$ 15.38
Clinician #6	Key South (SCI)	40	32,000	40	32,000	$ 15.38
Program Director	Men's Crest North	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Men's Crest North	40	52,000	40	52,000	$ 25.00
Counselor #1	Men's Crest North	40	32,000	40	37,500	$ 18.03
Counselor #2	Men's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #3	Men's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #4	Men's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #5	Men's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #6	Men's Crest North	40	32,000	40	32,000	$ 15.38

Staffing: All Substance Abuse Programs

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Counselor #7	Men's Crest North	20	16,000	20	16,000	$ 15.38
Program Director	Women's Crest North	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Women's Crest North	40	52,000	40	52,000	$ 25.00
Counselor #1	Women's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #2	Women's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #3	Women's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #4	Women's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #5	Women's Crest North	40	32,000	40	32,000	$ 15.38
Counselor #6	Women's Crest North	40	32,000	40	32,000	$ 15.38
Program Director	Crest Primary	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Crest Primary	40	52,000	40	52,000	$ 25.00
Clinical Supervisor	Crest Primary	40	52,000	40	52,000	$ 25.00
Counselor #1	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #2	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #3	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #4	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #5	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #6	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #7	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #8	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #9	Crest Primary	40	32,000	40	32,000	$ 15.38
Counselor #10	Crest Primary	40	32,000	40	32,000	$ 15.38
Program Director	Crest Central + Aftercare	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Crest Central + Aftercare	40	52,000	40	52,000	$ 25.00
Clinician #1	Crest Central + Aftercare	40	32,000	40	32,000	$ 15.38

Staffing: All Substance Abuse Programs

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Clinciain #2	Crest Central + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #3	Crest Central + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #4	Crest Central + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #5	Crest Central + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #6	Crest Central + Aftercare	40	32,000	40	32,000	$ 15.38
Program Director	Crest South + Aftercare	40	55,000	40	55,000	$ 26.44
Clinical Supervisor	Crest South + Aftercare	40	52,000	40	52,000	$ 25.00
Clinician #1	Crest South + Aftercare	40	32,000	40	32,000	$ 15.38
Clinciain #2	Crest South + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #3	Crest South + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #4	Crest South + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #5	Crest South + Aftercare	40	32,000	40	32,000	$ 15.38
Clinician #6	Crest South + Aftercare	40	32,000	40	32,000	$ 15.38
Program Director	Men's 6 for 1	40	55,000	40	55,000	$ 26.44
Counselor #1	Men's 6 for 1	40	32,000	40	32,000	$ 15.38
Counselor #2	Men's 6 for 1	40	32,000	40	32,000	$ 15.38
Counselor #3	Men's 6 for 1	40	32,000	40	32,000	$ 15.38
Counselor #4	Men's 6 for 1	40	32,000	40	32,000	$ 15.38
Program Director	YCOP	40	55,000	40	55,000	$ 26.44
Counselor #1	YCOP	40	32,000	40	32,000	$ 15.38
Counselor #2	YCOP	40	32,000	40	32,000	$ 15.38
Counselor #3	YCOP	40	32,000	40	32,000	$ 15.38
Counselor #1	Boot Camp	40	35,000	40	35,000	$ 16.83
Program Director	Women's 6 for 1	40	55,000	40	55,000	$ 26.44
Counselor #1	Women's 6 for 1	40	32,000	40	32,000	$ 15.38

Staffing: All Substance Abuse Programs

Agency Title	Location	Hrs Per Week	Annual Salary	Hrs Per Week	Annual Salary Charged to Program	Hourly Rate
Counselor #2	Women's 6 for 1	40	32,000	40	32,000	$ 15.38
Team Leader	Men's DUI	40	55,000	40	55,000	$ 26.44
Counselor #1	Men's DUI	40	32,000	40	32,000	$ 15.38
Counselor #2	Men's DUI	40	32,000	40	32,000	$ 15.38
Team Leader	Women's DUI	40	55,000	40	55,000	$ 26.44
Counselor #1	Women's DUI	40	32,000	40	32,000	$ 15.38
Counselor #2	Women's DUI	8	10,400	8	10,400	$ 15.38
		4428	**4,182,960**	**4,263**	**3,949,960**	
				107		

Sex Offender Treatment Team	
TOTAL SALARIES	**258,960.00**
BENEFITS:	
PAYROLL TAX	**19,810.00**
HEALTH BENEFITS	**33,000.00**
OTHER FRINGE BENEFITS	**10,000.00**
TOTAL BENEFITS	**62,810.00**
TOTAL SAL. & BEN.	**321,770.00**
STAFF TRAVEL & TRNG:	
STAFF TRAINING	**4,000.00**
STAFF MILEAGE	**5,500.00**
STAFF PUBLIC TRANSP.	**0.00**
OTHER STAFF TRAVEL	**0.00**
TOTAL TRAVEL	**9,500.00**
OPERATING COSTS:	
AUDIT AND LEGAL	**2,400.00**
TELEPHONE	**2,125.00**
POSTAGE	**100.00**
ADVERTISING/RECRUT'G	**325.00**
OFFICE SUPPLIES	**1,250.00**
OTHER OPERATING COST	**3,325.00**
TOTAL OPERATING COST	**9,525.00**
TOTAL DIRECT PROGRAM	**340,795.00**
INDIRECT COST ALLOC.	**40,895.00**
TOTAL PROG. COSTS	**381,690.00**

Vaughn/CVOP/Morris Mental Health	
TOTAL SALARIES	1,688,605.00
BENEFITS:	
PAYROLL TAX	129,178.00
HEALTH BENEFITS	216,150.00
OTHER FRINGE BENEFITS	65,500.00
TOTAL BENEFITS	410,828.00
TOTAL SAL. & BEN.	2,099,433.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	32,750.00
STAFF MILEAGE	2,750.00
STAFF PUBLIC TRANSP.	0.00
OTHER STAFF TRAVEL	0.00
TOTAL TRAVEL	35,500.00
OPERATING COSTS:	
AUDIT AND LEGAL	15,720.00
TELEPHONE	13,493.00
POSTAGE	200.00
ADVERTISING/RECRUT'G	2,063.00
OFFICE SUPPLIES	7,938.00
OTHER OPERATING COST	21,114.00
TOTAL OPERATING COST	60,528.00
TOTAL DIRECT PROGRAM	2,195,461.00
INDIRECT COST ALLOC.	167,952.77
TOTAL PROG. COSTS	2,363,413.77

SCI Mental Health	
TOTAL SALARIES	1,101,685.00
BENEFITS:	
PAYROLL TAX	84,279.00
HEALTH BENEFITS	150,480.00
OTHER FRINGE BENEFITS	45,600.00
TOTAL BENEFITS	280,359.00
TOTAL SAL. & BEN.	1,382,044.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	22,800.00
STAFF MILEAGE	2,750.00
STAFF PUBLIC TRANSP.	0.00
OTHER STAFF TRAVEL	0.00
TOTAL TRAVEL	25,550.00
OPERATING COSTS:	
AUDIT AND LEGAL	10,944.00
TELEPHONE	9,690.00
POSTAGE	150.00
ADVERTISING/RECRUT'G	1,482.00
OFFICE SUPPLIES	5,700.00
OTHER OPERATING COST	15,162.00
TOTAL OPERATING COST	43,128.00
TOTAL DIRECT PROGRAM	1,450,722.00
INDIRECT COST ALLOC.	174,087.00
TOTAL PROG. COSTS	1,624,809.00

Young Mental Health	
TOTAL SALARIES	1,272,133.00
BENEFITS:	
PAYROLL TAX	97,318.00
HEALTH BENEFITS	149,160.00
OTHER FRINGE BENEFITS	45,200.00
TOTAL BENEFITS	291,678.00
TOTAL SAL. & BEN.	1,563,811.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	22,600.00
STAFF MILEAGE	2,750.00
STAFF PUBLIC TRANSP.	0.00
OTHER STAFF TRAVEL	0.00
TOTAL TRAVEL	25,350.00
OPERATING COSTS:	
AUDIT AND LEGAL	10,848.00
TELEPHONE	9,605.00
POSTAGE	150.00
ADVERTISING/RECRUT'G	1,469.00
OFFICE SUPPLIES	5,650.00
OTHER OPERATING COST	15,029.00
TOTAL OPERATING COST	42,751.00
TOTAL DIRECT PROGRAM	1,631,912.00
INDIRECT COST ALLOC.	195,829.00
TOTAL PROG. COSTS	1,827,741.00

BWCI/Webb/WTC Mental Health	
TOTAL SALARIES	1,062,625.00
BENEFITS:	
PAYROLL TAX	81,291.00
HEALTH BENEFITS	152,460.00
OTHER FRINGE BENEFITS	46,200.00
TOTAL BENEFITS	279,951.00
TOTAL SAL. & BEN.	1,342,576.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	23,100.00
STAFF MILEAGE	2,750.00
STAFF PUBLIC TRANSP.	0.00
OTHER STAFF TRAVEL	0.00
TOTAL TRAVEL	25,850.00
OPERATING COSTS:	
AUDIT AND LEGAL	11,088.00
TELEPHONE	9,817.00
POSTAGE	150.00
ADVERTISING/RECRUT'G	1,501.00
OFFICE SUPPLIES	5,775.00
OTHER OPERATING COST	15,029.00
TOTAL OPERATING COST	43,360.00
TOTAL DIRECT PROGRAM	1,411,786.00
INDIRECT COST ALLOC.	169,414.00
TOTAL PROG. COSTS	1,581,200.00

Consolidated MH and Sex Offender Tx	
TOTAL SALARIES	5,384,008.00
BENEFITS:	
PAYROLL TAX	411,876.00
HEALTH BENEFITS	701,250.00
OTHER FRINGE BENEFITS	212,500.00
TOTAL BENEFITS	1,325,626.00
TOTAL SAL. & BEN.	6,709,634.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	105,250.00
STAFF MILEAGE	16,500.00
STAFF PUBLIC TRANSP.	0.00
OTHER STAFF TRAVEL	0.00
TOTAL TRAVEL	121,750.00
OPERATING COSTS:	
AUDIT AND LEGAL	51,000.00
TELEPHONE	44,730.00
POSTAGE	750.00
ADVERTISING/RECRUT'G	6,840.00
OFFICE SUPPLIES	26,313.00
OTHER OPERATING COST	15,029.00
TOTAL OPERATING COST	144,662.00
TOTAL DIRECT PROGRAM	6,976,046.00
INDIRECT COST ALLOC.	748,177.00
TOTAL PROG. COSTS	7,724,223.00

Key Village at BWCI	
TOTAL SALARIES	**278,210.00**
BENEFITS:	
PAYROLL TAX	**21,283.00**
HEALTH BENEFITS	**46,860.00**
OTHER FRINGE BENEFITS	**14,200.00**
TOTAL BENEFITS	**82,343.00**
TOTAL SAL. & BEN.	**360,553.00**
STAFF TRAVEL & TRNG:	
STAFF TRAINING	**19,000.00**
STAFF MILEAGE	**1,430.00**
TOTAL TRAVEL	**20,430.00**
OPERATING COSTS:	
ACCOUNTING AND LEGAL	**3,648.00**
TELEPHONE	**3,238.00**
POSTAGE	**100.00**
ADVERTISING/RECRUT'G	**500.00**
OFFICE SUPPLIES	**1,775.00**
OTHER OPERATING COST	**5,060.00**
TOTAL OPERATING COST	**14,321.00**
TOTAL DIRECT PROGRAM	**395,304.00**
INDIRECT COST ALLOC.	**47,436.00**
TOTAL PROG. COSTS	**442,740.00**

Young Key North Treatment Budget	
TOTAL SALARIES	562,710.00
BENEFITS:	
PAYROLL TAX	43,047.00
HEALTH BENEFITS	93,060.00
OTHER FRINGE BENEFITS	28,200.00
TOTAL BENEFITS	164,307.00
TOTAL SAL. & BEN.	727,017.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	52,500.00
STAFF MILEAGE	2,750.00
TOTAL TRAVEL	55,250.00
OPERATING COSTS:	
AUDITING AND LEGAL	7,200.00
TELEPHONE	6,400.00
POSTAGE	150.00
ADVERTISING/RECRUT'G	1,000.00
OFFICE SUPPLIES	3,750.00
OTHER OPERATING COST	10,000.00
TOTAL OPERATING COST	28,500.00
TOTAL DIRECT PROGRAM	810,767.00
INDIRECT COST ALLOC.	97,292.00
TOTAL PROG. COSTS	908,059.00

Key South Annual Operating Budget	
TOTAL SALARIES	362,710.00
BENEFITS:	
PAYROLL TAX	27,747.00
HEALTH BENEFITS	46,860.00
OTHER FRINGE BENEFITS	14,200.00
TOTAL BENEFITS	88,807.00
TOTAL SAL. & BEN.	451,517.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	25,000.00
STAFF MILEAGE	2,750.00
TOTAL TRAVEL	27,750.00
OPERATING COSTS:	
AUDITING AND LEGAL	4,800.00
TELEPHONE	4,260.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	660.00
OFFICE SUPPLIES	2,500.00
OTHER OPERATING COST	6,660.00
TOTAL OPERATING COST	18,980.00
TOTAL DIRECT PROGRAM	498,247.00
INDIRECT COST ALLOC.	59,790.00
TOTAL PROG. COSTS	558,037.00

Men's Crest North + Aftercare Annual Operating Budget	
TOTAL SALARIES	358,210.00
BENEFITS:	
PAYROLL TAX	27,403.00
HEALTH BENEFITS	63,360.00
OTHER FRINGE BENEFITS	19,200.00
TOTAL BENEFITS	109,963.00
TOTAL SAL. & BEN.	468,173.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	25,000.00
STAFF MILEAGE	1,375.00
TOTAL TRAVEL	26,375.00
OPERATING COSTS:	
AUDITING AND LEGAL	4,800.00
TELEPHONE	4,250.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	650.00
OFFICE SUPPLIES	2,500.00
OTHER OPERATING COST	12,300.00
TOTAL OPERATING COST	24,600.00
TOTAL DIRECT PROGRAM	519,148.00
INDIRECT COST ALLOC.	62,298.00
TOTAL PROG. COSTS	581,446.00

Women's Crest Program	
TOTAL SALARIES	342,210.00
BENEFITS:	
PAYROLL TAX	26,179.00
HEALTH BENEFITS	60,060.00
OTHER FRINGE BENEFITS	18,200.00
TOTAL BENEFITS	104,439.00
TOTAL SAL. & BEN.	446,649.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	22,500.00
STAFF MILEAGE	1,375.00
TOTAL TRAVEL/TRAINING	23,875.00
OPERATING COSTS:	
AUDITING AND LEGAL	4,320.00
TELEPHONE	3,825.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	585.00
OFFICE SUPPLIES	2,250.00
OTHER OPERATING COST	5,985.00
TOTAL OPERATING COST	17,065.00
TOTAL DIRECT PROGRAM	487,589.00
INDIRECT COST ALLOC.	58,511.00
TOTAL PROG. COSTS	546,100.00

