July 2010 Report to the

Governor's Office of State Planning and Budgeting

Recidivism Reduction Packages Status Report

FY2008 - FY2010 (July 1, 2007 through June 30, 2010)

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INTRODUCTION

Since entering office in January 2007, Governor Bill Ritter, Jr. has submitted an annual Recidivism Reduction package to the General Assembly as part of the budget process. The package represents his commitment to invest in evidence-based programs that protect public safety by reducing crime and recidivism and that maximize criminal justice resources by managing correctional populations using appropriate tools and sanctions.

The FY 2008 package enhanced the Division of Youth Correction's (DYC) Continuum of Care initiative, greatly expanded community-based substance abuse treatment aftercare programming (Short Term Intermediate Residential Remedial Treatment, or STIRRT), and increased the number of beds in the community corrections system, including beds for offenders with mental illness and substance abuse problems. The FY 2009 Recidivism Reduction package included training for DYC's Functional Family Parole program, reinstatement of DYC's SB94 funding targeting evidence-based programs, and an expansion of the Department of Human Services' (DHS) Collaborative Management Program to eight new counties, and provided funding to the Department of Corrections (DOC) for parole wrap-around substance abuse and other services. Additionally, the FY 2009 package expands DOC substance abuse therapeutic community treatment, services to mentally ill offenders in prison, vocational/educational instruction in prison, and increases community corrections diversion beds and substance abuse programming in community corrections.

The FY 2010 package provided Functional Family Therapy to juveniles, further increased community corrections beds, included funding for therapeutic community services and a non-residential pilot program, and expanded services for offenders transitioning from prison including discharge planning services and lengthening the duration of Intensive Residential Treatment programs. Additionally, DOC received funding for a pre-release program to transition inmates from facilities to the community, and to further increase the availability of therapeutic community treatment as well as academic and vocational services.

Due to the length of time between entry into programs and termination, outcome data on offenders who participate in and complete the programs funded in FY 2010 are not available at this time. Additionally, recidivism data are limited to those completing programs in FY 2008, as a post-discharge ‘at-risk’ period must elapse prior to collecting such information.

FY 2008 Recidivism Reduction and Offender Diversion Package

1. Division of Youth Corrections

a. Flexible funding for the Division of Youth Corrections Continuum of Care Initiative promoting alternatives to incarceration

The Continuum of Care Initiative, approved by the General Assembly and implemented in FY 2006, allows the Division of Youth Corrections (DYC) to apply a portion of funds appropriated for residential placements to provide non-residential treatment, transition and wraparound services to committed youth and youth on parole. The FY 2008 Recidivism Reduction Package designated $1.9 million toward this program. The Tri-West Group has been retained to conduct an evaluation of the initiative, and to provide annual reports on the status of Continuum of Care implementation and outcomes.[1] Findings from these reports are summarized below.

Expenditure records identified 1,695 youth committed to DYC who received services under the Continuum of Care Initiative during FY 2008, compared to the 1,703 youth served in FY 2007 and the 765 served in FY 2006. In terms of actual expenditures, $4,462,533 was spent for services in FY 2008, an 18 percent increase over the $3,790,116 spent in FY 2007. FY 2008 expenditures averaged $2,636 per youth served, which is substantially higher than the FY 2007 average of $2,225 per youth served.

During FY 2009, 1,715 youth received services under the Continuum of Care Initiative. More than half (52 percent) of the youth in residential placement received transitional services, and the vast majority of paroled youth (83 percent) received direct non-residential services paid through the Continuum of Care funding stream. Expenditures averaged $2,761 per youth served, totaling of $5,267,532 over the year.

One hundred percent of these expenditures were spent on the provision and enhancement of services to youth. During FY 2008, the majority of expenditures went to pay for treatment services (86 percent). Eight percent went to enhanced youth supervision, with the remaining 6 percent paying for youth support services. During FY 2009, slightly less was spent on supervision (6 percent) and treatment services (84 percent) while more was spent on support services (10 percent). Services provided to youth included:

- Community living & social skill development
- Individual, family, group therapy
- Mentoring

[1] Major portions of this section are excerpted or paraphrased from the following documents:
TriWest Group. (2008). *Continuum of Care Initiative Evaluation Annual Report: FY 2007-08.* Colorado Department of Human Services, Office of Youth and Family Services, Division of Youth Corrections. TriWest Group, Boulder, CO.
TriWest Group. (2009). *Continuum of Care Initiative Evaluation Annual Report: FY 2008-09.* Colorado Department of Human Services, Office of Youth and Family Services, Division of Youth Corrections. TriWest Group, Boulder, CO.

- Job/Skills Training
- Substance Abuse Treatment
- Offense-Specific Treatment
- Provider Network Maintenance
- Case management and planning
- Behavior training
- Restorative-Community Justice
- Behavior Training
- Art/Recreational Therapy
- Day Treatment
- Assessment

Continuum of Care outcomes are measured in a variety of domains, described below. An equivalent comparison group of youth discharged during FY 2005, the year prior to the Continuum of Care Initiative implementation, has been identified to examine outcomes over time.

Days in Residential Placement. Length of stay (LOS) in residential placement for Continuum of Care youth was compared to that of youth in the FY 2005 comparison cohort. The comparison cohort had a residential LOS of 20.1 months, significantly longer than that of the youth discharged over the next 3 years. The LOS for FY 2008 discharges was 18.1 months, followed by 19.0 months for FY 2009 and 18.9 months for FY 2010 discharges.

Commitment Residential ADP. Prior to FY 2006, the year of Continuum of Care implementation, the commitment average daily population (ADP) increased steadily over the previous 14 years. Since the implementation of the Initiative, this trend has been reversed with the commitment ADP declining over the past three years. During the first year of implementation, the commitment ADP demonstrated a slight decline, and an even more pronounced decline of 9.6 percent in FY 2008. Both FY 2009 and FY 2010 realized further declines of 5 percent each year.

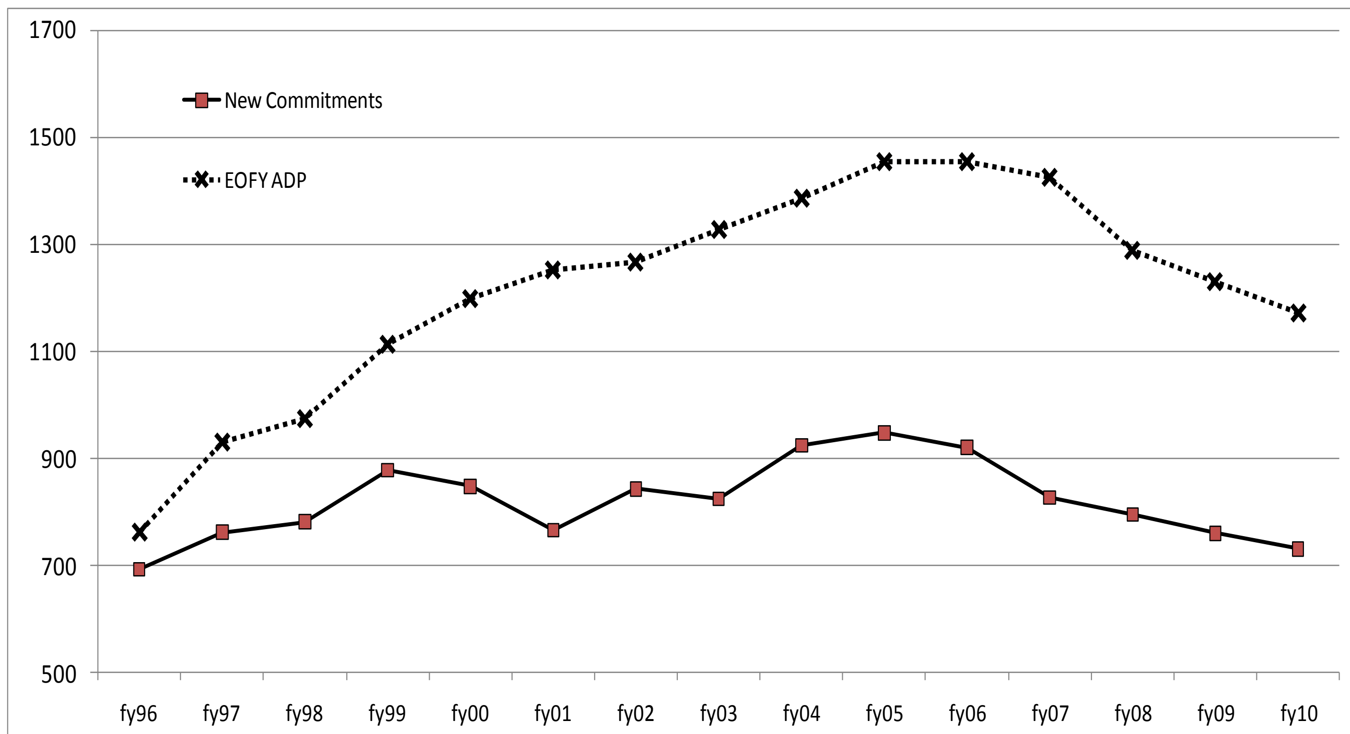
The slight decreases in LOS observed in the FY 2008 through FY 2010 discharges, combined with a fairly dramatic decline in the number of new commitments and a reduction in the number of youth recommitted prior to release, has led to the overall reductions in ADP. These trends are displayed in Figure 1. Table 1 gives the actual end of year ADP numbers for this time frame.