Crest Primary at CVOP	
TOTAL SALARIES	532,710.00
BENEFITS:	
PAYROLL TAX	40,752.00
HEALTH BENEFITS	99,000.00
OTHER FRINGE BENEFITS	30,000.00
TOTAL BENEFITS	169,752.00
TOTAL SAL. & BEN.	702,462.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	37,500.00
STAFF MILEAGE	2,750.00
TOTAL TRAVEL& Training	40,250.00
OPERATING COSTS:	
AUDITING AND LEGAL	7,200.00
TELEPHONE	6,375.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	975.00
OFFICE SUPPLIES	3,750.00
OTHER OPERATING COST	9,975.00
TOTAL OPERATING COST	28,375.00
TOTAL DIRECT PROGRAM	771,087.00
INDIRECT COST ALLOC.	92,530.00
TOTAL PROG. COSTS	863,617.00

Crest Central Aftercare at Morris	
TOTAL SALARIES	340,710.00
BENEFITS:	
PAYROLL TAX	26,064.00
HEALTH BENEFITS	60,060.00
OTHER FRINGE BENEFITS	18,200.00
TOTAL BENEFITS	104,324.00
TOTAL SAL. & BEN.	445,034.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	23,250.00
STAFF MILEAGE	1,375.00
STAFF PUBLIC TRANSP.	0.00
OTHER STAFF TRAVEL	0.00
TOTAL TRAVEL	24,625.00
OPERATING COSTS:	
AUDITING AND LEGAL	4,464.00
TELEPHONE	3,952.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	605.00
OFFICE SUPPLIES	2,325.00
OTHER OPERATING COST	6,185.00
TOTAL OPERATING COST	17,631.00
TOTAL DIRECT PROGRAM	487,290.00
INDIRECT COST ALLOC.	58,474.00
TOTAL PROG. COSTS	545,764.00

Crest South + Aftercare	
TOTAL SALARIES	343,960.00
BENEFITS:	
PAYROLL TAX	26,313.00
HEALTH BENEFITS	60,060.00
OTHER FRINGE BENEFITS	18,200.00
TOTAL BENEFITS	104,573.00
TOTAL SAL. & BEN.	448,533.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	23,500.00
STAFF MILEAGE	2,750.00
TOTAL TRAVEL	26,250.00
OPERATING COSTS:	
AUDITING AND LEGAL	4,512.00
TELEPHONE	3,995.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	611.00
OFFICE SUPPLIES	2,350.00
OTHER OPERATING COST	6,251.00
TOTAL OPERATING COST	17,819.00
TOTAL DIRECT PROGRAM	492,602.00
INDIRECT COST ALLOC.	59,112.00
TOTAL PROG. COSTS	551,714.00

Men's Six for One	
TOTAL SALARIES	222,710.00
BENEFITS:	
PAYROLL TAX	17,037.00
HEALTH BENEFITS	40,260.00
OTHER FRINGE BENEFITS	12,200.00
TOTAL BENEFITS	69,497.00
TOTAL SAL. & BEN.	292,207.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	15,500.00
STAFF MILEAGE	1,375.00
TOTAL TRAVEL	16,875.00
OPERATING COSTS:	
AUDITING AND LEGAL	2,976.00
TELEPHONE	2,635.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	403.00
OFFICE SUPPLIES	1,550.00
OTHER OPERATING COST	4,123.00
TOTAL OPERATING COST	11,787.00
TOTAL DIRECT PROGRAM	320,869.00
INDIRECT COST ALLOC.	38,504.00
TOTAL PROG. COSTS	359,373.00

YCOP	
TOTAL SALARIES	190,710.00
BENEFITS:	
PAYROLL TAX	14,589.00
HEALTH BENEFITS	33,660.00
OTHER FRINGE BENEFITS	10,200.00
TOTAL BENEFITS	58,449.00
TOTAL SAL. & BEN.	249,159.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	13,000.00
STAFF MILEAGE	1,375.00
TOTAL TRAVEL&TRAINING	14,375.00
OPERATING COSTS:	
AUDITING AND LEGAL	2,496.00
TELEPHONE	2,210.00
POSTAGE	100.00
ADVERTISING/RECRUT'G	338.00
OFFICE SUPPLIES	1,300.00
OTHER OPERATING COST	3,458.00
TOTAL OPERATING COST	9,902.00
TOTAL DIRECT PROGRAM	273,436.00
INDIRECT COST ALLOC.	31,385.00
TOTAL PROG. COSTS	304,821.00

Boot Camp	
TOTAL SALARIES	35,000.00
BENEFITS:	
PAYROLL TAX	2,677.00
HEALTH BENEFITS	6,600.00
OTHER FRINGE BENEFITS	2,000.00
TOTAL BENEFITS	11,277.00
TOTAL SAL. & BEN.	46,277.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	2,500.00
STAFF MILEAGE	-
TOTAL TRAVEL	2,500.00
OPERATING COSTS:	
AUDITING AND LEGAL	480.00
TELEPHONE	425.00
POSTAGE	-
ADVERTISING/RECRUT'G	65.00
OFFICE SUPPLIES	250.00
OTHER OPERATING COST	665.00
TOTAL OPERATING COST	1,885.00
TOTAL DIRECT PROGRAM	50,662.00
INDIRECT COST ALLOC.	6,079.00
TOTAL PROG. COSTS	56,741.00

Women's Six for One	
TOTAL SALARIES	$133,750
BENEFITS:	
PAYROLL TAX	10,232.00
HEALTH BENEFITS	33,000.00
OTHER FRINGE BENEFITS	10,000.00
TOTAL BENEFITS	53,232.00
TOTAL SAL. & BEN.	186,982.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	12,500.00
STAFF MILEAGE	1,250.00
TOTAL TRAVEL	13,750.00
OPERATING COSTS:	
AUDITING AND LEGAL	2,400.00
TELEPHONE	2,125.00
POSTAGE	50.00
ADVERTISING/RECRUT'G	325.00
OFFICE SUPPLIES	1,250.00
OTHER OPERATING COST	3,325.00
TOTAL OPERATING COST	9,475.00
TOTAL DIRECT PROGRAM	210,207.00
INDIRECT COST ALLOC.	25,225.00
TOTAL PROG. COSTS	235,432.00

Men's DUI	
TOTAL SALARIES	$133,750
BENEFITS:	
PAYROLL TAX	10,232.00
HEALTH BENEFITS	33,000.00
OTHER FRINGE BENEFITS	10,000.00
TOTAL BENEFITS	53,232.00
TOTAL SAL. & BEN.	186,982.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	12,500.00
STAFF MILEAGE	1,250.00
TOTAL TRAVEL	13,750.00
OPERATING COSTS:	
AUDITING AND LEGAL	2,400.00
TELEPHONE	2,125.00
POSTAGE	50.00
ADVERTISING/RECRUT'G	325.00
OFFICE SUPPLIES	1,250.00
OTHER OPERATING COST	3,325.00
TOTAL OPERATING COST	9,475.00
TOTAL DIRECT PROGRAM	210,207.00
INDIRECT COST ALLOC.	25,225.00
TOTAL PROG. COSTS	235,432.00

Women's DUI	
TOTAL SALARIES	133,750.00
BENEFITS:	
PAYROLL TAX	10,232.00
HEALTH BENEFITS	33,000.00
OTHER FRINGE BENEFITS	10,000.00
TOTAL BENEFITS	53,232.00
TOTAL SAL. & BEN.	186,982.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	12,500.00
STAFF MILEAGE	1,250.00
TOTAL TRAVEL	13,750.00
OPERATING COSTS:	
AUDITING AND LEGAL	2,400.00
TELEPHONE	2,125.00
POSTAGE	50.00
ADVERTISING/RECRUT'G	325.00
OFFICE SUPPLIES	1,250.00
OTHER OPERATING COST	3,325.00
TOTAL OPERATING COST	9,475.00
TOTAL DIRECT PROGRAM	210,207.00
INDIRECT COST ALLOC.	25,225.00
TOTAL PROG. COSTS	235,432.00

Substance Abuse Treatment Budget	
TOTAL SALARIES	3,949,960.00
BENEFITS:	
PAYROLL TAX	303,787.00
HEALTH BENEFITS	708,840.00
OTHER FRINGE BENEFITS	214,800.00
TOTAL BENEFITS	1,227,427.00
TOTAL SAL. & BEN.	5,177,387.00
STAFF TRAVEL & TRNG:	
STAFF TRAINING	296,750.00
STAFF MILEAGE	23,055.00
TOTAL TRAVEL	319,805.00
OPERATING COSTS:	
AUDITING AND LEGAL	54,096.00
TELEPHONE	47,940.00
POSTAGE	1,200.00
ADVERTISING/RECRUT'G	7,367.00
OFFICE SUPPLIES	28,050.00
OTHER OPERATING COST	109,618.00
TOTAL OPERATING COST	248,271.00
TOTAL DIRECT PROGRAM	5,745,463.00
INDIRECT COST ALLOC.	689,455.00
TOTAL PROG. COSTS	6,434,918.00

Appendix A
Resumes

John R. (Jack) McDonough

283 Avonwood Road
Kennett Square, PA 19348
W- (302) 252-2961

Employment United States Probation and Pretrial Services Office - District of Delaware
2006 - Present Chief
2001 - 2006 Deputy Chief
1993 - 2001 Supervisor
1991 - 1993 Senior U.S. Probation Officer
1988 - 1991 U.S. Probation Officer

Current Functions

* Instituted Evidenced-Based Practices in office's supervision approach.
* Created Workforce Development Program which reduced recidivism by 58% (University of Delaware study - 2009).
* Created district's first Job Developer position.
* Chair of the Reentry Expert Panel for Administrative Office of the U.S. Courts.
* Chair of Reentry and Transitional Working Group for the Administrative Office of the U.S. Courts. Focused on maximizing *Second Chance Act* spending (2008-2010).
* Integrally involved in planning of joint federal and state reentry "One-Stop" (Day Reporting Center). Projected opening September 2012.
* Developed partnership with local skills center, businesses, and community leaders to create jobs for ex-offenders.
* Working with the Federal Bureau of Prisons to open district's first Residential Reentry Center - October 2012.
* Assisted in development of district's first Reentry Court. Projected start May 2012.
* In conjunction with FCI Fairton, participate in Reentry sessions with staff and releasing inmates.
* Assisted in developing multi-agency coordinated strategy to reduce violence in the City of Wilmington by use of "Offender Notification" meetings.

Past Achievements

* 2010 "DOWD" National Workforce Development Commitment Award
* Special Service Awards - 1998, 2002, 2003, and 2005.
* Conducted training for Federal Judicial Center on "Managing Employee Relations," 1995-1996.
* Served on advisory committee to assist Delaware's Department of Correction in developing management workshops for Probation/Parole supervisors, 1993.
* Developed and instituted District's firearms program, 1989.

1981-1988 State of Delaware Probation & Parole Office
Probation and Parole Officer

* One of three trainers selected for implementation of sentencing reform, "SENTAC."
* Public Relations Speakers' Bureau.
* Liaison with drug/alcohol clinics.
* Trainer for the Tri-State Consortium on supervision of the mentally ill.
* Criminal Justice Council - Mental Retardation Subcommittee member.
* Commendations - 1982, 1984, and 1986. "Outstanding" evaluations 1984 - 1987.

Other Professional Experience
Fall 2003 Neumann College, Aston, Pennsylvania
Spring 2010 Part-time Instructor

* Taught college level course, "Corrections and Rehabilitation." Received overall

rating from students of 6.04 on a scale of 1.00 to 7.00.

1995 - 1997 Leadership Development Program

Federal Judicial Center, Washington D.C.

* Graduate of three-year intensive program to develop upper level managers.

1986-1988 National Institute of Corrections

Boulder, Colorado

* Certified trainer in communication skills in the context of probation supervision. Taught programs in Louisiana, New Jersey, and for Delaware's Department of Correction.

Education

1989 - 1992 Wilmington College Graduate Center

Wilmington, Delaware

* Master of Science Degree - Human Resource Management.

Cumulative average - 3.9.

1974 - 1978 Towson State University

Towson, Maryland

* Bachelor of Science Degree, Psychology.
* Member varsity baseball team.
* Work Study Program - 20 hours per week.

Community Activities

2007 - Present Andrew McDonough B+ Foundation - Board Member

Assist families with critically ill children and for childhood cancer research.

2010 - Present HOPE Commission - Board Member

Goal of reducing violence and revitalizing inner city of Wilmington, Delaware.

2004 - 2005 Unionville-Chadds Ford School District

* Parent representative for staffing and resource issues affecting high school students.

2002 - 2005 Delaware Valley Blaze and Chester County Girls Fast Pitch Softball Team.

* Assistant coach.

1999-2004 Unionville High School Ice Hockey Team and Chester County Skating Club

* Coach (boys and girls teams).

1996 - 1999 Reading Assist

(A phonics-based literacy program for elementary age children with dyslexia).

* Tutor - six hours per week in a Delaware public school.

1992 - 1995 Salem Woods Independent Baseball League, **Newark, Delaware**

* Founder and coach.

1991 - 1993 Christina School District

* "Parent Coordinator" for successful 1991 referendum.
* Served on Guidance Counselor Advisory Committee at May B. Leasure Elementary School.

1982 - 1989 Ministry of Caring

2002 - 2004 * Served meals at the Emmanuel Dining Room and volunteered at the House of Joseph I and III, shelters for homeless men and juveniles, respectively.

References: Will be provided upon request.

Christopher R. Devaney, MSCC, ICCDPD

Experience

12/14/1998 to Present: Connections Community Support Programs, Inc.

Positions Held:

12/01/05 to Present – Chief Operating Officeer

Provides clinical and administrative supervision for the agency's program operations including the Connections Supported Employment Program, Community Continuum of Care Program, seven licensed group homes for the mentally ill, six supervised apartment programs, eight permanent supportive housing programs, HIV case management service, PATH homeless outreach services, DDDS Day and residential services, employment services, services to the Department of Children, Youth and Families and twelve outpatient clinics providing integrated outpatient mental health, substance abuse, and primary care services. Has financial and clinical responsibility for 100% of the agency's clinical programs. Managed agency-wide JCAHO and CARF accreditation surveys in 2001, 2004, 2005, 2007, 2010. Provides direct supervision to ten direct reports, with almost 500 staff. Responsible for services to approximately 10,000 persons with mental health, substance use conditions, homelessness and HIV/AIDS.

12/18/03 – 12/31/06 – Director of the Community Continuum of Care Program

Provided clinical and administrative supervision in the Community Continuum of Care Program, five licensed group homes, and 4 supervised apartment programs.

2001 – 2003 – Program Director, Crosslinks Continuous Treatment Team

Responsible for the daily operation of a 120 person Assertive Community Treatment team. Provided the clinical and administrative supervision to 13 staff.

2000 – 2001 – Director of Homeless Outreach Services

Provided supervision to the agency's supported housing program. Was also responsible for providing mental health and substance abuse counseling to the residents in our supported housing programs.

1998 – 2000 – Associate Clinician

Provided direct clinical and case management services to persons enrolled in the former Crosslinks CTT, Meadows Group Homes, and the agency's homeless housing programs funded by HUD.

Education

Master of Science in Community Counseling, Wilmington College, 2002, 4.00 GPA

Bachelor of Science in Criminal Justice, Wilmington College, 1998, 3.49 GPA

Certifications

International Certified Co-Occurring Disorders Professional Diplomate

Awards and Memberships

Connect to Work, Inc. – Secretary, Board of Directors. 2009-2010

USDOL Re-Entry Program Annual Conference – Presenter, Panelist on Integrated Services, One Stop Shop, Developing Micro Businesses to Employ Ex-Offenders. 2010

HOPE Commission Reentry Initiative Team. 2011

DelARF Behavioral Health Commission – Chair. 2011 – present

Rick Vanstory Resource Center – Chairman of the Board – 10/01/2011 -- present

CATHERINE DEVANEY MCKAY

QUALIFICATIONS

- 30 year record as executive leader of nonprofit organizations, 25 as founder and leader of a large multi-service organization serving vulnerable and disenfranchised Delawarean, providing treatment, housing and employment opportunities.
- 30 year record as consultant to government entities and nonprofit organizations
- Demonstrated effectiveness in all aspects of executive leadership including vision and mission development; strategic planning; program and business development; financial management; marketing and public relations; team building; organization development; fund raising; community collaboration; multicultural staff recruitment; platform and writing skills.

EXPERIENCE

1986-Present ***Founder and Chief Executive Officer*, Connections Community Support Programs, Inc.**
Wilmington, DE

- Founded and led the development of a private not-for-profit healthcare and social services agency serving more than 10,000 people annually in 55 locations.
- Developed more than 500 units of housing for persons with low incomes and special needs.
- Increased annual revenue from sales of service from $500,000 to more than $25 million and assets to over $20 million.
- Designed, implemented and managed programs to deliver healthcare, housing and social services to diverse target populations with multiple challenges in under-served rural and urban locations.
- Expanded agency offerings to include a full range of integrated treatment, support, employment and housing services for vulnerable and disenfranchised adults living with and recovering from mental health and substance use conditions, homelessness, cognitive disabilities and HIV/AIDS.
- Implemented evidence-based practices for serving individuals with mental health and substance use conditions including assertive community treatment (ACT); individual placement and support (supported employment); integrated dual disorder treatment (IDDT); illness management and recovery (IMR); family psychoeducation; and PATHWAYS to housing.
- Recruited and developed a multicultural, interdisciplinary staff of more than 400 and a Board of Trustees that represents both the community at large and those served by the organization.
- Achieved full accreditation from JCAHO and CARF, and membership in the United Way of Delaware.
- Successfully competed for over $120 million in state, local, and federal government grants and contracts form SAMHSA, U.S. Department of Labor, U.S. Department of Justice, U.S. Department of Housing and Urban Development, Delaware Department of Health and Social Services, Delaware Department of Labor, Delaware State Housing Authority.
- Developed a collaborative strategic business plan which led to the expansion of the agency by more than 1000% and the completion of multiple capital and operating fund drives raising more than $20 million.
- Managed real estate acquisition, financing, and construction for more than 30 agency sites, including 500 units of low income housing using HUD 811, 202, HOPWA and SHP funds and Low Income Housing Tax Credits.
- Developed a subsidiary entrepreneurial venture that offers janitorial, construction clean up and food services with gross revenues of $400,000 and employs persons with barriers to employment including reentering offenders and persons with disabilities.

1985-Present ***Consultant (supplemental to work as CEO of Connections)***
Springfield University School of Human Services, Adjunct Faculty
Indiana Private Industry Council, Customized Employment Project
Danville-Pittsylvania, Fairfax County, Hampton-Newport News, Central Virginia and District 19, Virginia, Community Services Boards, ACT Implementation
Council on Accreditation of Rehabilitation Facilities (CARF)
Corporation for Supportive Housing
North Carolina Department of Human Resources

- Provided consultation, advocacy and training to assist government and nonprofit organizations to obtain funding and to develop, implement, and evaluate community support services, housing, and employment programs in New York, Virginia, Florida, Delaware, Indiana and North Carolina.
- Assisted Virginia Community Services Boards to implement ACT.
- Assisted the North Carolina DHR to resolve the Thomas S. lawsuit and to implement community-based alternatives to institutionalization.

1984-1986 ***Executive Director,*** **CONTACT-Delaware**
Wilmington, DE

- Founded statewide Rape Crisis program.
- Managed 24-hour multi-service crisis intervention agency.
- Administered fund raising, budgeting, fiscal management and accounting functions.
- Trained and supervised more than 200 volunteers.

1983-1984 ***National Director of Program Development,*** **Big Brothers/Big Sisters of America**
Philadelphia, PA

- Managed program development department of national youth-serving agency with the primary objective of improving services to women and girls following the merger of Big Brothers of America and Big Sisters of America.
- Worked with national field staff to provide evaluation, training and consultation to 450 affiliated agencies.
- Designed and published training materials for services to girls and child sexual abuse prevention.

1974-1983 ***Mental Health and Substance Abuse Counselor***

- Provided individual, group, and family counseling to persons in mental health and substance abuse settings, focusing primarily on school age children, adolescents and their families, and women in crisis.

EDUCATION

Certificate in Nonprofit Management College of Urban Affairs and Public Policy, University of Delaware, 1993
Master of Counseling University of Delaware, 1981
Bachelor of Arts in English & Sociology University of Delaware, 1975
Supplemental Accounting Courses *(23 credits)* Goldey-Beacom College, 1999-2000

MAJOR PRESENTATIONS

- **Balanced Housing, Balanced Communities.** Delaware Housing Coalition, 2009.
- **Ten-Year Plan to End Chronic and Reduce Long-Term Homelessness in Delaware.** Ending Homelessness in Delaware. Homeless Planning Council of Delaware and University of Delaware Center for Community Research and Service, 2007.
- **Customized Employment Strategies for Homeless Adults with Behavioral Health Disorders.** Indiana Private Industry Council. Indianapolis, Indiana, 2005
- **What Works: Financing Strategies and Benefits.** National Policy Academy on Co-Occurring Disorders. U.S. Substance Abuse and Mental Health Services Administration. Baltimore, MD, 2004.
- **Expanding Medicaid Coverage for ACT.** Increasing Access to Mainstream Services for Individuals and Families Experiencing Homelessness. National Learning Meeting, U.S. Department of Housing and Urban Development. Arlington, VA, 2004.
- **Supporting ACT in Medicaid.** U.S. Centers for Medicare and Medicaid Services Invitational Conference on Medicaid and Mental Health Services. Baltimore, MD, 2004.
- **Best Practice Models for Providing Substance Abuse Treatment for Persons with Dual Diagnosis.** Florida Assertive Community Treatment Network Statewide Conference. Orlando, FL, 2002.
- National Expert Series in Mental Health: Assertive Community Treatment: A Review of Key Concepts and Practices. **MCP Hahnemann University Behavioral Healthcare Education. Harrisburg, PA, 2000.**
- **Negotiating Complex Systems of Care: Treating Persons with Severe and Persistent Mental Illness**. American Association of Marriage and Family Therapists Winter Institute. Williamsburg, VA. 2000.
- **Doing What it Takes: Getting Clients Ready for Work**. Housing and Employment for Persons with Co-Occurring Disorders. New York State Office of Mental Health, 2000.
- **Developing Motivation to Work in Individuals with Dual Diagnosis.** The International Association of Psychosocial Rehabilitation Services 22nd Annual Conference, 1997.
- **Service Needs and Therapeutic Accommodations.** Keynote Address. National Institute on Dual Diagnosis. Association of Community Therapeutic Supports (ACTS), 1996.
- **Assertive Community Treatment Teams.** Plenary Session. The Business of Serving People with Special Needs. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, 1995.

MAJOR PUBLICATIONS

McKay, CD and Johnson S. *Ten Year Plan to End Chronic and Reduce Long-Term Homelessness in Delaware.* Delaware Interagency Council on Homelessness, 2007.
Meisler N, McKay CD, Gold PB, Schales-Elkins P, Benasutti R, Santos AB: *Assertive Community Treatment of Dually Diagnosed Persons with Mental Illness and Mental Retardation*. Journal of Psychiatric Practice, 6:77-83, 2000.
Meisler N, McKay CD, Benasutti R: *An ACT Program for Co-Occurring Disorders*. Psychiatric Services, 50:1640, 1999.
Meisler, N; Blankertz, L; McKay CD; Santos, AB: *Impact of Assertive Community Treatment on Homeless Persons with Co-occurring Severe Psychiatric and Substance Use Disorders*. Community Mental Health Journal, Vol. 33, No. 2, April 1997.
Blankertz, L; McKay, CD; Robinson, S: *Work as a Rehabilitative Tool for Individuals with Dual Diagnosis*. Conference Proceedings IAPRS 22nd Annual Conference, Vancouver B.C., June 1997.
Kirszner, M; McKay, CD; Tippett, M. *Homelessness and Mental Health: Replication and Adaptation of the PACT Model in Delaware* in 2nd Annual Conference Proceedings, the NASMHPD Research Institute, Inc. Second Annual Conference on State Mental Health Agency Services Research. NASMHPD: Arlington, VA. June 1991.
Devaney, C. *Growing Up Female: The Need to Serve Girls.* New Designs for Youth Development, November/December, 1983.
Devaney, C. *A Manual for the Prevention of Child Sexual Abuse* published and distributed by BB/BSA, copyright 1984.

MEMBERSHIPS
Delaware Interagency Council on Homelessness (Co-Chair 2005-2008; Chair 2008-Present)
State Associations of Substance Abuse Services (Board of Directors, Secretary, 2004-2005)
National Policy Academy to End Chronic Homelessness. (Delaware Team Leader 2003-Present)
Delaware Homeless Planning Council Board of Directors (Vice President 1999-2003; President 2003-2004; 2005-2007)
Delaware Association of Rehabilitation Facilities (Vice President 2000-2003; President 2003-2007; Past President 2007-2009)
Delaware Governor's Advisory Council on Alcoholism, Drug Abuse and Mental Health (1985-Present)
Delaware Mental Health Counselors Association (President 1988-90).

AWARDS

- **City of Wilmington Award**. 2007
- **Bank of America Neighborhood Builder Award**. 2006
- **Lilly Reintegration Awards: First Place for Housing**. 2006
- **Kelley/Pazzaglini Memorial Award**. 2004
- **National Association of Case Management XCEL Award: National Case Management Organization of the Year.** 2002
- **Alliance for the Mentally Ill in Delaware Provider Excellence Award** 1990 and 2002
- **Delaware Psychological Association Psychologically Healthy Workplace Award.** 2002
- **Service Provider of the Year**. Delaware Governor's Committee on Employment of People with Disabilities. 2000 and 2002
- **Agenda for Delaware Women 18th Annual Trailblazer Award** honoring a professional woman in Delaware who has enhanced the visibility and status of Delaware women. 1999
- **Mayor of Wilmington's Agency Excellence Award**. 1992
- **American Psychiatric Association: Warren Williams Speaker's Award for Area III**. 1990

Frederick Rotgers, Psy.D., A.B.P.P.

EDUCATION:	1983	Psy.D.	Rutgers University Clinical Psychology
	1969-1972		Vanderbilt University 74 Graduate Credits in Clinical Psychology (Master's Equivalent)
	1969	B.A.	Rutgers University Psychology
INTERNSHIP:	1972-1973		NJ Department of Human Services
POSTDOCTORAL TRAINING:	January, 1984- December, 1985		Carrier Foundation Belle Mead, NJ Postdoctoral Resident in Neuropsychological Assessment

LICENSES :
Licensed Psychologist in the State of New Jersey, License Number SI 01969

CERTIFICATIONS:
American Board of Professional Psychology Diplomate in Clinical Psychology No. 5585
American Board of Professional Psychology Diplomate in Cognitive and Behavioral Psychology No. 5880
National Register of Health Service Providers in Psychology, No. 40658
Association of State and Provincial Psychology Boards Certificate of Professional Qualification, No 3457

HONORS:
President, Society of Addiction Psychology (Division 50 of the American Psychological Association), 2010-2011
Fellow of the American Psychological Association,Division 12 (Society of Clinical Psychology), Division 50 (Addictions)
Who's Who in America 2005

PROFESSIONAL POSITIONS:

July, 2011-Present	Rutgers Psychological Clinic Program for Addictions Consultation and Treatment Director
January, 2011-Present	Independent Practice of Psychology
July, 2008-December, 2010	Walden University Program Director, Clinical Psychology PhD
April, 2002-July 2008	Philadelphia College of Osteopathic Medicine Associate Professor of Psychology and Internship Coordinator Tenured Position
June, 2001-Present	Independent Practice of Psychology and Co-Director, T.A.P.E.R.™ Project
September, 2001-January 2003	Capella University Adjunct Instructor in Psychology
August, 2001-March 2002	John Jay College of Criminal Justice Adjunct Instructor in Psychology

August, 1999-July, 2001	Smithers Treatment Center St. Lukes-Roosevelt Hospital Assistant Chief Psychologist
June, 1997-December, 1999	Walden University Adjunct Faculty in Human Services
January, 1996-June, 1999	Program for Addictions Consultation and Treatment (PACT) of the Rutgers Center of Alcohol Studies
January 1995-September, 1997	Director Center of Alcohol Studies Consultation and Treatment Service Center of Alcohol Studies Rutgers University
April, 1991-May 1995	Princeton Evaluation and Treatment Service (PETS) Partner
November, 1990-June, 1999	Center of Alcohol Studies (Joint Appointment at the Graduate School of Applied and Professional Psychology) Rutgers University Assistant Research Professor
February, 1990-July, 2001	Center of Alcohol Studies Rutgers University Summer School of Alcohol Studies Instructor
March, 1989-December, 1995	Center of Alcohol Studies Rutgers University Program for Addictions Consultation and Treatment (PACT) Director of Evaluation Services
October, 1987-August, 1998	Center of Alcohol Studies Rutgers University NJ Dental Association Chemical Dependency Program Staff Clinician
September, 1990-April, 1991	St. Lawrence Rehabilitation Center Consulting Neuropsychologist
June, 1989-October, 1990	Center of Alcohol Studies Rutgers University Visiting Professor
September, 1986-November, 1990	Rutgers University Graduate School of Applied and Professional Psychology Contributing Faculty
January, 1985-April, 1991	Carrier Foundation Consulting Psychologist

February, 1983-Sept. 1987	**NJ State Parole Board** **Chief, Mental Health and Community Resources**
January, 1979-September, 1986	Rutgers University Graduate School of Applied and Professional Psychology Practicum Supervisor
May, 1977-January, 1984	**Rahway State Prison** **Director of Psychology**
June, 1977-August, 1981	Adult Diagnostic and Treatment Center Psychology Consultant
September, 1973-May, 1977	**Trenton State Prison** **Director of Psychology**
September, 1973-August, 1984	Trenton State College Adjunct Instructor in Psychology

PUBLICATIONS:

Books, Book Chapters, Monographs, Online Publications:

Rotgers, F. (2011, in Press). Negative reactions to substance using clients: Where they come from, what they are, and what to do about them. In A.W. Wolf, M.R. Goldfried & J.C. Muran (Eds.). Managing Negative Reactions to Clients: From Frustration to Compassion. New York: Guilford.