Risk of Re-offending. One measure of whether youth are receiving services that address their criminogenic needs is the degree to which dynamic risk scores change for youth over their stay in DYC. The Colorado Juvenile Risk Assessment (CJRA) provides a profile across 12 domains of risk and protective factors.

The FY 2008 evaluation report examined the changes in the scores between the first CJRA assessment and the last across five dynamic risk domains. The domains analyzed included attitudes, relationships, aggression, social skills, and family. Continuum of Care youth demonstrated significant improvement across each of these except for the family domain.

The FY 2009 evaluation report took a different approach to examining changes in risk of reoffending. In this case, the proportion of youth falling into the high-risk range at initial assessment and at discharge was reported. Significant improvement in seven of the eight domains examined was found. Additionally, significant increases in the proportions of youth falling into the high range of scores on 10 domains of protective factors were found. These findings indicate that the Initiative is successful in addressing and reducing criminogenic needs while increasing protective factors. The national research base is clear in drawing the direct link between reduced risk factors, increased protective factors, and reductions in delinquent behavior and re-offense.

Figure 1. Division of Youth Corrections End of Fiscal Year (EOFY) Average Daily Population (ADP) and Annual New Commitments FY 1994 through FY 2010.



Source: CDHS DYC Monthly Population Reports.

Table 1. Division of Youth Corrections End of Year Average Daily Population (ADP) and Annual New Commitments FY 1994 through FY 2010.

	New Commitments	EOFY ADP
FY 1994	552	613
FY 1995	606	634
FY 1996	693	763
FY 1997	762	929
FY 1998	781	974
FY 1999	878	1112
FY 2000	848	1198
FY 2001	766	1252
FY 2002	843	1267
FY 2003	824	1328
FY 2004	924	1386
FY 2005	948	1454
FY 2006	920	1453
FY 2007	823	1425
FY 2008	793	1287
FY 2009	760	1229
FY 2010	731	1171

Source: CDHS DYC Monthly Population Reports.

Recommitment. The Continuum of Care Initiative appears to have had an initial impact on recommitment numbers. A statistically significant lower proportion of the youth served under the Initiative were recommitted to DYC prior to discharge from their original commitment than youth in the FY 2005 comparison cohort, as shown in Table 2. This decrease contributes to the reductions in LOS and in ADP discussed above.

Table 2. Recommitment Rates of Discharged Youth Served by the Continuum of Care Initiative and of FY 2005 Comparison Group*

Study Group	Percent Recommitted
FY 2004-05 Comparison Cohort	25.0%
Continuum of Care FY 2008 Discharges	22.1%
Continuum of Care FY 2009 Discharges	22.2%

* These differences are statistically significant: $p<.05$

Source: TriWest Group. (2008). *Continuum of Care Initiative Evaluation Annual Report: FY 2007-08.* Colorado Department of Human Services, Office of Youth and Family Services, Division of Youth Corrections. TriWest Group, Boulder, CO; TriWest Group. (2009). *Continuum of Care Initiative Evaluation Annual Report: FY 2008-09.* Colorado Department of Human Services, Office of Youth and Family Services, Division of Youth Corrections. TriWest Group, Boulder, CO.

Recidivism. In addition to recommitment rates, the TriWest evaluation effort includes a recidivism analysis. However, only preliminary analyses of recidivism have been conducted. For both the FY 2008 and the FY 2009 evaluation reports, only pre-discharge recidivism, or new filings occurring while a youth is still under DYC supervision (whether in a residential placement or on parole), were examined. Post-discharge recidivism remains unavailable for youth committed during FY 2008 or FY 2009 because the necessary 12 months of time at risk had not yet elapsed at the time of the most recent evaluation report.

As illustrated in Table 3, pre-release recidivism rates for the Continuum of Care youth discharged in FY 2007 and in FY 2008 were significantly lower than for the FY 2005 comparison cohort.

Table 3: Pre-Discharge Recidivism Rates for Discharged Youth Served by the Continuum of Care Initiative and for the FY 2005 Comparison Group*

Study Group	Percent with New Court Filings
FY 2004-05 Comparison Cohort	39.1%
Continuum of Care FY 2008 Discharges	33.3%
Continuum of Care FY 2009 Discharges	34.7%

* These differences are statistically significant: $p<.001$.

Source: TriWest Group. (2008). *Continuum of Care Initiative Evaluation Annual Report: FY 2007-08.* Colorado Department of Human Services, Office of Youth and Family Services, Division of Youth Corrections. TriWest Group, Boulder, CO. TriWest Group. (2009). *Continuum of Care Initiative Evaluation Annual Report: FY 2008-09.* Colorado Department of Human Services, Office of Youth and Family Services, Division of Youth Corrections. TriWest Group, Boulder, CO.

This reduction in pre-discharge recidivism represents substantial cost savings, by deterring returns to and additional days spent in residential facilities. However, the data required to determine the magnitude of these savings are not currently available.

For a more detailed description of the TriWest Group's Continuum of Care Initiative evaluation methodology and findings, please refer to the Continuum of Care Initiative Annual Reports which are available on the Division of Youth Corrections website at *http://www.cdhs.state.co.us/dyc/Research.htm*.

2. Division of Behavioral Health

a. Expansion of Short-Term Intermediate Residential Remedial Treatment (STIRRT) and Continuing Care

The FY 2008 Recidivism Reduction package provided $1.3 million toward the expansion of STIRRT programming in Colorado. These programs are designed to provide 14 days of intensive residential treatment followed by 8 to 9 months of continuing care in the community. Program representatives expect these funds to provide services for 560 residential clients and 800 continuing care clients each year. Table 4 describes the beds funded with these monies.

While the additional beds provided augmented those in the existing programs at Arapahoe House and Crossroads, the female beds provided to Arapahoe House enabled the creation of a STIRRT program serving women only. The Arapahoe House STIRRT has been in existence since 1996, and the Crossroads program since 2000. As the Arapahoe House and the Crossroads programs were already operational prior to the addition of these beds, it is not possible to partition out the status of the additional beds from those already existing.

The beds provided at the Larimer County and Mesa County sites enabled the implementation of new STIRRT services in those areas. However, services at the Mesa County Community Corrections program were terminated at the end of FY 2010. The other three programs are providing ongoing services.

Table 4. Short Term Intensive Residential Remedial Treatment Beds Funded by the Governor's FY 2008 Recidivism Reduction Package

Facility	Male Beds	Female Beds	Program Start Date
Arapahoe House (Denver)	20 beds	8 beds	1996
Crossroads (Pueblo)	10 beds	10 beds	October 2000
Larimer County Community Corrections	10 beds	0 beds	October 2007
Mesa County Community Corrections	10 beds	5 beds	December 2007
Total	50	23	

STIRRT Client Population and Outcomes

The following provides a description of the client population served by the STIRRT programs over the 18-month period between January 1, 2008 and June 30, 2009. The data presented here are based on information collected by the Division of Behavioral Health (DBH) via the Drug/Alcohol Coordinated Data System (DACODS), with the exception of the LSI data which were obtained from the treatment facilities themselves at quarterly meetings held by DBH. Individuals served by the STIRRT programs are included.