Rotgers, F. (2011, In Press). Cognitive theories of substance abuse. In Walters, S.T. & Rotgers, F. (Eds.). Treating Substance Abuse: Theory and Technique (3rd Ed.). New York: Guilford.

Walters, S.T. & Rotgers, F. (2011, In Press). Treating Substance Abuse: Theory and Technique (3rd Ed.). New York: Guilford.

Rotgers, F. (2009). Client-treatment matching. In G. Fisher & N. Roget (Eds.). Encyclopedia of Substance Abuse Prevention, Treatment and Recovery. Thousand Oaks: Sage Publications.

Rotgers, F. (2009). Inventory of Drinking Situations. In G. Fisher & N. Roget (Eds.). Encyclopedia of Substance Abuse Prevention, Treatment and Recovery. Thousand Oaks: Sage Publications.

Rotgers, F. (2009). Social skills training. In G. Fisher & N. Roget (Eds.). Encyclopedia of Substance Abuse Prevention, Treatment and Recovery. Thousand Oaks: Sage Publications.

Rotgers, F. (2009). Moderation Management. In G. Fisher & N. Roget (Eds.). Encyclopedia of Substance Abuse Prevention, Treatment and Recovery. Thousand Oaks: Sage Publications.

Rotgers, F. (2009). Moderation training to alcohol problems. In G. Fisher & N. Roget (Eds.). Encyclopedia of Substance Abuse Prevention, Treatment and Recovery. Thousand Oaks: Sage Publications.

Rotgers, F. (2007). Motivational interviewing in clinical settings. Available from HealthForumOnline at http://www.healthforumonline.com/Our_Courses/.

Rotgers, F. & Maniacci, M. (2007). Die antisoziale personlichkeitsstorung: Therapien im vergleich: Ein Praxisfuhrer. Bern: Hofgrefe Huber. (German Translation of Rotgers & Maniacci, 2005).

Rotgers, F. & Nguyen, T. (2006). Group Cognitive Behavior Therapy for Alcohol Problems. In P. Bieling (Ed.). Group Cognitive Behavior Therapy, New York: Guilford Publications.

Rotgers, F. & Davis, B. A. (2006). Treating Alcohol Problems. New York: Wiley.

Rotgers, F. & Maniacci, M. (Eds.) (2005). Comparative Treatments for Antisocial Personality Disorder.New York: Springer.

Rotgers, F. & Sharp, L. (2005). Enhancing Behavior Change and Maintenance in the Treatment of Alcohol Problems. In M.M Antony, D.R. Ledley, & R.G. Heimberg (Eds.) Improving outcomes and preventing relapse in cognitive behavior therapy. New York: Guilford Publications.

Rotgers, F. (2005). Relapse Prevention. In A. Freeman (Editor-in-Chief). Encyclopedia of Cognitive Behavior Therapy. New York: Kluwer.

Rotgers. F. (2005). Motivational Interviewing: Promoting Change. In A. Freeman (Editor-in-Chief). Encyclopedia of Cognitive Behavior Therapy. New York: Kluwer.

Rotgers, F. & Christner, R.W. (2005). Cognitive Behavioral Treatment for Non-Substance Addictive Behavior. In A. Freeman (Editor-in-Chief). Encyclopedia of Cognitive Behavior Therapy. New York: Kluwer.

Rotgers, F. & Davis, B.A. (2005). Cognitive Behavior Therapy for Substance Abuse. In A. Freeman (Editor-in-Chief). Encyclopedia of Cognitive Behavior Therapy. New York: Kluwer.

Rotgers, F., Morgenstern, J., & Walters, S. (2003). Treating Substance Abuse: Theory and Technique, 2nd Edition. New York: Guilford.

Rotgers, F. (2003). Cognitive Behavioral Theories of Substance Abuse. In F. Rotgers, J. Morgenstern, S.T. Walters, Eds. Treating Substance Abuse: Theory and Technique, 2nd Edition. New York: Guilford

Rotgers, F. (2003). Behavior Modification Therapies. Encyclopedia of Bioethics, 3rd Edition. New York: MacMillan.

Rotgers, F. (2003). Moderate Drinking Training for Problem Drinkers. In W. O'Donohue, J.E. Fisher, & S.C. Hayes (Eds.) Cognitive Behavior Therapy: Applying Empirically Supported Techniques in Your Practice. New York: John Wiley & Sons.

Rotgers, F., Kern, M.F. & Hoeltzel, R. (2002). Responsible Drinking: A MODERATION MANAGEMENT Approach for Problem Drinkers. Oakland: New Harbinger Publications.

Ginsburg, J.I.D., Mann, R.E., Rotgers, F, & Weekes, J.R. (2002). Motivational Interviewing with Criminal Justice Populations. In W.R. Miller & S. Rollnick, Motivational Interviewing, 2nd Edition: Preparing People for Change. New York: Guilford.

Dayton, G. & Rotgers, F. (2002). What if the Client Says "No" to Abstinence?: A Harm Reduction Approach to Treating an Individual with Comorbid Alcohol and Anxiety Disorders. In A. Tatarsky (Ed.) The Practice of Harm Reduction Psychotherapy. New York: Jason Aronson.

Rotgers, F. & Graves, G. (2000). Motivational Enhancement Treatment Therapist Manual. State of Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, Xice of Substance Abuse. Ottawa: Jamieson, Beals, Lalonde and Associates.

Rotgers, F. a kol. (1999) Lecba Drogovych Zavislosti. Praha: Grada Publishing. (Czech translation of Rotgers, Keller and Morgenstern, 1996, Treating Substance Abuse: Theory and Technique.)

Graves, G. & Rotgers, F. (1999). Guide to the Computerized Screening Assessment (CSA). Augusta, ME: State of Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, Xice of Substance Abuse.

Rotgers, F. & Graves, G. (1999) . Differential Substance Abuse Treatment (DSAT) Model. Bethesda: Center for Substance Abuse Treatment.

Rotgers, F. (1999). Client-driven , research-guided treatment for substance users: Bringing harm reduction to clinical practice. In E. T. Dowd & L. Rugle (Eds.) Comparative Treatments of Substance Abuse. New York: Springer.

Rotgers, F. (1998) Harm Reduction Programs. In Summary Report: 1998 Conference on the Management of Infectious Diseases in a Correctional Environment. Ottawa: Canadian Public Health Association.

Rotgers, F. (1998). The treatment of problem drinking using harm reduction techniques. In L. Vandecreek, S. Knapp, & T.L. Jackson (Eds.). Innovations in Clinical Practice: A Sourcebook, Vol. 16. Sarasota: Professional Resource Press.

Rotgers, F., Keller, D.S., & Morgenstern, J. (Eds.) (1996). Treating Substance Abuse: Theory and Technique. New York: Guilford Press.

Rotgers, F. (1996). Behavioral Theory of Substance Abuse Treatment: Bringing Science to Bear on Practice. In F. Rotgers, D. S. Keller & J. Morgenstern (Eds.) Treating Substance Abuse: Theory and Technique. New York: Guilford Press.

Rotgers, F. (1995). Alcoholism. Collier's Encyclopedia. New York: P.E. Collier, Inc.

Rotgers, F. & Franks, C.M. (1995). Behavior Modification Therapies. Encyclopedia of Bioethics, 2nd Edition. New York: MacMillan.

Rotgers, F. (1993). Early intervention with problem drinkers. New Jersey Alcohol/Drug Clearinghouse Fact Sheet.

Rotgers, F. (1992). Coercion and substance abuse treatment: Does what we know guide what we do? In P.E. Nathan, J.W. Langenbucher, B.S. McCrady, & W. Frankenstein (Eds.), Annual Review of Addictions Research and Treatment, Volume 2, 403-416.

Rotgers, F. (1988). Scientific psychology: A failed enterprise or merely in need of revitalization?: Implications of social learning theory and constructive empiricism for the broader field. Proceedings of the XXIV International Congress of Psychology, Sydney, Australia.

Rotgers, F. (1988). Social learning theory, philosophy of science and the identity of behavior therapy. In D.B. Fishman, F. Rotgers, & C.M. Franks (Eds.). Paradigms in behavior therapy: Present and promise. New York: Springer Publishing Co.

Fishman, D.B., Rotgers, F. & Franks, C.M. (Eds.), (1988). Paradigms in behavior therapy: Present and promise. New York: Springer Publishing Co.

Rotgers, F. (1988). Prison classification: A tool for rehabilitation or a response to public pressure? In D.R. Peterson & D.B. Fishman (Eds.). Assessment for decision-making. New Brunswick: Rutgers University Press.

American Association of Correctional Psychologists (Co-Author) (1980). Standards for psychological services to prisons and jails. Criminal Justice and Behavior, 7, 88-127.

Journal Articles:

Rotgers, F. (2008). Thinking and acting ethically, Part 2. *The Addiction Professional*, January/February.

Rotgers, F. (2007). Bioethics and addiction treatment, Part 1. *The Addiction Professional*, November, pp. 29-33.

Rotgers, F., Little, J., & Denning, P. (2005). Harm Reduction and Traditional Treatment: Shared Goals and Values *The Addiction Professional, 3.*

Rotgers, F. (2002). Clinically Useful, Research Validated Assessment of Persons with Alcohol Problems. Behaviour Research and Therapy, 40, 1425-1441.

Rotgers, F. & Kishline, A. (1999) Moderation Management ®: A support group for persons who want to reduce their drinking, but not necessarily abstain. International Journal of Self Help and Self Care, 1, 145-158.

Rotgers, F. (1998) . Beyond the war on drugs: Harm reduction in corrections. Corrections Today, 60, 110-113.

Rotgers, F. (1996). It's Time to Truly Broaden the Base of Treatment for Alcohol Problems: Empowering Clients with Respect to Drinking Goals as a First Step. The Counselor, 14 , 33-36.

Rotgers, F. & Barrett, D. (1996) *Daubert v. Merrell Dow* and Expert Testimony by Clinical Psychologists: Implications and Recommendations for Practice. Professional Psychology: Research and Practice, 27, 467-474.

Rotgers, F. (1996). Who should determine the goals of alcohol treatment? What the research says. The Addictions Newsletter, 3, 8-9.

Rotgers, F. (1994). Motivating Substance Dependent Patients for Change: New Thinking and Techniques. Carrier Letter No. 186.

Rotgers, F. & Morgenstern, J. (1992). What makes treatment work?: Views of a sample of NAADAC members. The Counselor, 10, 8-12.

Rotgers, F. (1991). Progress in patient treatment matching. Science Matters.

Rotgers, F. (1990). Matching patients to alcoholism treatments: Current perspectives.
Carrier Foundation Letter, No. 156.

Rotgers, F. (1990). Social learning theory, constructive empiricism and behavior therapy: Some implications for scientific psychology. International Newsletter of Uninomic Psychology, 11.

Rotgers, F. (1989). Distressed psychologists: Are we helping others while neglecting our own? New Jersey Psychologist, 39, 16-18.

Rotgers, F. (1985). Relapse prevention: Strategies for maintaining behavior change. Carrier Foundation Letter, No. 108.

Rotgers, F. (1984). Psychologists and correctional administrators: An uneasy relationship. New Jersey Psychologist, 34, 7-8.

Book Reviews:

Rotgers, F. (2004). Behavioral Assessment: Has it Become Mainstream? Contemporary Psychology.

Rotgers, F. (2002). Review of F.M. Bishop, Managing Addictions: Cognitive, Emotive and Behavioral Techniques. Journal of Studies on Alcohol, 63, 776.

Rotgers, F. (2000). Review of F. J. Dyer. Psychological Consultation in Parental Rights Cases. Child and Family Behavior Therapy, 22, 55-59.

Rotgers, F. (2000) Can Humanitarianism and Pragmatism Guide Our Approach to Substance Users? Review of G. A. Marlatt (Ed.) Harm reduction: Pragmatic strategies for managing high-risk behaviors. Contemporary Psychology, 45, 469-471.

Rotgers, F. (1998) Review of P. Erickson, et al. (Eds.). Harm Reduction: A New Direction for Drug Policies and Programs, Journal of Studies on Alcohol. 59, 619-620.

Rotgers, F. (1997). Review of J.P. Allen & M. Columbus (Eds.). Assessing Alcohol Problems: A Guide for Clinicians and Researchers. Journal of Studies on Alcohol, 58, 106.

Rotgers, F. (1996). Forensic psychiatry meets Pulp Fiction. Review of R.I. Simon Bad Men do What Good Men Dream: A Forensic Psychiatrist Illuminates the Darker Side of Human Nature. Contemporary Psychology.

Rotgers, F. (1996) Review of M.B. Sobell & L.C. Sobell. Problem Drinkers: Guided Self-Change Treatment. Child and Family Behavior Therapy, 18.

Rotgers, F. (1996). Review of D. Cameron. Liberating Solutions to Alcohol Problems: Treating Problem Drinkers Without Saying No. Journal of Studies on Alcohol, 57, 459.

Rotgers, F. (1996). Review of R.K. Hester & W.R.Miller (Eds.) Handbook of Alcoholism Treatment Approaches, 2nd Edition. Journal of Studies on Alcohol, 57, 101-102.

Rotgers, F. (1995). Review of M. Galanter & H.D. Kleber (Eds.) Textbook of Substance Abuse Treatment. Journal of Studies on Alcohol, 56, 122-123.

Rotgers, F. (1994). Review of D. Barlow (Ed.) Clinical Handbook of Psychological Disorders, 2nd Edition, Child and Family Behavior Therapy, 16, 52-53.

Bennett, M. E. & Rotgers, F., (1994). Review of M. Galanter, Network Therapy for Alcohol and Drug Abuse: A New Approach in Practice., Journal of Studies on Alcohol., 55, 634-635.

Rotgers, F. (1994). Review of L. Lindstrom. Managing Alcoholism: Matching Clients to Treatments. Journal of Studies on Alcohol, 55, 509-510.

Rotgers, F. (1993). Review of J.H. Lowinson, P. Ruiz, R.B. Millman & J.G. Langrod (Eds.). Substance Abuse: A Comprehensive Textbook, 2nd Ed. Journal of Studies on Alcohol, 54, 635-636.

Rotgers, F. (1993). Review of W.R. Miller & S. Rollnick. Motivational Interviewing: Preparing People to Change Addictive Behavior. Journal of Studies on Alcohol, 54, 507.

Rotgers, F. (1993). Review of P. H. Wilson (Ed.) Principles and Practice of Relapse Prevention. Child and Family Behavior Therapy.

Rotgers, F. (1993). Review of K.J. Sher. Children of alcoholics: A critical appraisal of theory and research. Child and Family Behavior Therapy, 15, 68-71.

Rotgers, F. (1992). Review of P.R. Martin (Ed.). Handbook of behavior therapy and psychological science: An integrative approach. Child and Family Behavior Therapy, 14, 87-89.

Rotgers, F. (1992). Review of S. A. Doherty & C. R. Bennett (Eds.). Substance abuse in dentistry: A proviso for a drug-free profession. Journal of Studies on Alcohol, 53, 648-649.

Russell, C. & Rotgers, F. (1989). Review of D. Barlow & P. Czerny, Psychological treatment of panic. Child and Family Behavior Therapy, 11, 137-139.

Rotgers, F. (1988). Review of J. Stumpfhauzer,Helping delinquents change. Child and Family Behavior Therapy, 9.

Rotgers, F. (1986). Review of G.A. Marlatt & J. Gordon. Relapse prevention. Child and Family Behavior Therapy, 7, 65-66.

Franks, C.M. & Rotgers, F. (1984). Behavior therapy: Advancing or merely expanding? Contemporary Psychology, 29, 957-958.

Rotgers, F. (1983). Review of V.F. Guidano & G. Liotti. Cognitive processes and the emotional disorders. Child and Family Behavior Therapy, 5, 65-67.

Rotgers, F. & Franks, C.M. (1982). Review of G.R. Weekes & L. L'Abate. Paradoxical psychotherapy: Theory and practice with individuals couples and families. Child and Family Behavior Therapy, 4, 85-87.

PRESENTATIONS AND POSTERS:

Addressing Substance Use in General Practice: Tools for Practitioners. Continuing Education Workshop Presented as part of the Clinician's Corner series at the American Psychological Association, Washington, D.C, November 19, 2010.

Addressing Substance Use in General Practice: Tools for Practitioners. Continuing Education Workshop Presented at the American Psychological Association Annual Convention, San Diego, CA, August 8, 2010

Addressing Substance Use in General Practice: Tools for Practitioners. Continuing Education Workshop Presented at the American Psychological Association Annual Convention, Toronto, ON, August 6, 2009.

Integrating Harm Reduction and Traditional Substance Abuse Treatment, Grand Rounds, Princeton Medical Center, Princeton, NJ, September 22, 2008.

Half Day Workshop: Harm Reduction Therapy. (with Aaron Brinen, MA). Pennsylvania Psychological Association Convention, Harrisburg, PA, June 18, 2008

Paper: Bioethics of Harm Reduction Therapy. Presented as part of the Symposium Harm Reduction Therapy, 2007 International Drug Policy Reform Conference, New Orleans, LA, December 6, 2007.

Paper: Introduction to Harm Reduction Therapy. Presented as part of the Symposium Harm Reduction Therapy for Substance Users: An Emerging Evidence-Based Approach. 115th Annual Convention of the American Psychological Association, San Francisco, CA, August 17, 2007.

Paper: Bioethics of Harm Reduction Therapy. Presented as part of the Symposium Harm Reduction Therapy for Substance Users: An Emerging Evidence-Based Approach. 115th Annual Convention of the American Psychological Association, San Francisco, CA, August 17, 2007.

Invited Presentation: Bioethics and Harm Reduction for Substance Users. Institute of Health and Society, University of Newcastle Medical School, Newcastle, UK. June 27, 2007.

Invited Presentation: Harm Reduction Therapy for Substance Users: An Idea Whose Time Has Come.. PCOM Psychology Department Friday Lecture Series, Philadelphia, PA., November 19, 2006.

Invited Presentation: Ethics and Harm Reduction Therapy. 1st National Harm Reduction Therapy Conference, Seattle, WA, May 6, 2006.

Invited Presentation: Empirical Support for Harm Reduction Therapy. 1st National Harm Reduction Therapy Conference, Seattle, WA, May 6, 2006.

Paper: Moderation Training for Problem Drinkers. Presented as part of symposium Evidence Based Treatments for Addiction. 113th Annual Convention of the American Psychological Association, Washington, DC, August 19, 2005.

Invited Presentation: Moderation Training for Problem Drinkers: Prevention and Intervention. F. Rotgers. Hempfield Counseling Associates Conference on Building Communities. Harrisburg, PA, May 6, 2003.

Poster: Binge Drinking College Students: Acceptability of Screening and Group Interventions. J. Foote, C. Wilkens, P. Vavagiakis, F. Rotgers. Annual Convention of the American Psychological Association, Chicago, IL, August, 2002.

Paper: Clinically Useful Empirically Validated Assessment of Alcohol Problems. F. Rotgers Presented as part of the symposium Clinically Useful Assessment of Addictive Behaviors, 35th Annual Convention of the Association for Advancement of Behavior Therapy, Philadelphia, PA, November, 2001.

Paper: Research and Moderation Management. F. Rotgers. Presented as part of the symposium Moderation Management: A Harm Reduction Approach to Problem Drinking. 109th Annual Convention of the American Psychological Association, San Francisco, CA, August 24, 2001.

Paper: A Research Driven Treatment System for Substance Users in Prison: The Maine Differential Substance Abuse Treatment (DSAT) model. F. Rotgers, G. Graves, W. Jamieson & C. Mowatt. Conference on Encouraging Health Promotion for Drug Users Within the Criminal Justice System. Hamburg, Germany, November 24, 2000.

Paper: Bringing Stepped Care to Correctional Treatment: The Maine DSAT Model. F. Rotgers, G. Graves, W. Jamieson, C. Mowatt. 9th International Conference on Treatment of Addictive Behaviors; Cape Town, South Africa; Sept 24, 2000.

Poster: Application of Self-Determination Theory to the Development of a Group Motivational Intervention. J. Foote, F. Rotgers, A. Grand & N. Kosanke. 9th International Conference on Treatment of Addictive Behaviors; Cape Town, South Africa; September 22, 2000.

Invited Presentation: What to Do If the Client Doesn't Change: An Introduction to Motivational Counseling. New Jersey Association of Cognitive-behavioral Therapists, Kenilworth, NJ, June 11, 2000.

Colloquium Presentation: Understanding Motivation to Change Addictions: Application of Self-Determination Theory. Carlton University, Ottawa, Ontario, Canada. March 27, 2000.

Invited Presentation: A Cognitive-Behavioral Harm Reduction Approach to Addictions Treatment. New York State Psychological Association Addictions Division Conference: Addiction: Psyche and Soma. New School University, New York, NY, March 11, 2000.

Psychiatry Grand Rounds: Assessment and brief intervention with substance users: The PACT model.VA Medical Center, Brooklyn, NY, March 13, 1998.

Invited Presentation: What if the patient says "no" to abstinence? Harm reduction in working with IDUs .Correctional Services of Canada and Canadian Public Health Association, 1998 National Conference on the Management of Infectious Diseases in a Correctional Environment. Ottawa, Ontario, Canada, March 2, 1998.

Presentation: Research Supporting a Clinical Harm Reduction Approach. Harm Reduction in Clinical Practice: A New Paradigm for Working with People Who Use Substances. New York, NY, October 24, 1997

Invited Commentary: What Works in Substance Abuse Assessment. International Community Corrections Association 5th Annual Research Conference. Cleveland, OH, October 5-7, 1997.

Poster: Diagnostic Concordance of Six Tests of Executive Functions. M.E. Bates, E. Labouvie & F. Rotgers. Presented at the 104th Annual Meeting of the American Psychological Association, Toronto, Canada, August 10, 1996.

Keynote Address. Client Determined Drinking Goals: Putting the Client Back in Chargeof Alcohol Treatment. Rowan College Summer Institute on Alcohol and Other Drugs. Glassboro, NJ, August 5, 1996

Keynote Address: Drinking Goals in Treatment: Client Choice or Therapist Prescription?. Wisconsin Association on Alcohol and Other Drugs of Abuse 30th Annual Meeting. Milwaukee, WI, March 24, 1996.

Invited Presentation: Client-determined drinking goals: Broadening the Range of Alcohol Treatment. Annual Symposium of the American Academy of Psychologists Treating Addiction, Albuquerque, NM, October 28, 1995.

Poster: Non-Abstinence Drinking Goals in the United States: A Re-emergence from Under the Thrall of a 12 Step/Disease Model Dominated Treatment System. The Addictions Forum, Durham, England, September 21, 1995.

Invited Presentation: Assessment for Moderate Drinking Goals. Counseling Service E.D.N.Y., Brooklyn, NY, July 26, 1995.

Poster : Probability of Clinical Impairment Classification Across Neuropsychological Screening Tests. M.E. Bates, R.M. Hamer & F. Rotgers.Research Society on Alcoholism, Steamboat Springs, CO, June 19, 1995.

Invited Presentation: The Rutgers Alcohol Research Center: Combining Basic Science and Clinical Practice. Faculty Seminar Series, Department of Psychology, University of Glasgow, Glasgow, Scotland. November 25, 1994.

Poster: The Rutgers Alcohol Research Center: Combining Basic Science and Clinical Practice for the 1990s. B.S. McCrady, F. Rotgers, G.T. Wilson, H. Pettinati, T. Morgan, J. Langenbucher, E. Leventhal, J. Morgenstern, M.E. Bates, E. E.Epstein, L. Pople, E. LaBouvie, R. Hamer, & K. CyBulski. Association for Advancement of Behavior Therapy, San Diego, CA, November, 1994.

Poster: Treatment Expectancies and Consequences of Use: New Measures for the Substance Abuse Field. L.E. Pople, K.A. CyBulski, D.Epstein, F. Rotgers, B.S.McCrady, & J. Morgenstern. American Psychological Association, Los Angeles, CA, August, 1994.

Poster: Acute and Chronic Effects of Alcohol on Cognitive Control. M.E. Bates, F. Rotgers, L.E. Pople & J.L. Tracy. Research Society on Alcoholism, Maui, Hawaii, June, 1994

Poster: Measuring the Consequences of Alcohol and Drug Use: The Rutgers Consequences of Use Questionaire. (Presenter and Second Author with David Epstein, Helen Pettinati, Barbara McCrady, Jon Morgenstern & Elizabeth Epstein). Association for Advancement of Behavior Therapy, November 19, 1993.

Paper: Comorbid Psychopathology and the Neuropsychology of Alcoholism: Unresolved Issues and Suggestions. Presented as part of the workshop Unresolved Issues in the Neuropsychology of Alcoholism, Research Society on Alcoholism, San Antonio, TX. June 24,1993.

Poster: Curative Factors in Alcohol and Drug Treatment: A Survey of the Views of Treatment Providers. (Jon Morgenstern & Barbara S. McCrady co-authors).Sixth International Conference on Treatment of Addictive Behaviors, Santa Fe, NM, January 13,1993.

Paper: Doing what works: A proposal for a pragmatic philosophy for behavior therapy. Presented as part of the symposium Relativism in clinical science: Philosophical Issues. Association for Advancement of Behavior Therapy, Boston, MA, November 22, 1992.

Paper: Assessment of Cognitive Impairments in Substance Abusers. NIDA National Conference on Drug Abuse Research and Practice, Washington, DC, January 12-15, 1991.

Paper: The NJ Dental Association's Chemical Dependency Program: A social learning theory based approach to substance abuse programming for healthcare professionals. Tenth Annual Meeting of the Berkshire Association for Behavioral Analysis and Therapy, Amherst, MA, 1989.

Paper: Constructive empiricism, social learning theory and behavior therapy: Implications for psychology at large. Presented as part of the symposium Paradigms in behavior therapy: Implications for general psychology. American Psychological Association, New Orleans, LA, 1989.

Poster: Epistemological value systems of first year clinical Ph.D. and Psy.D. students.American Psychological Society, Alexandria, VA, 1989.

Paper: A social skills and anger management program for juvenile parolees. New Jersey Psychological Association, Morristown, NJ, 1987.

Paper: Coping with diversity in behavior therapy: Social learning theory and constructive empiricism as bridging approaches. Presented as part of the symposium Paradigms in behavior therapy: Trade-xs among diversity. Association for the Advancement of Behavior Therapy, Boston, MA, 1987.

SEMINARS AND WORKSHOPS:

Half Day Workshop: Moderation Training for Problem Drinkers. Foundation for Social Welfare Services, Luqa, Malta, November 30, 2007.

Half Day Workshop: Elephant in the Consulting Room: Addictions In General Psychological Practice. Wellspan Behavioral Health, Inc, York, PA., September 22, 2006.

Two Day Workshop: Cognitive Behavioral Treatments for Substance Users. Harm Reduction Therapy Center, San Francisco, CA, January 26-27, 2006.

Half Day Workshop: The Elephant in the Consulting Room: Addictions for General Practitioners. Pennsylvania Psychological Association Fall Conference, Exton, PA, October 27, 2005.

Four Day Workshop (with Greg Graves, M.A.): Motivational Interviewing and Motivational Enhancement Treatment. Ohio Drug and Alcohol Summer Institute, Bowling Green, OH, June 8-11, 2004.

One Day Workshop: The Differential Substance Abuse Treatment System (DSAT). Presented to the Dodge, Fillmore Olmstead County, Minnesota Community Services Department. Rochester, MN, May 17, 2004.

One Day Workshop: Moderation Training for Problem Drinkers. National Football League Substance Abuse Program Treating Clinicians Conference, Houston,Tx. September 20, 2003.

Three Day Workshop (with Donna Martin, Psy.D.): Introduction to Cognitive Behavioral Therapy. 32nd Summer Institute, Delaware Division of Mental Health and Substance Abuse, Newark, Delaware, July 28-30, 2003.

Five Day Workshop: Harm Reduction: The Cutting Edge Paradigm in Addiction Management. Philippines Center for Substance Abuse Management, Manila, Philippines, May 26-30, 2003.

Two Half-Day Workshops: Mindfulness in the Treatment of Substance Abuse. Middlesex County Chapter of the National Council on Alcoholism and Drug Dependence, East Brunswick, NJ, April 29 and 30, 2003.

One Day Workshop: Training for T.A.P.E.R. Clinicians. Rutgers Center for Applied Psychology, April 25, 2003 (With Raymond Hanbury, Ph.D.).

Three Day Workshop: Introduction to Motivational Interviewing for Mental Health Professionals. Diocese of Metuchen Catholic Charities and Middlesex County Chapter of the National Council on Alcoholism and Drug Dependence, Perth Amboy, NJ, September 18, 2002, October 16, 2002, November 20, 2002.