Table 5 displays the numbers of individuals served in the residential and in the continuing care components by program. As shown, a total of 1,324 clients participated in the STIRRT program between January 2008 and June 2009, with 1,241 terminating during this time frame. The majority, 91.0 percent, successfully completed the program. Of these, 646, or 44.1 percent went on to continuing care.

Table 5. STIRRT Program Participants: January 2008 – June 2009[a]

	N Served	N Discharged	N Successful Discharges	% Successful Discharges	N Admitted to Continuing Care[b]	% Admitted to Continuing Care[b]
Arapahoe House	638	579	537	92.7%	333	42.2%
Crossroads Turning Point	453	426	371	87.1%	169	55.1%
Larimer County	148	144	133	92.4%	84	32.3%
Mesa County	85	82	79	96.3%	60	25.0%
Total	1324	1241	1120	91.0%	646	44.1%

Source: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health, Dept. of Human Services. Female participants from Arapahoe House are excluded.
[a] Includes unduplicated STIRRT participants admitted to and discharged from treatment between January 2008 and June 2009, as reported on DACODS.
[b] Only those successfully discharged from STIRRT a minimum of 60 days prior to the end of the data collection time frame are included in this analysis. Admission to outpatient treatment must have occurred within 60 days of the STIRRT treatment episode.

Average Level of Service Inventory (LSI) and Adult Substance Use Survey (ASUS) scores are given in Table 6. The LSI is one of the most common tools used to classify adult offenders, and is used to assess offender needs and risk of recidivism. The ASUS is designed to differentially screen and assess an individual's alcohol and other drug use involvement in ten commonly defined drug categories and to

measure the degree of disruptive symptoms that result from the use of these drugs. As information concerning LSI and ASUS scores is not collected by DBH via DACODS, this information was obtained directly from the STIRRT providers.

Table 7 outlines the characteristics of clients served between January 2008 and June 2009. As shown, three-quarters of the clients served in STIRRT were male. About half (49.7 percent) were Caucasian, one-third were Hispanic, and 12.8 percent were black. The largest percentage were employed (38.7 percent), followed by those who were unemployed but looking for work (35.6 percent) at the time of admission to the residential program. The majority of STIRRT participants had achieved at least a high school diploma or G.E.D. (51.6 percent), and the average age was 34 years.

The majority of STIRRT participants had never been married (53.9 percent). However, almost 20 percent were married, and another 20 percent were divorced at the time of their admission to the program. The majority of participants were also living independently at the time that they were admitted to the program (63 percent). Very few homeless individuals were admitted (5.2 percent).

Table 8 gives the substances used by STIRRT participants at admission to the program. These drug categories are not mutually exclusive, as substance abusers often use multiple drugs. The top four substances used by STIRRT participants used included marijuana (49.7 percent), cocaine (43.5 percent), alcohol (44.3 percent), and methamphetamine (34.9 percent).

Table 6. Average Level of Supervision Inventory (LSI) and Adult Substance Use Scale (ASUS) Scores of STIRRT Participants: January 2008 – June 2009

<table>
<tr><th colspan="2">Scale</th><th>Average Score</th><th>Scale Range</th></tr>
<tr><td colspan="2">Level of Supervision Inventory (LSI)</td><td>32.8</td><td>0-51</td></tr>
<tr><td rowspan="4">Adult Substance Use Scale (ASUS)</td><td>AOD Involvement</td><td>10.7</td><td>0-39</td></tr>
<tr><td>AOD Disruption</td><td>20.8</td><td>0-78</td></tr>
<tr><td>Social Non-Conforming</td><td>10.9</td><td>0-34</td></tr>
<tr><td>Mood Adjustment</td><td>8.6</td><td>0-29</td></tr>
</table>

Source: Provider reports presented at quarterly STIRRT advisory committee meetings.
Note: N is not reported as this information was not consistently available.

Table 7. Description of STIRRT Program Participants: January 2008 – June 2009 (N=1324)

Gender[a]	Male	75.4%
	Female	24.6%
	Total	100%
Race/Ethnicity	Caucasian	49.7%
	African American	12.8%
	Hispanic	33.3%
	Other[5]	4.2%
	Total	100%
Age at Admission	Mean	34.1
	Median	32
	Minimum	18
	Maximum	67
Employment Status at Admission	Employed[b]	38.7%
	Unemployed, looking for work	35.6%
	Unemployed, not looking for work	15.1%
	Unemployed, for accepted reason[c]	8.5%
	Other/Unknown	2.1%
	Total	100%
Level of Education at Admission	Less than High School	28.6%
	High School Diploma or G.E.D.	51.6%
	Some College	17.4%
	College	2.3%
Marital Status at Admission	Never married	53.9%
	Married	19.7%
	Widowed	1.2%
	Separated	5.5%
	Divorced	19.7%
	Total	100%
Living Status at Admission	Homeless	5.2%
	Dependent living with parents	22.9%
	Dependent living in supervised setting	9.1%
	Independent living	62.8%
	Total	100%

Source: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health, Dept. of Human Services.
Female participants from Arapahoe House are excluded with the exception of data concerning gender.
[a] Internal data provided by Arapahoe House were used to determine actual numbers of female clients served.
[b] "Employed" includes both full time and part time employment.
[c] Accepted reasons for unemployment include: homemaker, full time student, retired, and disabled.

Table 8. Drug Use at Admission to STIRRT: January 2008 – June 2009 (N=1324)

Drug type	%
Marijuana	49.7
Cocaine	43.5
Alcohol	44.3
Methamphetamine	34.9
Heroin	4.6
Other Opiate	3.0
LSD	0.9
Other Drug	2.3

Source: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health, Dept. of Human Services. Female participants from Arapahoe House are excluded.

Predicting Successful Program Completion

Excluding those cases with a termination status of "other" or "unknown," participants who entered the program with any methamphetamine use were 80 percent more likely to be unsuccessfully terminated from the program than those without any methamphetamine use. Further, those that were employed were 90 percent more likely to be terminated successfully, and African Americans were 3.4 times as likely to be terminated successfully as those of any other race/ethnicity (see Table 9).

Table 9. Predictors of Termination Status from STIRRT Residential Component: January 2008 – June 2009

Predictor	Outcome	Odds Ratio	P-value	N
Admitted with any methamphetamine use	Unsuccessful Termination	1.8	.009	1231
Employed at admission	Successful Termination	1.9	.024	1194
African American	Successful Termination	3.4	.046	1194

Source: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health, Dept. of Human Services. Female participants from Arapahoe House are excluded.

Continuing Care

Although the philosophy of the STIRRT program includes continuing care, this is not mandated. Less than half (42.5%) of the 1,120 STIRRT residential participants who completed the program successfully

went on to participate in this portion of the program (see Table 10, below).[2] Continuing care participation ranged greatly between program locations with Mesa County having the lowest percentage of continuing clients at 25.3%, and Crossroads having the greatest at 50.9%.

Table 10. Participation in STIRRT Continuing Care by Provider: January 2008 – June 2009[a]

	N	Participated in Continuing Care		Total
		No	Yes	
Arapahoe House	537	57.5%	42.5%	100%
Crossroads Turning Point	371	49.1%	50.9%	100%
Mesa County	79	74.7%	25.3%	100%
Larimer County	133	72.2%	27.8%	100%
Total	1120	57.7%	42.3%	100%

Source: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health, Dept. of Human Services. Female participants from Arapahoe House are excluded.

[a] Only those successfully discharged from STIRRT a minimum of 60 days prior to the end of the data collection time frame are included in this analysis. Admission to outpatient treatment must have occurred within 60 days of the STIRRT treatment episode.