Five Day Workshop: Clinical Applications of Cognitive Behavior Therapy. Delaware Department of Mental Health and Substance Abuse, 31st Summer Institute, Newark, DE, July 22-26, 2002.

Half Day Workshop: Assessment and Treatment of Compulsive Gambling: Part 2: Assessment and Cognitive-Behavioral Treatment. Middlesex County Chapter of the National Council on Alcoholism and Drug Dependence, East Brunswick, NJ, February 28, 2002.

Half Day Workshop: Assessment and Treatment of Compulsive Gambling: Part 1: Theories and

Diagnosis. Middlesex County Chapter of the National Council on Alcoholism and Drug Dependence, East Brunswick, NJ, February 21, 2002.

One Day Workshop: Introduction to Addictions Counseling: Basic Principles of Psychopharmacology and Diagnosis. Middlesex County Chapter of the National Council on Alcoholism and Drug Dependence. Perth Amboy, NJ, February 20, 2002.

Half Day Workshop: Integrating Harm Reduction with Traditional Addictions Treatment. Southeastern Virginia Association of Alcohol and Drug Abuse Counselors Winter Conference, Virginia Beach, VA, January 21, 2002.

Two Day Workshop: Assessment and Treatment of Persons with Co-Occurring Disorders. Center for Addiction and Mental Health Summer Institute, Ottawa, Ontario, Canada, June 11-12, 2001.

Two Hour Workshop: Research Based Clinical Practice: Data Show Harm Reduction is a Good Idea! 3rd Annual Conference on Bridging the Gap in San Francisco: Harm Reduction, Research, Policy and Practice. San Francisco, CA, January 11-12, 2001.

One Day Workshop: Moderate Drinking Training: Why, For Whom, How?. North Carolina School of Alcohol and Drug Studies, Wilmington, NC, August 4, 1998.

One Day Workshop: Taking drug users seriously: An introduction to harm reduction. University of Medicine and Dentistry of New Jersey AIDS Education Center, March 31, 1998.

Half-day Workshop: Assessment and Brief Intervention with Substance Users. New Jersey Department of Human Services Psychology Staff. Princeton, NJ, February 11, 1998

Four Day Workshop: Substance Abuse: Concepts, Assessment, Treatment and Advocacy.Center for Alternative Sentencing and Employment Services, New York, NY. (With J. Morgenstern). March 10-14, 1997.

One Day Workshop. Motivational Interviewing. Center for Alternative Sentencing and Employment Services (CASES), New York, NY, January 16, 1997.

Two Hour Workshop. Controlled Drinking as Harm Reduction with Stanton Peele. Lindesmith Center, New York, NY, December 4, 1996.

Half Day Workshop. Moderate Drinking Goals: Who, When and How? Rowan College Summer Institute on Alcohol and Other Drugs. Glassboro, NJ, August 5, 1996

One Day Workshop. Client Determined Treatment Goals: A Clinical Harm Reduction Approach. SUNY-Buffalo Summer Institute for Alcohol and Other Drug Studies, Buffalo, NY, July 21, 1996.

Two Hour Workshop. Client Driven Treatment: Working Within a Harm Reduction Framework. Presented as part of Princeton House Education Seminar The Challenge of Brief Therapy within a Managed Behavioral Healthcare Model. Princeton, NJ. June 14, 1996.

One Day Workshop. Motivational Interventions and Client-Driven Treatment: A Harm Reduction Approach. Virginia Association of Drug and Alcohol Programs 21st Annual Training Institute, Williamsburg, VA, June 6, 1996.

One Day Workshop (with Stanton Peele) Moderate Drinking: Wishful Thinking? Union County Chapter of the National Council on Alcoholism and Drug Dependence, Cranford, NJ, April 19, 1996.

Four Day Workshop: Substance Abuse: Concepts, Assessment, Treatment and Advocacy.Center for Alternative Sentencing and Employment Services, New York, NY. (With J. Morgenstern). February 5-9, 1996.

One Day Workshop: Assessment and Brief Intervention with Problem Drinkers. Center of Alcohol Studies Continuing Education Seminars. January 25, 1996.

Two Day Workshop: Assessment and Motivational Intervention with Substance Abusers .First Options/Mental Health Network Providers Seminar, CentraState Hospital, Freehold, NJ, December 6-7, 1995.

Half-Day Seminar: Motivational Interviewing. Center for Alternative Sentencing and Employment Services (CASES), New York, NY, December 5, 1995.

One Day Workshop: Assessment and Brief Motivational Interviewing with Substance Abusers. Veteran's Administration Medical Center, Lyons, NJ, September 15, 1995.

Two Day Workshop: Assessment and Brief Motivational Intervention for Problem Drinkers. New Jersey Department of Human Services, Division of Mental Health, Psychology Staff Training Program, Lawrenceville, NJ, June 19-20, 1995.

Workshop: Psychological Aspects of Addiction. New Jersey Department of Human Services, Princeton, NJ. April 26, 1995.

Four Day Workshop: Substance Abuse: Concepts, Assessment, Treatment and Advocacy Center for Alternative Sentencing and Employment Services, New York, NY. (With J. Morgenstern). February 14-17, 1995.

Workshop: Motivational Interviewing. Center for Alternative Sentencing and Employment Services, New York, NY. December 6, 1994.

One Day Workshop: Before Dependency: Early Identification and Brief Intervention with Non-Dependent Problem Drinkers. Center of Alcohol Studies Continuing Education Seminars. April 6, 1994.

One Day Workshop: Before Dependency: Early Identification and Brief Intervention with Non-Dependent Problem Drinkers. Center of Alcohol Studies Continuing Education Seminars. November 11, 1993.

Half Day Workshop on New Approaches to Treatment of Psychoactive Substance Use Disorders: Motivational Techniques. Presented as part of the course Psychoactive Substance Use Disorders: Current Controversies and Directions sponsored by the New Jersey Academy of Psychology and Rutgers Center of Alcohol Studies, October 22, 1993.

Half Day Workshop on Diagnosis and Etiology: Current Controversies. Presented as part of the course Psychoactive Substance Use Disorders: Current Controversies and Directions sponsored by the New Jersey Academy of Psychology and Rutgers Center of Alcohol Studies, October 1, 1993.

Two One-hour Lectures: Monitoring Recovery, American Dental Association's Fifth National Conference on Chemical Dependency and Well Being Issues, Chicago, IL, July 14-15, 1993.

One Day Workshop: Before Dependency: Brief Interventions with Problem Drinkers. National Council on Alcoholism Union County Summer School, Cranford, NJ, July 13, 1993.

Three Day Workshop: Substance Abuse: Concepts, Assessment,and Treatment. New York City Department of Corrections Training Academy and CASES, Queens, NY, (with J. Morgenstern), June 14-16, 1993

One Day Workshop: Assessment of Substance Abusing Patients: Planning Effective Treatments. New Jersey Academy of Psychology, Edison, NJ, April 2, 1993.

Four Day Workshop: Substance Abuse: Concepts, Assessment, Treatment and Advocacy Center for Alternative Sentencing and Employment Services, New York, NY. (With J. Morgenstern). January 19-22, 1993.

One Day Seminar: Screening and Assessment of Alcohol and Drug Abusers for Treatment Planning. Center of Alcohol Studies Continuing Education Seminars, November 19, 1992

Half Day Workshop: Alcohol, Drugs and Crime. Presented as part of the New Jersey Alcohol and Drug Resource Center and Clearinghouse Public Lecture Series, Rutgers University, October 23, 1992.

Three One-Day Workshops: The Decision to Refer Adolscents for Substance Abuse Treatment. Drug Free Schools and Community Counselor Training Project of the Division of Education and Training, Rutgers University, Center of Alcohol Studies, May, 1992.

Three Day Training Course: Substance Abuse Assessment and Matching Treatment Needs to Program Services. Center for Alternative Sentencing and Employment Services, New York, NY. (With J. Morgenstern). March-April, 1992.

One Day Seminar: Screening and Assessment of Alcohol and Drug Abusers for Treatment Planning. Center of Alcohol Studies Continuing Education Seminars, February 13,1992.

One Week Training Course: Substance Abuse: Concepts, Assessment, Treatment and Advocacy. Center for Alternative Sentencing and Employment Services, New York, NY. (With J. Morgenstern). August, 1991.

One Day Workshop: Matching Patients to Substance Abuse Treatments. Union County, NJ Council on Alcohol and Drug Abuse Summer Seminar, July 8, 1991.

CONSULTING:
State of Arkansas Employee Assistance Program, Little Rock, AR
Center for Alternative Sentencing and Employment Services (CASES), New York, NY.
AT&T Employee Assistance Program: Clinician Member Quality Improvement Committee
Cosmair Cosmetics, Inc., North Brunswick, NJ
Volunteers of America, Delaware Valley, Collingswood, NJ
Correctional Service of Canada, Ottawa, Canada
Addiction Research Foundation, Toronto, Canada, External Grant Reviewer
The CDM Group, Inc. and Center for Substance Abuse Treatment: Treatment Improvement Protocol Consensus Panel Member and Facilitator
State of Maine Xice of Substance Abuse and CSAT: Project to design a Differentiated Treatment System for Maine Department of Adult Corrections
Jamieson, Beals, Lalonde and Associates, Ottawa, Canada. Associate
Jamieson, Hart, Graves Consulting, Ottawa, Canada. Associate
National Research and Development Institute (NDRI), New York, NY
Deltametrics, Philadelphia, PA
Philippine Center for Substance Abuse Management (PCSAM), Manila, Philippines.
Dodge, Fillmore and Olmsted Counties Community Corrections, Rochester, MN
Substance Abuse and Mental Health Services Administration (SAMHSA), Bethesda, MD, Grant Reviewer.
Connections CSP, Wilmington, DE
Brandywine Counseling, Wilmington, DE

MEDIA APPEARANCES:

Radio:
Voices in the Family (National Public Radio): "Can People with Alcohol Problems Learn to Moderate?"
WCTC Radio: Liz Maita Show "Alcohol Awareness"
Mental Health Matters, WHWH Princeton "Moderate Drinking for Problem Drinkers"
Mental Health Matters, WHWH Princeton "Alternatives to 12-step Support Groups for Substance Abusers"

Mental Health Matters, WHWH Princeton "How People Change"

Television:

Court TV: "The Abuse Excuse"
ABC News-Good Morning America: "Moderate Drinking"
New Jersey Network- New Jersey Live: "Moderate Drinking"
NewsTalk TV: "Binge Drinking by College Students"
Oprah Winfrey: "Can Alcoholics Learn to Moderate Their Drinking?"
Good Day New York: "Can Problem Drinkers Learn to Drink Moderately?"
Pulse-CFCF Montreal: "Harm Reduction and Moderate Drinking"
WPIX TV Channel 11: "Can Problem Drinkers Learn to Moderate?"
WNET Channel 13: Within Reach: Follow-up to Moyers on Addiction
ABC News: World News Now: "Responsible Drinking"
WWOR Channel 9: Garden State Matters "The T.A.P.E.R.™ Project"
WPVI, Channel 6, Philadelphia: "Harm reduction therapy."

EDITORIAL ACTIVITIES:

Addiction Research and Theory, American Editor in Chief
Journal of Drug Issues, Editorial Board Member (1999-2008).
Journal of Studies on Alcohol, Editorial Board Member (1992-1999) and Book Review Editor (1992-1999).
Journal of Consulting and Clinical Psychology. Editorial Reviewer.
Behavior Therapy. Editorial Reviewer.
Criminal Justice and Behavior. Editorial Reviewer.
American Psychologist. Editorial Reviewer.
Child and Family Behavior Therapy. Editorial Reviewer.
International Journal of Drug Policy. Editorial Reviewer.

PROFESSIONAL MEMBERSHIPS:
American Psychological Association
Association for Behavioral and Cognitive Therapies
New Jersey Psychological Association

COMMITTEE MEMBERSHIPS:
Governor's Task Force on Developmentally Disabled Juvenile Offenders-New Jersey
National Institute on Drug Abuse (NIDA) Planning Committee for the NIDA National Conference on Drug Abuse Research and Practice.
Steering Committee of the Addictive Behaviors Special Interest Group of the Association for the Advancement of Behavior Therapy.
Research Review Committee of Carrier Foundation
Ad Hoc Committee on Establishment of an AABT Registry, Chair
AABT Committee on Clinical Directory and Referral Issues, Chair, 1997-2000
AABT/ABCT Program Committee, 2004-2006
Division 50, American Psychological Association, ABPP Credentialing Committee
Division 50, American Psychological Associations, Elections Xicer, 1999-2001
Board of Directors, Moderation Management, Inc., Member 1998-Present, Chairman, 2000-2003.
Board of Directors and Research Advisory Board, Harm Reduction Therapy Center, San Francisco, CA, 2001-2007.
Philadelphia College of Osteopathic Medicine, Institutional Review Board. Member 2003- 2008.
American Psychological Association Practice Directorate Committee for the Advancement of Professional Practice (CAPP): Division 50 Liaison, 2004-2009.
American Psychological Association Committee for the Advancement of Professional Practice, Integration Group (CAPP-IG), Chair, 2007-2009.

1st National Harm Reduction Therapy Conference Planning Committee.
2nd National Harm Reduction Therapy Conference Planning Committee and Conference Coordinator

RESEARCH GRANTS:
New Jersey Psychological Association Research Grant, 1987, Anger Management for Juvenile Offenders. $500.00. Principal Investigator.
New Jersey Higher Education Consortium, 1995, Screening and Brief Intervention for High-Risk Student Drinkers.$7960.00. Principal Investigator.
Substance Abuse and Mental Health Services Administration (SAMHSA) Grant # 7 KD1 TI10355-01, Group Motivational Interventions for College Binge Drinking. $1.3 Million. Co-Investigator. (Jeffrey Foote, Ph.D., Principal Investigator.)

FORENSIC ACTIVITIES:
Qualified in Superior Court of New Jersey and Supreme Court of New York State as expert witness in neuropsychology; diagnosis, course and outcome of alcoholism; alcoholism and substance abuse treatments; behavioral, cognitive and emotional effects of alcohol; and forensic psychology. Have testified for both prosecution/plaintiff and defense in a variety of criminal and civil matters.

CURRICULUM VITAE

James G. O'Quinn, D.Min., CSOTP
MHM-Services, Inc.
Delaware Regional Office
300 West Water Street
Dover, Delaware 19904

Personal cell phone: (804) 467-9543
Personal email: oquinnjim@gmail.com

EDUCATIONAL BACKGROUND

1994 Doctor of Ministry (D.Min.)
United Theological Seminary in Dayton, Ohio
Researched areas of Domestic Violence, Clergy Sexual Misconduct.
Dissertation title: Beyond Tactics of Power and Control: Power Sharing in Churches.

1981 Master of Divinity (M.Div.)
Candler School of Theology, Emory University in Atlanta, Georgia
Course work in areas of Pastoral Counseling, Theology, and Christian Education.
Thesis title: On Being Alone: Existentialism and Pastoral Ministry

1978 Bachelor of Arts (B.A.)
Birmingham-Southern College, Birmingham, Alabama

PROFESSIONAL TRAINING (selected)

Certified Sex Offender Treatment Provider (CSOTP # 0812-000102)
Department of Health Professions, Board of Psychology, Commonwealth of Virginia

- Abel Assessment for Sexual Interest (AASI-2)
- Assessing and Treating Personality Disorders (Certificate)
- Persona lity Assessment with the MMPI-2 (Certificate)
- Sex Offender Re-Offense Risk Prediction (ASSECT Certificate)
- Assessing Individuals Charged with Sexual Crimes (ILPPP Certificate)
- Risk Assessment of Sexually Violent Predators: Dynamic Risk Factors in Sexual Offender and Sexually Violent Predator Risk Assessment (ILPPP Certificate)
- Sex Offender Evaluation and Treatment Training. (ASSECT Certificate)
- Testing and Clinical Evaluation of Psychopathy using the PCL-R (Certificate)

Certified Domestic Violence Counselor (Level IV Certificate)

- Diplomate - National Board of Forensic Counselors (Certificate)
- Working with Men who Batter. (Certificate)
  Domestic Abuse Intervention Project, Duluth, Minnesota
- Conflict Meditation and Intervention Procedures. (Certificate)

Pastoral Counselor appointed by the Virginia Conference, The United Methodist Church

- Endorsed by United Methodist Endorsing Agency, General Board of Higher Education and Ministry
- The Diana Screen (designed for measuring sexual interest in clergy)
- Working with Perpetrators of Clergy Sexual Misconduct. (Certificate)

PROFESSIONAL EXPERIENCE

MHM-Services, Inc. Delaware Special Treatment Program (Lead Counselor)
November 2011 - Present

Lifeline Counseling Associates, Inc.
April 1999 – January 1, 2012

United Methodist Minister in the Virginia Conference
June 1982 - Present

Case Manager, Chesterfield County Community Corrections and Pre-Trial Services
December 1996 – September 1999

United Methodist Minister in the North Alabama Conference
June 1976 - June 1982

REFERENCES AVAILABLE UPON REQUEST

Appendix B
Evaluation Tools

Proposal for DSATweb Implementation and Support

Submitted to

Cathy McKay
President
Connections Community Support Programs, Inc.
500 w. 10th Street
Wilmington, Delaware 19801

Submitted by

Richard Bell
Linda Frazier
Third Stage Software
20 Belmont Place
Melrose, MA 02176

April 24, 2012

Table of Contents

Executive Summary 1
DSATweb Introduction 2
Project Objective 3
Project Goals 3
Project Scope 3
Detailed Work Plan 4
Phase 1: Discovery 4
Phase 2: Configuration & Deployment 4
Phase 3: Training 5
Phase 4: Analysis & Reporting 6
Analyze Data 6
Publish Analysis Report 7
Phase 5: Support & Maintenance 7
Subject Matter Expertise 7
Web User Support and System Administration 8
Project Assumptions 9
Project Agreement 10
Clinical Assessments 10
Change Notice 10
Project Qualifications 12
Project Management 14
Appendix 15
Outline of DSAT Measures/Assessment Instruments: 15

Executive Summary

Connections Community Support Programs, Inc (Connections, Inc) has requested consulting services to adapt DSATweb to their use as they plan to expand services in the context of Criminal Justice and substance abuse treatment. In response, Linda J. Frazier, RN, MA, MCHES, Senior Partner at Public Health Connections, and Rick Bell, President of Third Stage Software (Third Stage), have come together to provide a solution for Connections.

Specifically, Connections Inc. has requested consultation and implementation, and associated web system support for access to the Differential Substance Abuse Treatment (DSAT) Community curriculum and DSATweb services. The DSAT Program includes gender specific motivational and cognitive behavioral treatment manuals to support delivery of evidence based, substance use dependency treatment for criminal justice involved clients. DSAT is an intensive, phased program that includes screening, assessment, pre-treatment, intensive treatment, and maintenance curriculum for both men and women. The DSAT Program integrates a series of screening , pre-, mid-, and post- treatment program measures and psychometric instruments that are intended to serve as both tools for ongoing assessment and treatment planning for clients; as well as measures for outcome evaluation and research on the DSAT Treatment Program. All DSAT Program measures are captured and reported in the web-based DSATweb system.

Third Stage has provided DSAT support services to the State of Maine, Office of Substance Abuse, since 2000. As the primary support for DSAT Program screening and DSATweb program support, Third Stage has been given access to all components of the DSAT Program policies, procedures and treatment manuals, and permission to make these available to all users of the DSATweb System.

This project is defined in five phases, the first being discovery followed by system configuration and deployment, training, data validation reporting, and ongoing DSAT/DSATweb support/maintenance. A thorough description of each phase of the project is provided as part of this proposal. Project fees and expenses are summarized below by phase. Expenses in this proposal refer to airfare, ground transport, and lodging expenses related to on-site consulting by Mr. Bell or Ms. Frazier. Conference calls and webinars related to this DSATweb proposal will be hosted by Third Stage.

Total Project cost: $207,200, plus expenses

DSATweb Introduction

The Maine DSAT Program is a manual-driven, evidence-based motivational and cognitive behavioral treatment curriculum developed for criminal justice involved clients. DSAT was designed to integrate client assessment and outcome measures throughout all phases of the treatment curriculum.

DSATweb is a website providing comprehensive data gathering and reporting tools to complement the DSAT methodology for substance abuse treatment. The website was developed by Rick Bell of Third Stage Software to support the DSAT program directed, at the time, by Linda Frazier of Maine Office of Substance Abuse.

The DSATweb program delivers DSAT content over the web streamlining the various DSAT paper records. DSATweb provides information management for the DSAT program increasing staff efficiency and effective information gathering and dissemination. Client progress measures are consolidated and stored in DSATweb, and individual client progress summary reports are generated. Quarterly and annual analysis of system usage and aggregate client DSAT data provide for ongoing monitoring of program implementation, progress and outcome evaluation. As a repository for client treatment data, DSATweb support allows for development of regular reports, annual validation analysis, and data access for additional research and evaluation.

All of the DSAT program measures administered during the Community DSAT Program are used to match clients to the appropriate level of DSAT services, and serve as both tools for the ongoing assessment and treatment planning process for clients; as well as measures for outcome evaluation and research on the DSAT treatment model. Each individual client's score on each DSAT Program Measure are securely maintained within the DSATweb program.

DSATweb is designed and built applying best practices in software and database development technology, using widely-accepted, industry standard tools from Microsoft. It meets industry standards as a web-based, password-protected system that uses 256-bit SSL encryption to secure all data communications and user activities. User accounts are only assigned after vetting from an administrator working for the client. Security management also includes auto-expiring passwords, procedures for handling forgotten passwords using challenge questions to assist help desk to validate identity, audit logging for monitoring user activity, and role- and permission-based limits to data access.

An outline of the screening, assessment, pre-treatment, intensive treatment, post-treatment, and maintenance measures, followed by an overview summary of process and outcome evaluation results for the Maine DSAT Program is provided in the appendix ,

Project Objective

Third Stage Software (TSS) will deliver the *Services* of providing DSATweb configuration, implementation, and post-implementation support and DSATweb user training to assist Connections Community Support Programs, Inc in implementing a DSAT program.

Project Goals

The project will accomplish the following goals:

1. Conduct discovery work to identify data required by the Connections treatment program;
2. Customize DSATweb to capture data identified during discovery work;
3. Deliver orientation and training to DSATweb users;
4. Conduct a validation study on preliminary data gathered by DSATweb;
5. Deliver a report on findings of validation study; and
6. Deliver post-implementation help desk, data reporting and system support.

Project Scope

In delivering the services of this project, we have identified a sequence of phases through which to progress. The phases closely match our project goals stated above:

#	Phase	Deliverable(s)
1	**Discovery**	Requirements documentation
2	**Configuration & Deployment**	Customized DSATweb web system established in our server environment and available for use by Connections.
3	**Training**	Training materials
4	**Analysis & Reporting**	Data analysis report
5	**Support & Maintenance**	Periodic utilization reports, subsequent data analyses

Detailed Work Plan

The work and deliverables for each phase are described as follows.

Phase 1: Discovery

DSATweb is a complete software system for capturing DSAT program data; however, Connections may have additional elements they wish to capture. An example is the ASI scores discussed during the initial conference call about the project on April 20, 2012.

During the Discovery Phase, our team will work with Connections staff to review all data existing in the DSATweb system and to identify any data to be added to the system.

The work of Discovery will occur through a series of on-site visits and phone calls between Connections staff and Ms. Frazier and Mr. Bell.

At minimum, we will conduct a presentation meeting where DSATweb will be demonstrated and its RNI report will be analyzed with the goal of generating discussion about what data needs to be added to fulfill Connections' needs.

Also, we will discuss with Connections staff two new features to be added to DSATweb: (1) Curriculum, for accessing the DSAT curriculum on-line, and (2) Treatment, for keeping track of treatment sessions attended by each client who undergoes treatment.

The information gathered at the meeting will be assembled into a plan for use in Phase 2 (Configuration & Deployment). Then, a sign-off process will be initiated whereby Connections management confirms the plan is correct before we continue to Phase 2.

We feel DSATweb is a complete tool and we would discourage efforts to reduce its functionality during the discovery-configuration cycle. We can discuss changing labels to better fit requirements, but we do not recommend removing any existing elements from DSATweb in its current configuration.

Deliverable: Requirements Document(s)

Discovery Service On-site Fees: $2,400, plus expenses for two persons (accounting for one day)

Discovery Service Documentation Fee: $5,000

Phase 2: Configuration & Deployment

Upon completion and sign-off of the Discovery phase, we will configure DSATweb appropriately per the requirements document(s) generated from Phase 1.

We will do the programming work on all DSATweb elements affected by the configuration requirements set out in the deliverable(s) of Phase 1:

- Web pages
- Data entry sections
- Output reports
- System database objects

When the programming work is completed, the customized DSATweb will be deployed to our server environment and be made available for web users.

Configuration & Deployment Services Fee: $80,000

Phase 3: Training

Upon completion of the Configuration phase, we will schedule with Connections to conduct training of their staff.

We will conduct comprehensive DSATweb Classroom Training of treatment providers who will use the DSATweb in the field. Other individuals may attend at Connections' discretion.

We will provide training materials (hand-outs) and perform a product demonstration of DSATweb for the class. Time will be allowed for questions and discussion. Linda Frazier and Rick Bell will go on-site to conduct the training.

The training will cover the following topics:

- Introduction and Orientation to the DSAT system
- The importance of the DSATweb in the DSAT system
- Tutorial on DSATweb screening and administration

We will provide training materials tailored for use at Connections.

Our current projections indicate two days of training is likely necessary to train Connections staff.

We expect to conduct DSATweb training to support staff in one-half day.

The second half of the day will be used assisting users to practice with DSATweb in a controlled environment. The trainers will be present to provide support and answer questions during this time.

Connections will provide a room for the training session. At minimum, the room will have computers with internet access for attendees; have an internet access connection for the presenters' computer; and a projector with a computer connection for a laptop computer.

Deliverables: Training Materials

Training Service Fee: $4,800, plus expenses for two persons (accounting for two training days)

Phase 4: Analysis & Reporting

We believe collected data of this nature requires a periodic review. The DSATweb evaluation process involves complex software programming and is based on a self-adjusting statistical model. Therefore, we recommend evaluating data collected over a reasonable time to periodically validate DSATweb performance. Our validation team consists of Dr. Frederick Rotgers and Rick Bell and our process involves the following activities:

- Analyze the data collected by the SUSA; and
- Write a DSATweb Analysis Report about our findings.

Each validation cycle will include the services described below. After, the initial validation described here, we recommend performing a DSATweb Analysis annually.

Analyze Data

We consider the DSATweb a sound tool for collecting information about clients and evaluating their severity according to the approach described in the DSAT system. We also recommend evaluating DSATweb performance through an analysis of the resultant screening data.

In the process of our evaluation, we will issue an Analysis Report described in the next section. The analysis gives Connections the opportunity to clearly examine the characteristics of its client population as reflected by the DSATweb data.

We will conduct our first analysis of the collected data, after the DSATweb screenings database grows to approximately 10% of the clients projected to be served by Connections in this setting.

We will organize data using a cross-tabular process as we break out various categories determined by the data which is gathered. Each year, subsequent analyses will include a comparison of annual figures to determine if any changes occurred.

The analysis may consist of the following information:

- Calculate the distribution of severity levels in the client population;
- Calculate the distribution of drugs being used by the client population;

- Validate statistical norms used in the evaluation algorithm;
- Consider what, if any, adjustments are needed against the statistical model and data norms; and
- Other analysis criteria deemed useful at the time.

Publish Analysis Report

We will publish the data analysis in a DSATweb Analysis Report, describing our findings, including reporting on variables against the severity levels (e.g. community location and gender) and severity level against drug types (e.g. meth, heroin, cocaine, alcohol). We will present the analysis in a consistent, easy- to-read format, with visual charts and graphs and a descriptive analysis explaining the variables under consideration.

Analysis & Reporting Services Fee: $30,000

Phase 5: Support & Maintenance

As part of this project we will provide user support and system maintenance for 1 year upon completion of delivery Training Services.

DSATweb is an intuitive, easy-to-use system. However, during its use, users periodically have questions about DSATweb operations as it relates to the DSAT implementation, forget passwords, request support on a system error, etc. Also, a web-based system requires support and maintenance.

Support and Maintenance Services for DSATweb involves the following:

- Subject Matter Expertise
- Web User Support
- System Administration

Subject Matter Expertise

Users contact us, inquiring about

- the basis for assessment scores,
- the accuracy of scores (generally and specifically),
- screening practices for users of various backgrounds,
- screening approaches for clients of different backgrounds, and
- explanations of which DSATweb feature supports a DSAT activity.

New users inquire to understand how DSATweb relates to

- the design of the DSAT model,
- the benefits of using DSATweb,
- proper online procedures,
- tips for more efficient system use.

Without our direct involvement, some of the issues that arise may take considerable time to resolve. We believe time delays are a detriment to the quality of the user experience online as well as clinicians' acceptance of DSAT/DSATweb overall.

Our team expertise—in depth and breadth—provides direct support to the users in a timely and responsive manner.

Using our team's subject expertise, we assist our clients to establish reasonable policies regarding DSATweb practices.

As the only research team to thoroughly analyze DSAT data, we are in a unique position to address DSATweb issues relating to subject matter. Our team responds from a position of experience. We have found our subject expertise promotes greater user acceptance and participation.

Web User Support and System Administration

We provide the following benefits from our user support and system administration services:

System support and maintenance – ensuring overall DSATweb availability / functionality; hosting system and data; providing data integrity checks on as needed basis; monitoring and resolving issues in system operation, reviewing system logs, system code and data; and providing regular backups of system infrastructure and data.