Recidivism Rates

Recidivism is defined as a new district or county court filing[3] within 6 or 12 months of release from the two week residential component of the STIRRT program. Table 11 summarizes average LSI scores and recidivism rates by provider. As shown, the overall 6-month recidivism rate for STIRRT participants was 14.8 percent. The overall 12 month recidivism rate was 24.9 percent.

While this study found that 6 month recidivism rate were significantly lower for those that participated in continuing care than for those who did not (12.4% vs. 16.6%), this difference was not apparent after 12 months. After 12 months, approximately a quarter of former STIRRT clients recidivated, regardless of whether they did or did not participate in continuing care. In some cases, recidivism rates were lower for those who *did not* participate in continuing care than for those that did, but these differences were not statistically significant.

[2] Only those admitted to both the residential and the continuing care components between January 1, 2008 and June 30, 2009 are included. Admission to an outpatient facility must have occurred within 60 days of STIRRT discharge in order to be considered an admission to STIRRT continuing care.

[3] Filings from Denver County court are not available and are excluded from this analysis.

Table 11. Recidivism Rates, Level of Supervision Inventory (LSI) Scores and Continuing Care Participation by STIRRT Provider: January 2008 – June 2009

	Average LSI Score[a]	6 Month Recidivism Rate[b]	12 Month Recidivism Rate[c]
Arapahoe House, Denver	33.2	**13.8% (521)**	**22.1% (331)**
Participated in CC		10.1% (228)	17.6% (142)
Did not participate		16.7% (293)	25.4% (189)
Crossroads Turning Point, Pueblo	33.7	**15.3% (359)**	**25.6% (238)**
Participated in CC		14.8% (189)	30.9% (123)
Did not participate		15.9% (170)	20.0% (115)
Mesa County, Grand Junction	31.2	**15.2 (79)**	**11.1% (36)**
Participated in CC		20.0% (20)	22.2% (9)
Did not participate		13.6% (59)	7.4% (27)
Larimer County, Fort Collins	33.3	**17.2% (128)**	**40.0% (85)**
Participated in CC		10.8% (37)	36.4% (22)
Did not participate		19.8% (91)	41.3% (74)
Overall	32.8	**14.8% (1087)**	**24.9% (690)**
Participated in CC		12.4% (of 474)	24.7% (296)
Did not participate		16.6% (of 613)	25.1% (394)

Data Sources: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health, Dept. of Human Services. Female participants from Arapahoe House are excluded. Recidivism data was obtained from the Colorado Integrated Online Network (ICON) maintained by the Colorado Judicial Department. Data concerning filings originating from Denver County are not included. This is most likely to underestimate the recidivism rates for Arapahoe House clients.

[a] The LSI is the Level of Supervision Inventory, a 54-item instrument that measures individual risk/need levels. LSI data was obtained from provider reports presented at quarterly STIRRT advisory committee meetings.

[b] Only clients at risk for a minimum of 6 months post discharge are included.

[c] Only clients at risk for a minimum of 12 months post discharge are included.

Summary and Findings

- Most participants (91.0 percent) successfully completed the 14-day residential component of STIRRT.

- Less than half (42.3%) of the 1,120 STIRRT participants who completed the residential component successfully enrolled in outpatient treatment within 60 days of discharge from the residential program.

- While this study found that 6 month recidivism rate were significantly lower for those that participated in continuing care than for those who did not (12.4% vs. 16.6%), this difference was not apparent after 12 months. After 12 months, approximately a quarter of former STIRRT clients recidivated, regardless of whether they did or did not participate in continuing care.

    - In comparison, 61.3 percent of community corrections clients successfully completed the program in FY 2008. Of these, 14.6 percent recidivated within 12 months.[4]
    - However, the severity of the STIRRT population exceeded that of the community corrections population. As shown in Table 12, the offenders included in the STIRRT evaluation scored substantially higher on the LSI, the AUS alcohol/other drug involvement subscale, and the ASUS alcohol/other drug disruption scale than did those included in the community corrections study.

Table 12. Comparison of Recidivism Rates and Client Severity for STIRRT and Community Corrections Discharges.

	STIRRT Residential Discharges	Community Corrections Discharges
Successful discharge rate	91.0%	61.3%
1-year recidivism rate	24.9%	14.6%
Average LSI score	32.8	27.1
Average ASUS AOD involvement score	10.7	9.3
Average ASUS AOD disruption score	20.8	16.8

Data sources: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health. Recidivism data obtained from the Colorado Integrated Online Network (ICON) maintained by the Colorado Judicial Department. Data concerning filings originating from Denver County are not included. STIRRT LSI and ASUS data obtained from provider reports presented at quarterly STIRRT advisory committee meetings. Community Corrections termination data provided by the Division of Criminal Justice Office of Community Corrections.

[4] Community Corrections termination data provided by the Division of Criminal Justice Office of Community Corrections and analyzed by the Office of Research and Statistics. Recidivism data obtained from the Colorado Integrated Online Network (ICON) maintained by the Colorado Judicial Department. Data concerning filings originating from Denver County are not included.

3. Division of Criminal Justice--Community Corrections expansion

a. Therapeutic Community Diversion Programs (20 beds)

The FY 2008 Recidivism Reduction Package provided $1.7 million toward the expansion of community corrections. These funds included the creation of 20 new therapeutic community (TC) diversion beds for the treatment of substance abuse at Addiction Research and Treatment Services (ARTS) of the University of Colorado Health Sciences Center. These were distributed between the Peer 1 and The Haven programs.

Related to the expansion of TC services, a Scope of Work report was developed in FY 2008 to address the need for residential dual diagnosis treatment services. The results of this analysis were used to develop programs implemented in FY 2010. This Scope of Work document can be found in Appendix A.

Outcome data, including recidivism rates,[5] are provided on all offenders who participated in Peer 1 and The Haven between FY 2005 and FY 2008 in Table 13 below. Due to complications arising from the implementation of a new billing system, termination data for FY 2009 and FY 2010 are not yet available. Additionally, recidivism data concerning discharges in the two most recent fiscal years are not yet available, as these terminations have not been in the community for an adequate time to determine recidivism rates. Future studies will yield a more accurate representation of the impact these additional services have had on the recidivism rates of community corrections clients.

DCJ contracted with the Health Resources Consortium to examine the reasons these ARTS programs have traditionally had higher rates of success (as measured by 1-year and 2-year recidivism) than other community corrections programs in Colorado. The findings from this study are compiled in Appendix B.

[5] For the purposes of this report, recidivism is defined as a new misdemeanor or felony filing within 12 months of successful termination from residential supervision. Recidivism data from county and district court are included, with the exception of misdemeanor filings originating from Denver County as these data are unavailable.

Table 13. Diversion Community Corrections Client Outcomes: FY 2005 – FY 2008

Program	Fiscal Year	Successful Terminations % (Total N Terminations)	1 Year Recidivism[a] % (N Successful Terminations)	2 Year Recidivism[b] % (N Successful Terminations)	Mean Criminal History Score[c]
The Haven	FY 2005	45.1 (51)	0.0 (23)	8.7 (23)	2.4
	FY 2006	59.0 (39)	9.1 (22)	18.2 (22)	2.4
	FY 2007	43.1 (51)	4.5 (22)	4.5 (22)	2.8
	FY 2008	70.4 (54)	8.1 (37)	0.0 (14)	3.0
Peer 1	FY 2005	56.4 (78)	2.4 (42)	19.0 (42)	2.8
	FY 2006	43.4 (53)	13.0 (23)	39.1 (23)	2.9
	FY 2007	60.5 (81)	4.2 (48)	16.7 (48)	3.1
	FY 2008	51.4 (37)	5.9 (17)	12.5 (16)	3.0
Statewide	FY 2005	50.7 (2594)	14.0 (1254)	25.6 (1254)	2.4
	FY 2006	54.6 (2375)	17.8 (1244)	28.4 (1244)	2.5
	FY 2007	59.3 (2460)	15.4 (1394)	25.7 (1394)	2.5
	FY 2008	61.3 (2377)	13.8 (1380)	25.1 (666)	2.5

[a] New filing in district or county court. Denver county court filings are excluded

[b] 2-year recidivism figures for FY 2008 terminations are available only for those discharged between July 1, 2007 and December 31, 2008.

[c] The Colorado Criminal History Score, developed by M. Mande in the mid-1980s, is an index derived from a weighted combination of the following data items (weights shown in parentheses): number of juvenile adjudications (.5); number of juvenile placements in secure institutions (1.0); number of prior adult felony convictions (1.0); number of prior adult violent felony convictions (1.5); number of adult probation revocations (.75); and number of adult parole revocations (2.0). Scores are collapsed to form a five-point scale ranging from 0-4, with 0 representing the lowest and 4 representing the highest measure of criminal history.

Source: Offender termination data provided by DCJ's Office of Community Corrections and analyzed by DCJ's Office of Research and Statistics

b. Community Corrections Expansion for Offenders with Mental Illness (20 diversion and 45 transition)

Included in the $1.7 million provided for the expansion of community corrections, 65 beds for offenders with mental illness were allocated. Twenty beds were designated for diversion clients, and 45 for transition clients. Starting January 1, 2008, these beds were placed at the following facilities: Intervention Community Corrections Services (ICCS) in Lakewood, ComCor, Inc. in Colorado Springs, Larimer County Community Corrections, and Mesa County Community Corrections. Details regarding their placement are given in Table 14, below.

Table 14. Residential Mental Health Services (RMHS) Beds Funded Through FY 2008 Recidivism Reduction Package

Facility	# of Diversion Beds	# of Transition Beds	Gender
Intervention Community Correction Services (ICCS) (Lakewood)	10 beds	12 beds*	M and F
Larimer County Community Corrections	4 beds	12 beds	M and F
ComCor, Inc. (Colorado Springs)	4 beds (added beds)	12 beds (added beds)	M
Mesa County Community Corrections	2 beds	9 beds	M and F
Total	20	45	

* These transition beds represent the John Eachon Reentry program (JERP).

While programs initially experienced difficulty reaching bed capacity, there are currently more residential mental health clients than there are allocated beds, a reflection that this additional funding met a significant demand. Some difficulties have persisted, however, in the referral of transition offenders with mental illness. To address this issue, two discharge planners were funded in FY 2010. However, these funds were eliminated in the FY 2010 budget reductions. In an effort to facilitate this process, the Office of Community Corrections within the Division of Criminal Justice has implemented regular meetings with Department of Corrections personnel. Collaboration has significantly improved over the past several years.

Between July 2008 and June 2010, 394 clients have been discharged. Program termination data for these discharges are presented in Table 15. Discharges from the John Eachon Reentry Program (JERP) are separated from other diversion and transition discharges. Recidivism data concerning discharges in the most recent two fiscal years are not yet available, as these terminations have not been 'at-risk' in the community for an adequate time to determine recidivism rates.

The Division of Community Corrections undertook an analysis of the needs among the community corrections population for dual-diagnosis treatment services. This analysis resulted in the development of scope of work for the implementation of programming addressing the needs of this population. This program was implemented beginning in FY 2010 to continue forward into future years. This scope of work can be found in Appendix A.

Table 15. FY 2009 and FY 2010 Community Corrections Residential Mental Health Services (RMHS) Clients: Discharge Status.

	Total N Terminations	Success	Escape	Technical Violation	New Crime	Other
Diversion Mental Health	160	44.9%	10.2%	37.7%	1.2%	1.8%
Transition Mental Health	189	60.8%	9.8%	18.6%	0.0%	3.4%
John Eachon Reentry Program (JERP)	45	34.7%	12.2%	42.9%	0.0%	2.0%
Total	394	51.4%	10.2%	29.0%	0.5%	2.6%

Source: Community Corrections Information and Billing (CCIB) system.

c. Expansion of Community Corrections Transition Programs (74 beds)

The $1.7 million allocated for the expansion of community corrections included the addition of 74 transition beds. These beds were allocated on July 1, 2008 to the 33 transition community corrections programs across the state. All of these beds are in use as planned. As it is not possible to separate the additional beds from those previously existing for transition community corrections clients, program outcome data for all transition beds for fiscal years 2005 through 2010 are presented in Table 16 below. Due to the implementation of the Community Corrections Information and Billing (CCIB) system, it is not possible to separate fiscal years 2009 and 2010 at this time. Note that successful completion rates have improved over time, coinciding with the influx of resources from the Recidivism Reduction Package. Discharge outcomes and criminal history scores for FY 2008 discharges from individual transition programs are given in Table 17. Figure 2 compares discharges for successful completion and escape along with criminal history scores for individual transition programs.

Table 16. FY 2005 - FY 2010 Community Corrections Transition Clients: Discharge Status

Fiscal Year	Total N Terminations	Success %	Escape %	Technical Violation %	New Crime %	Other %
FY 2005	2,499	58.8	14.1	24.0	3.0	0.1
FY 2006	2,450	62.7	14.0	20.3	3.0	0.0
FY 2007	2,469	65.3	11.7	20.1	2.8	0.1
FY 2008	2,672	65.9	11.5	19.1	3.5	0.0
FY 2009/ FY 2010 combined	5,950	62.0	10.5	24.3	1.43	1.8

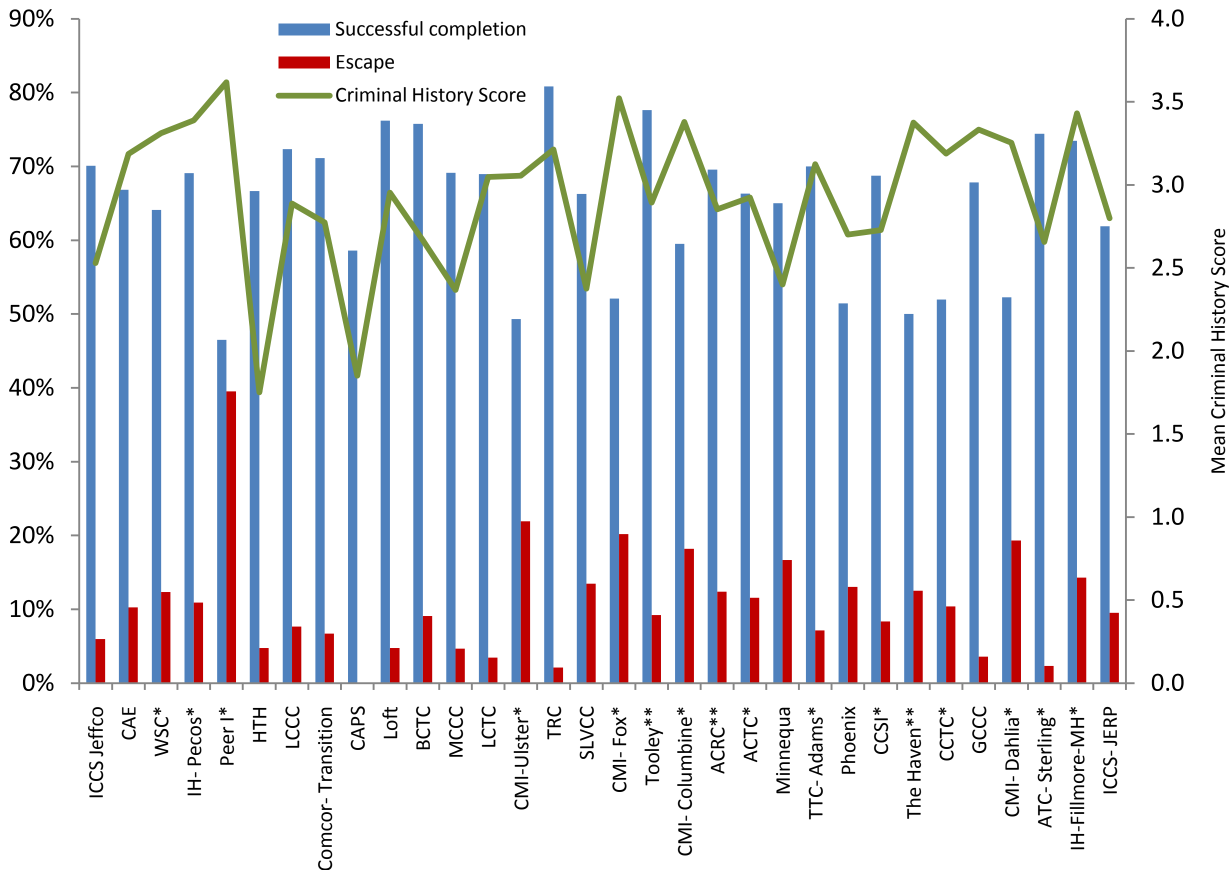
Source: Prior to FY 2009: DCJ Office of Research and Statistics analysis of Community Corrections Termination Forms. FY 2009/2010: Community Corrections Information and Billing (CCIB) system.