Repair of code errors includes fixing issues with existing functionality. Adding new functionality is not included except at the discretion of Third Stage Software.

User support – proactively addressing user issues; resolving questions about proper usage of DSATweb in the context of DSAT methodology and policies; managing user access for new and existing users, including handling forgotten passwords; and monitoring user behavior as needed to improve productivity, both by soliciting input from and providing feedback to users.

Data support and reporting –providing aggregate quarterly reports to client management about user activity, case activity, the generation of available assessment reports by type, and other events as needed.

Help Desk contact information:
support@DSATweb.com
781-620-0390
Contact information is also posted at DSATweb.com.

We ensure a telephone line is available during support hours defined below, appropriate computer hardware and software tools are available for use for supporting the website, and web server hosting and domain addresses are available during DSATweb operating hours.

First response to request for service will occur within 24 hours of initial request, but typically occurs within several business hours of the request. Should more time be required to address a service request, we respond with a response status update and information about when we expect the issue to be resolved.

Help Desk support is available during normal business hours, 8 AM – 5 PM, Monday through Friday. The Help Desk is closed on a schedule matching that of the following U.S. federal holidays:

- New Year's Day
- Birthday of Martin Luther King, Jr.
- Washington's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving Day
- Christmas Day

The DSATweb Support and Maintenance contract is renewable on an annual basis.

Support & Maintenance Services Fee: $85,000 (annually)

Project Assumptions

Proper operation of DSATweb depends on using Internet Explorer 8 or above.

Project Agreement

This is a services contract only. This project is not a work for hire. The finished software system will not be delivered to the client for installation on their network. No ownership transfer is conveyed through any language in this document.

The copyright of all other deliverables (training materials & reports, etc.) is held by Third Stage Software. We grant full, unrestricted license of use for these materials alone.

The information collected by DSATweb for the purposes of Connections' DSAT Program and Services will not be used for any purposes except those specifically requested by Connections. Aggregated data and research on DSATweb data that includes client data from DSATweb will be subject to review and approval by Connections before distribution. A strict, high level of confidentiality is maintained at all times.

We will ensure all IT products and services delivered as part of this proposal conform to policies, standards, and procedures as determined by the IT authority of the State of Delaware effective at the time a contract is executed.

In conformance with applicable Federal and State statutes, regulations, and ethical standards, we will take all necessary steps to protect confidential information regarding all persons served by Connections, including the proper care, custody, use, and preservation of records, papers, files, communications, and any such items that may reveal confidential information about persons served by Connections, or whose information is utilized in order to accomplish the purposes of this project.

Clinical Assessments

Centre for Addiction & Mental Health (CAMH), Toronto, Ontario, Canada, granted permission to Rick Bell and Greg Graves to develop software based on the IDTS and DTCQ instruments licensed and managed by the Centre. License was granted verbally in early March 2004 after extensive telephone discussions and negotiations.

Budget

#	Phase	Fees and Expenses
1	**Discovery**	$2,400 on-site, plus expenses for two persons $5,000 for Requirements documentation
2	**Configuration & Deployment**	$80,000
3	**Training**	$4,800, plus expenses for two persons (two training days)
4	**Validation Analysis & Reporting**	$30,000
5	**Support & Maintenance**	$85,000 (annually)
	Total	$207,200

Conference calls and webinars related to this DSATweb proposal will be hosted by Third Stage.

Change Notice

This Project Plan is based on strict adherence to the work effort described. Variations to this work plan will require a change order process to be engaged whereby all new work items are discussed and estimated for time and materials. Upon completion of the change order, a new project schedule and cost will be presented.

Project Qualifications

Linda J. Frazier, MA, RN, MCHES
Health Care Consultant & NIATx Coach
Public Health Connections: Linda@PublicHealthConnections.com
www.PublicHealthConnections.com

Linda Frazier provides NIATx process improvement coaching and consultation in criminal justice, primary care, and mental health service settings to improve processes and outcomes.

Ms. Frazier currently provides process and quality improvement consultation for 7 Drug Treatment Courts and Prison sites focused on improving criminal justice outcomes. Prior to consulting Linda managed treatment services for the Maine DHHS Office of Substance Abuse (OSA) overseeing treatment services state wide, including Criminal Justice treatment programs for adults. Ms. Frazier has been involved with the Maine DSAT program since 2001 and directed implementation of the Maine Differential Substance Abuse Treatment (DSAT) program in the six adult correctional institutions and the six adult drug treatment courts. The Maine DSAT program received a SAMHSA Science and Service Award in 2008 recognizing OSA for the effective delivery of this continuum of research based services through effective collaboration, training, and quality assurance mechanisms. For details see:
http://www.samhsa.gov/scienceandservice/substanceRSS2008.aspx

Linda is a Registered Nurse and Master Certified Health Education Specialist (MCHES) who has worked in public health and behavioral health services for over 25 years. Ms. Frazier has extensive training and experience in motivational (MI/MET) and cognitive behavioral therapy (CBT) treatment programs and is a certified DSAT and MI/MET trainer. She is also a NIATx certified change leader and coach.

Richard B. Bell
President
Third Stage Software: Rick@ThirdStageSoftware.com

Richard Bell has over 20 years of experience in the field of Information Technology. He has worked in a variety of IT roles across a range of different industries including consulting, financial services, law enforcement, education, and government. Since 2004, he has been the founder and president of Third Stage Software. Third Stage is a company focused on web software development and marketing with a focus on products to support DSAT implementation. These include the Substance Use Severity Assessment (SUSA), FastIDTS, FastDTCQ and DSATweb.

Mr. Bell has worked in many areas of the information technology industry in New England, including hardware support, system operations, global technical support, desktop/user support, systems analysis, database administration, database design, software design, software programming, software implementation, and management consulting for PricewaterhouseCoopers.

Some of Mr. Bell's many clients include the following:

- BP Exploration
- Dodge-Fillmore-Olmsted (DFO) County Corrections, Minnesota
- IBM
- Maine Department of Health & Human Services, Office of Substance Abuse
- Maine Department of Marine Resources
- New Hampshire Enhanced 911
- New Hampshire State Police
- New Hampshire State Police Forensics Laboratory
- University of Massachusetts

Frederick Rotgers, PsyD, ABPP
Dr. Frederick Rotgers is a clinical psychologist who was a principle in the development of the original DSAT project for the State of Maine. He has been on the research faculty of the Rutgers Center of Alcohol Studies, and is currently in independent clinical and consulting practice in New Jersey.

Project Management

Third Stage Software
20 Belmont Place
Melrose, MA 02176

Richard Bell
President
Office: 781.620.0390
Direct: 617.320.4928
Rick@ThirdStageSoftware.com

Linda Frazier
Senior Partner
Office: 781.620.0390
Direct: 612.424.3860
Linda@ThirdStageSoftware.com

Appendix

Outline of DSAT Measures/Assessment Instruments:

The outline below presents all the assessment instruments that are administered over the course of delivering the DSAT program. The measures are listed according to the sequence in which they are administered over the course of DSAT program delivery.

A. Substance Use Screening Assessment

- Short Alcohol Dependence Data (SADD)
- Michigan Alcoholism Screening Test (MAST)
- Severity of Dependence Scales (SDS)
- Drug Abuse Screening Test (DAST)

B. Comprehensive Assessment

- DSAT Interview Rating Sheet
- Problem Solving Scenarios ✸
- Pre-Treatment Rating Scale ♦

C. Intensive Phase of the DSAT Program

- Pre-Treatment Questionnaire Battery ❖
- Inventory of Drug-Taking Situations (IDTS) during Session #5 ✪
- Post-Intensive Questionnaire Battery ❖
- Problem Solving Scenarios ✸
- Post-Intensive Facilitator Ratings ♦

D. Maintenance Phase of the DSAT Program

- Pre-Maintenance Drug Taking Confidence Questionnaire (DTCQ) ✠
- Post-Maintenance Drug Taking Confidence Questionnaire (DTCQ) ✠
- Post-Maintenance Questionnaire Battery ❖
- Problem Solving Scenarios ✸
- Post-Maintenance Facilitator Ratings ♦

A Summary of the Maine DSAT Program Implementation Evalaution Results

In their 2006 Process and Site-Specific Outcome Evaluation of Maine's Adult Drug Treatment Court (ADTC) Programs, Ferguson, McCole and Raio of the University of Southern Maine, did an analysis of Pre- and Post- Outcome measures. A summary of the results of this state wide, cross program analysis for DSAT Program implementation within the six Adult Treatment Courts are presented below. Overall findings were positive across all measures, indicating improvement in scores for both male and female participants.

	Pre-Test	Post-Test	% +/Change
Alcohol and Drug Refusal Self-Efficacy Questionnaire (ADRESQ)			
Social Pressure Self-Efficacy	48.5	57.6	18.76%
Emotional Relief Self-Efficacy	46.6	54.1	16.09%
Opportunistic Self-Efficacy	35.8	43.1	20.39%
Drug Avoidance Self-Efficacy Questionnaire (DASES)	68.5	88.4	29.05%
Commitment Scale (CS)	7.9	8.4	6.33%
Problem Solving Questionnaire	54.1	60.3	11.46%
Perceived Modes of Processing Inventory (PMPI)	90.9	99.4	9.35%
Coping Behaviors Inventory	65.3	46.4	28.94%

* Optimal positive outcomes should result in an increase in scores between the pre-test and the post-test, except for the Coping Behaviors Inventory (CBI) where optimal positive outcomes would result in lower scores as evidenced above.

As part of the process and outcome evaluation of the Maine Adult Drug Courts, Taxman, Pattavina and Bouffard completed an evaluation of Maine DSAT treatment in 2005. .The authors noted the following about the DSAT Program Curriculum:

- The DSAT curriculum is "a thorough and strategic approach…built on a solid curriculum—assisting the offender in achieving skills to address recovery issues…"
- That "DSAT can be effectively delivered through the mechanisms that were employed by OSA to include training the counselors, using quality assurance mechanisms…" and;
- That "The DSAT curriculum appears to engage many of the offenders in the treatment process – more social conformity and less risk taking behavior … clients have good rapport with the counselors…"

As part of the executive summary of their 2006 Process and Site-Specific Outcome Evaluation of Maine's Adult Drug Treatment Court Programs, Ferguson, McCole and Raio identify the following outcomes.

- From inception (April 2001) to November 30, 2005 there were 540 offenders admitted to these courts and the overall completion rate in Maine was 60%, compared to a national rate of 48%;

- Fewer participants recidivated (17.5%) during a 12 month post program follow-up than a comparison group of traditionally adjudicated offenders (33.1%); and

- Analysis of DSAT clinical pre/post treatment measures reveal significant improvement in attitudes, coping behaviors, confidence to refrain from alcohol/drug use

- Costs saving were significant given the small population of a state like Maine. The 4 year net correctional saving was $11,345,726.00.

- Additional savings associated with family and social issues (i.e. TANF, Medicaid) and loss in functional taxpaying citizens is not included in this calculation.

Finally, a 2009 summary of Evaluations/Outcomes findings for the Maine DOC Adult Institutions includes analysis of outcomes for implementation of DSAT in the Men's TC (called the CRA-TRA). This study included the 2009 CRA-TRA Recidivism Brief by Muskie School of Public Service which noted that by 2006, CRA-TRA Client recidivism rates were 50% below the comparison cohort; and the program was rated "very satisfactory" by the Correctional Program Assessment Inventory (CPAI) tool.

Appendix C
Letters of Support

April 25, 2012

Dear Ms. McKay,

On behalf of the Wilmington HOPE Commission and our Board of Directors, I am pleased to extend our support of Connections Community Support Programs, Inc. (Connections).

Connections has a proven track record of more than 25 years of providing evidenced-based services to improve the quality of life of people throughout our state, serving Delaware's most disadvantaged populations with programs and services that include community-based housing; health care; employment (including ex-offenders); and treatment of individuals with cognitive disabilities, substance abuse conditions and cognitive disabilities. Connections has a wealth of experience providing quality care and services utilizing evidenced-based practices and techniques—those practices and approaches that have been proven to work—and is committed to helping people returning to the community from prison to engage in productive and successful behavior.

As we work to establish a one-stop Reentry Service Center for ex-offenders, Connections has been an important partner in helping the Wilmington HOPE Commission to develop evidence-based programming for medium- to high-risk ex-offenders who are most response to our treatment model. If awarded the Prison Mental Health treatment RFP, Connections is committed to being a primary partner with the Reentry Center and Governor Markell's I-ADAPT program to make the appropriate referrals and provide cognitive behavioral treatment, substance abuse and mental health treatment, and employment services. The HOPE Commission will work with Connections and our community partners to implement a coordinated, multi-system approach that combines pre-release transition planning to ex-offenders along with community-based case management, training, employment and mentoring services that are proven to reduce recidivism and long-term success—complementing our strategy of working with residents and community-based agencies to create meaningful collaborations that will build their capacity and stabilize communities.

Wilmington HOPE Commission strongly believes that Connections' award of this RFP and support of the Reentry Service Center initiative will profoundly and positively impact both Wilmington and the entire state of Delaware. We are committed to working with Connections Community Support, Inc. and urge you to favorably consider Connections' response to this RFP.

If I can provide any additional information that would support your decision-making process, please feel free to contact me at 302-573-3776.

Sincerely,

Charles A. Madden
Executive Director

625 Orange Street, Third Floor ❖ Wilmington, DE 19801
(302) 573-3735 ❖ info@wilmingtonhopecommission.org
www.wilmingtonhopecommission.org

DELAWARE DEPARTMENT OF LABOR

DIVISION OF
VOCATIONAL REHABILITATION

OFFICE OF THE DIRECTOR

April 16, 2012

Connections CSP
500 West 10th St.
Wilmington, DE 19801

To Whom It May Concern:

The Division of Vocational Rehabilitation is pleased to provide a letter of support for Connections Community Support Programs, Inc. in its proposal to provide community mental health services to individuals being served through the Department of Corrections' Level IV Facilities. The Division of Vocational Rehabilitation (DVR) and Connections have been collaborating to serve individuals with mental health disabilities in Delaware for more than 17 years. Connections have been and continue to be a community rehabilitation program in excellent standing with the DVR. Connections CSP has made significant strides and advancements in serving individuals with significant disabilities, particularly those with mental health disabilities, in coordination with and aligned with the mission of DVR.

Connections CSP is willing to collaborate with DVR to find new and innovative ways to serve our mutual constituents, including individuals with disabilities coming through the Delaware Department of Corrections that are eligible for DVR services. It is DVR's intention to continue developing their relationship with Connections CSP and to maintain and improve upon the success that we are currently seeing through their program. DVR supports Connections in expanding their program to serve persons with disabilities under this initiative.

Sincerely,

Andrea Guest, Director, DVR

4425 North Market Street • P O Box 9969 • Wilmington DE 19809-0969
Phone (302) 761-8275 Voice/TTY • Fax (302) 761-6611