Table 17. Outcomes and Criminal History Score by Program: FY 2008 Transition Terminations

Program	Success %	Escape %	Technical Violations %	New Crimes %	Average Criminal History Score	N+
ICCS Jeffco	70.1	6.0	19.7	4.3	2.5	117
CAE	67.2	10.3	16.2	6.4	3.2	204
WSC*	64.5	12.4	19.5	3.6	3.3	169
IH- Pecos*	69.1	10.9	14.5	5.5	3.4	110
Peer I*	46.5	39.5	14.0	0.0	3.6	43
HTH	66.7	4.8	23.8	4.8	1.8	21
LCCC	74.1	7.8	14.5	3.6	2.9	166
ComCor Inc.	76.7	7.2	12.8	3.3	2.8	180
CAPS	58.6	0.0	31.0	10.3	1.9	29
Loft	76.2	4.8	19.0	0.0	3.0	21
BCTC	75.8	9.1	15.2	0.0	2.7	33
MCCC	69.2	4.7	23.4	2.8	2.4	107
LCTC	71.4	3.6	17.9	7.1	3.0	28
CMI-Ulster*	49.3	21.9	21.9	6.8	3.1	73
TRC	80.9	2.1	17.0	0.0	3.2	47
SLVCC	66.3	13.5	15.7	4.5	2.4	89
CMI- Fox*	52.1	20.2	23.5	4.2	3.5	119
Tooley**	77.6	9.2	13.2	0.0	2.9	76
CMI- Columbine*	59.5	18.2	20.7	1.7	3.4	121
ACRC**	69.6	12.4	16.5	1.5	2.9	194
ACTC*	67.0	11.7	19.1	2.1	2.9	94
Minnequa	68.4	17.5	12.3	1.8	2.4	57
TTC- Adams*	70.0	7.1	20.0	2.9	3.1	70
Phoenix	51.4	13.0	31.9	3.6	2.7	138
CCSI*	70.2	8.5	21.3	0.0	2.7	47
The Haven**	50.0	12.5	37.5	0.0	3.4	8
CCTC*	51.9	10.4	33.8	3.9	3.2	77
GCCC	67.9	3.6	25.0	3.6	3.3	28
CMI- Dahlia*	52.3	19.3	20.5	8.0	3.3	88
ATC- Sterling*	76.2	2.4	16.7	4.8	2.7	42
IH- Fillmore- MH*	73.5	14.3	12.2	0.0	3.4	49
ICCS- JERP	61.9	9.5	23.8	4.8	2.8	21
TTC- Commerce City*	33.3	33.3	33.3	0.0	~	3
Total	65.9	11.5	19.1	3.5	2.9	2669

Source: Community Corrections termination data provided by the Division of Criminal Justice Office of Community Corrections and analyzed by the Office of Research and Statistics.
+ Excludes cases discharged to an intensive residential treatment program. * Facilities serving males only. ** Female only facilities. ~ Data not available.

Figure 2. FY 2008 Community Corrections Transition Terminations: Program Outcomes and Criminal History (N=2669)



Source: Community Corrections termination data provided by the Division of Criminal Justice Office of Community Corrections and analyzed by the Office of Research and Statistics. Note: Facilities with fewer than 5 terminations are excluded.

* Facilities serving males only. ** Female only facilities.

Recidivism rates for successful transition discharges between FY 2005 and FY 2008 are given in Table 18.[6] Note that recidivism rates fell slightly in FY 2008 from those found for the prior three years. Recidivism outcomes by program for all transition discharges are presented in Table 19.

Recidivism data concerning discharges in the most recent two fiscal years are not yet available, as these terminations have not been 'at-risk' in the community for an adequate time to determine recidivism

[6] For the purposes of this report, recidivism is defined as a new misdemeanor or felony filing within 12 months of successful termination from residential supervision. Recidivism data from county and district court are included, with the exception of misdemeanor filings originating from Denver County as these data are unavailable.

rates. Future studies will yield a more accurate representation of the impact these additional services have had on the recidivism rates of transition community corrections clients.

Table 18. Community Corrections Transition Clients: Recidivism Rates of Successful Terminations FY 2005 – FY 2008

Fiscal Year	Successful Terminations N	New court filing[1] within 1 year of termination	New court filing[a] within 2 years of termination
FY 2005	1453	18.6%	29.7%
FY 2006	1525	18.8%	30.0%
FY 2007	1585	17.8%	30.2%
FY 2008	1736	15.3%	28.1%[b]

[a] New filing in district or county court. Denver County court filings are excluded

[b] 2-year recidivism figures for FY 2008 are available only for those discharged between July 1, 2007 and December 31, 2008 (N=915).

Source: The Division of Criminal Justice, Office of Research and Statistics analyzed data provided by Judicial Department's Integrated Colorado Online Network (ICON).

Table 19. Community Corrections Transition Clients: Recidivism Rates of Successful FY 2008 Terminations by Program

Program	New court filing[1] within 1 year of termination				New court filing[1] within 2 years of termination[2]			
	% within Program			N	% within Program			N
	No	Yes	Total		No	Yes	Total	
ICCS Jeffco	90.2	9.8	100.0	82	80.4	19.6	100.0	46
CAE	86.0	14.0	100.0	136	68.9	31.1	100.0	61
WSC	77.6	22.4	100.0	107	64.5	35.5	100.0	62
IH- Pecos	92.0	8.0	100.0	75	79.5	20.5	100.0	39
Peer I	90.0	10.0	100.0	20	75.0	25.0	100.0	16
HTH	85.7	14.3	100.0	14	83.3	16.7	100.0	6
LCCC	89.3	10.7	100.0	121	62.7	37.3	100.0	51
ComCor- Transition	87.6	12.4	100.0	137	77.3	22.7	100.0	66
CAPS	76.5	23.5	100.0	17	81.8	18.2	100.0	11
Loft	68.8	31.3	100.0	16	66.7	33.3	100.0	12
BCTC	76.0	24.0	100.0	25	75.0	25.0	100.0	12
MCCC	83.6	16.4	100.0	73	60.0	40.0	100.0	40
LCTC	78.9	21.1	100.0	19	85.7	14.3	100.0	7
CMI-Ulster	83.3	16.7	100.0	36	66.7	33.3	100.0	18
TRC	83.8	16.2	100.0	37	70.4	29.6	100.0	27
SLVCC	74.6	25.4	100.0	59	56.8	43.2	100.0	37
CMI- Fox	85.2	14.8	100.0	61	78.4	21.6	100.0	37
Tooley	89.5	10.5	100.0	57	87.0	13.0	100.0	23
CMI- Columbine	88.7	11.3	100.0	71	76.4	23.6	100.0	55
ACRC	85.7	14.3	100.0	133	81.7	18.3	100.0	71
ACTC	88.9	11.1	100.0	63	67.7	32.3	100.0	31
Minnequa	84.2	15.8	100.0	38	76.5	23.5	100.0	17
TTC- Adams	77.8	22.2	100.0	45	55.0	45.0	100.0	20
Phoenix	78.9	21.1	100.0	71	67.4	32.6	100.0	43
CCSI	81.8	18.2	100.0	33	70.6	29.4	100.0	17
The Haven	100.0	0.0	100.0	4	100.0	0.0	100.0	2
CCTC	90.0	10.0	100.0	40	76.5	23.5	100.0	17
GCCC	78.9	21.1	100.0	19	100.0	0.0	100.0	3
CMI- Dahlia	82.6	17.4	100.0	46	69.2	30.8	100.0	26
ATC- Sterling	80.6	19.4	100.0	31	71.4	28.6	100.0	14
IH- Fillmore- MH beds	82.4	17.6	100.0	34	65.0	35.0	100.0	20
ICCS- JERP	84.6	15.4	100.0	13	71.4	28.6	100.0	7
Total	84.7	15.3	100.0	1736	71.9	28.1	100.0	915

[1] New filing in district or county court. Denver County court filings are excluded

[2] 2-year recidivism figures for FY 2008 are available only for those discharged between July 1, 2007 and December 31, 2008 (N=915).

Source: The Division of Criminal Justice, Office of Research and Statistics analyzed data provided by Judicial Department's Integrated Colorado Online Network (ICON).

FY 2009 Crime Prevention and Recidivism Reduction Package

1. Division of Youth Corrections

a. Functional Family Therapy Program

Functional Family Parole Services (FFPS) is an integrated parole supervision and case management model for engaging, motivating, assessing and working successfully with high risk youth and their families. The focus for FFPS is the family relational system reminding parole officers that the family system is the client, not just the youth. The FY 2009 Recidivism Reduction Package included $359,062 to fund the statewide expansion of this program. However, these funds were eliminated in the FY 2009 budget reductions and this program was never implemented.

b. Senate Bill 94 funding reinstatement targeting evidence-based programs

This portion of the Recidivism Reduction Package targets $666,308 toward the development and implementation of evidence-based programs within the State's 22 judicial districts as managed by the Senate Bill 94 program. Senate Bill (SB) 94 became law on June 5, 1991, and authorized the creation of local, judicial-district based programs designed to provide alternatives to incarceration for pre-adjudicated and adjudicated youth. These programs work to reduce the incarcerated population by impacting the number of admissions into DYC facilities, or by reducing the length of stay for youths placed in DYC facilities. These funds are also used in each judicial district to implement a uniform intake screening and assessment of all youth taken into custody by law enforcement. The goal of this intake screening is to determine the most appropriate placement for youth. Four levels of placement are identified on the screening instrument, including secure detention, staff secure detention, residential/shelter, and home detention with monitoring.

DYC has invested significant resources toward the implementation of evidence-based programs statewide. The most significant of these has been the statewide implementation of the Colorado Juvenile Risk Assessment (CJRA) for SB 94. The use of the CJRA as a tool to screen and assess juveniles upon entry, to build case plans, and to make placement decisions fulfills the first principle of evidence-based practice. Additional efforts include a focus on evidence-based programming which is shown to reduce recidivism, allowing districts to expand the scope of SB 94 services to include services intended to prevent a commitment to DYC, and further development of the detention continuum.

A standard set of objectives for youth served under SB 94 have been identified as follows:

- Attaining low rates of youth failing to appear for court hearings. Over 96 percent of preadjudicated and sentenced youth were successful.

- Attaining low rates of youth with new charges. Over 88 percent of the youth did not receive new charges.
- Achieving a high rate of positive or neutral reasons for youth leaving SB 94 programs. Over 89 percent of youth had positive or neutral leave reasons.

Additional objectives identified in the Recidivism Reduction Package decision items included:

- A reduction in the duplication of services. The statewide initiative implemented by House Bill 1451 (the Collaborative Management Program, or CMP) supported DYC's efforts to implement the continuum concept by facilitating increased interagency collaboration across agencies. This program has been successful in reducing the duplication of services.
- Matching services with the needs of youth. Toward this end, the CJRA was implemented to enhance building case plans and making placement decisions.

2. Department of Human Services

a. Expand HB 1451, the Collaborative Management Program

The FY 2009 Recidivism Reduction Package included $622,372 targeted for this program, to provide funding to eight new counties. Funds totaling $313,000 for the evaluation of this program were included in this amount.

House Bill 1451 was passed by the Colorado General Assembly in 2004, reflecting the idea that the development of a uniform system of collaborative management is necessary for agencies at the state and county levels to effectively and efficiently collaborate to share resources or to manage and integrate the treatment and services provided to children and families who benefit from multi agency services. Participating partners include county departments of human/social services, local judicial districts, health department, school district(s), community mental health centers and behavioral health organizations, parent or family advocacy organizations, community agencies, and other state agencies. Collaborative Management Programs have developed throughout Colorado in urban, rural, and frontier counties.

While the structure of programs varies across communities, the goals remain the same. These goals include:

1. Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent advocacy or family advocacy organizations;
2. Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi agency services;
3. Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi agency services;
4. Encourage cost sharing among service providers; and
5. Lead to better outcomes and cost reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado.

The Division of Child Welfare within the Colorado Department of Human Services (CDHS) is charged with oversight of HB 1451. In FY 2009 there were 24 Colorado counties participating, compared to the 17 participating in FY 2008. The oversight body for each county is the Interagency Oversight Group (IOG). These oversight groups are composed of the mandatory agencies and are signatories to Memorandums of Understanding with the community agencies involved. The entire process is overseen by a state steering committee composed jointly of state, county, and community participants. The steering committee co-chairs include a representative from the counties and a representative from a mandatory state agency participant.

The original statute requires that HB 1451 collaboratives develop and track outcomes in the areas of child welfare, juvenile justice, education and health/mental health services. The State offers incentive dollars to each County Collaborative, based upon the number of outcomes achieved. Youth currently served through HB 1451 are youth and/or families involved in multiple agencies. These youth are tracked in the CDHS information management system (Trails), as the State intends to use this database as an evaluation resource.

As required per statute,[7] a two-year summary of youth served and services provided by the 1451 initiative is compiled in the *Collaborative Management Program - Executive Report Summary* for state fiscal years 2008 and 2009. Table 20 summarizes these findings.

Table 20: Collaborative Management Program: Services Provided FY 2007 and FY 2008.

Item Reported	FY 2007-2008	FY 2008-2009
The number of children and families served through the local-level individualized service and support teams	10,290 children served in 17 counties	12,718 children served in 24 counties
The estimated costs of implementing the collaborative management approach	The 17 counties estimate cumulative implementation costs to be approximately $2,900,000.	The 24 counties estimate cumulative implementation costs to be approximately $3,400,000.
The estimated amount of moneys that were reinvested in additional services provided to children or families.	The counties estimate approximately $5,000,000 in monies that were reinvested in additional services.	The counties estimate approximately $6,000,000 in monies that were reinvested in additional services.
Identified barriers to the ability of the state and county to provide effective services to persons who received multi-agency services.	Cross systems information sharing, multiplicity of assessments, integration of service information, lack of services in rural areas, education of mid-level and line staff in collaborative management principles, family engagement, engagement of partners, staff turnover.	Continued need for data sharing and uniform information sharing protocols, ability to blend funding, lack of uniform service plans, acceptance of family members as active partners, barriers in employing family support partners, funding shortages.

Source: Collaborative Management Program (24 – 1.9 – 103) Executive Report Summary SFY 2008-2009

Cited outcomes of the services provided over FY 2008 and FY 2009 include the following:

- Integrated staffings,
- Increase in use of System of Care models,
- Reducing length of stay in institutional settings,
- Improved school attendance and reduction in truancies,
- Increase in successful probation terminations and reduction in recidivism,
- Increased child and family involvement in case planning,

[7] C.R.S. 24-1.9-103

- Reduction in use of inpatient services,
- Increase in measured level of functioning,
- Reduction in substance abuse,
- Reduction in unplanned moves in placement,
- Increase in number of children remaining at home after service delivery completed,
- Further development and expansion of outcome based services,
- Improvement in interagency collaborative processes,
- Reduced school dropout rates,
- Reduced truancy rates and increase in attendance,
- Increase in successful termination of probation,
- Increase in number of children remaining at home after service episode,
- Reduction in DYC commitments,
- Expansion of programs designed to serve children and families in community settings,
- Reduction in high-end residential placements, and
- Implementation of high fidelity wraparound services and wraparound training and coaching capacity.

In July, 2009 the OMNI Institute was hired by CDHS to conduct a statewide evaluation of the CMP for FY 2010. The contract was received and work began in October 2009. Between October 2009 and January 2010, the OMNI Institute developed the infrastructure needed to conduct a statewide evaluation of the HB 1451 initiative. This foundation and the overall multi-method evaluation approach, which includes formative, process and outcome components, will allow for the assessment of project outcomes, a determination of the importance of collaborative efforts, and the identification of best practices and lessons learned to help improve the functioning of all CMP projects.

The overall evaluation infrastructure will include the following components:

1. Finalization of the web-based quarterly reporting system
This reporting system is designed to collect key information that can inform the legislature, existing CMP projects and new 1451 counties about the significant work CMPs are doing.

2. Development and implementation of multiple tools to assess collaboration
In addition to key informant interviews with selected counties and state level stakeholders, two survey instruments will be collected from all IOG members in all 27 sites. These surveys will be collected in April of 2010, with results presented in the final evaluation report.

3. Descriptions of project process models to identify structural approaches to local program implementation

Process data collected through these efforts will be linked to information related to collaborative practices and service models being implemented across the state. The first round of data collection has been completed and counties will continue submitting these data via an on-line quarterly reporting system.

4. Development of data sets related to common outcome areas

In the coming months OMNI will complete work identifying standardized performance measures in each outcome area and trend data related to common outcomes identified by the CMP sites.

5. Full implementation of the HB 1451 portal

This portal is a web-based system designed to assist communities in working in a collaborative environment. The HB 1451 collaborative portal is expected to support inter-project communication; disseminate information of project efforts to help projects learn from each other; and support the development of a knowledge base to continue to inform local efforts.

6. Development of a cost model

Another area for exploration in the evaluation is a comparison of costs savings to collaborative practices and processes with the inclusion of CMP support costs.

An initial progress report was issued by OMNI Institute in February, 2010. This progress report covers a four month period, from October 1 through January 31, 2010 and thus represents very early and inconclusive results. More summary results will be available after the completion of a full year of evaluation activities. The full report can be found in Appendix C.

3. Department of Corrections

a. Parole wrap-around substance abuse and other services

The FY 2009 Recidivism Reduction package provided $1.8 million to proven parole wrap-around services. This proposal was intended to provide year-long wrap-around community-based services to approximately 200 parolees as well as mental health and substance abuse follow-up services in the second year. However, these funds were eliminated as part of the budget reduction packages for both FY 2009 and FY 2010.

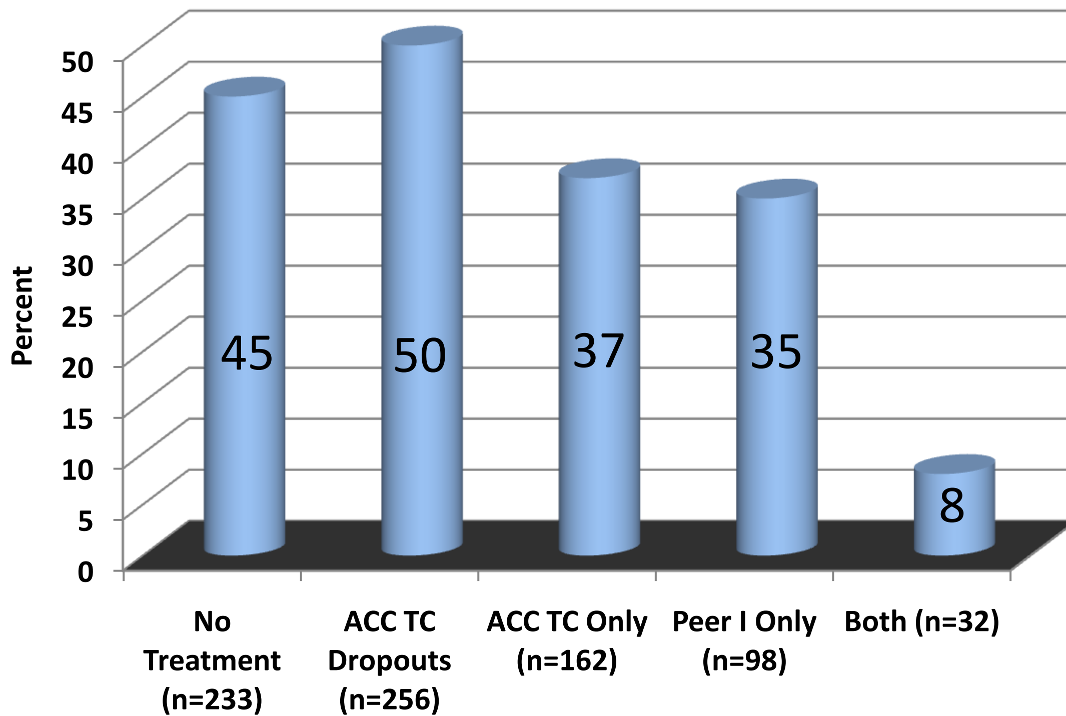
b. Expand substance abuse therapeutic community treatment

The FY 2009 Recidivism Reduction package provided $375,000 to add seven contract counselors to provide services to an expanded therapeutic community (TC) program at Arrowhead. This is intended to exist in conjunction with the CDPS decision item for expanded funding for community substance abuse therapeutic communities. This program was expected to reduce recidivism by 1 percent per calendar year, lowering the overall recidivism rate to 47.7 percent by 2010.

A 6-year National Institute of Drug Abuse (NIDA) funded study evaluated a Modified TC with aftercare services for mentally ill substance abusing offenders in Colorado. It was found that a significant reduction in recidivism and crime occurred with these programs as compared to offenders who received standard services within the general population. Another study conducted in 1998 on the effectiveness of Colorado DOC TC programs found that TC participants who stayed in treatment at least 6 months had a 43 percent reduction in 1-year recidivism rates when compared to control groups.

A continuation study of the TC program at Arrowhead Correctional Center was funded by the National Institute of Justice (NIJ) as a collaborative research project between DOC and the University of Colorado. This study was completed in 2004 and further demonstrated that the TC programs in Colorado significantly reduce recidivism. The outcome effect is dramatically improved when prison treatment is combined with the community-based Peer I TC and parole supervision. Results of this continuation study are shown in Figure 3 below.

Figure 3: One-Year Reincarceration Rates by Therapeutic Community Program Participation



Implementation of the new TC at Arrowhead was delayed by the statewide conversion of contract positions to FTE, the hiring freeze and the need to request exemptions for each direct service position, and initially a lack of applicants for Certified Addiction Counselor positions. To resolve this, Clinical Services initiated a targeted advertising campaign. Since then, these funds have allowed the Arrowhead Therapeutic Community (TC) to expand to a total of 195 substance abuse beds, an increase of 99 from the previous 96 beds. Inmates were placed into expansion beds in July, 2009 and the program reached its full capacity in May, 2010. In order to adhere to the model already in place, it was necessary to also expand TC worksites, which included canteen, on-site ground maintenance for Centennial prison and the Colorado State Penitentiary, maintenance, and the fishery. There are currently 12 hired staff and 3 vacancies.

Due to the lengthy expected of stay in such a program, an inadequate amount of time has elapsed for any clients served under these funds to be successfully discharged from the program. Therefore, no discharge information or recidivism data are available at this time.

c. Expand staffing to increase services for mentally ill offenders in prison

The FY 2009 Recidivism Reduction package provided $1.75 million to increase services to mentally ill offenders within DOC. This program was expected to reduce recidivism by 1 percent per calendar year, lowering the overall recidivism rate to 47.7 percent by 2010.

All of the mental health clinician positions have been filled, although there may periodically be vacancies due to staff turnover. The funding under the FY 2009 recidivism reduction package enabled the hiring of one additional clinician at virtually every DOC facility. A few facilities with high mental health needs (e.g., San Carlos, CSP) gained two additional mental health positions.

d. Expand vocational and academic instruction for offenders

The FY 2009 Recidivism Reduction package provided $644,000 to expand academic and vocational training within DOC. This program was expected to reduce recidivism by 1 percent per calendar year, lowering the overall recidivism rate to 47.7 percent by 2010.

The Department is to provide GED instruction to an additional 400 students per year and 130 vocational students per year with the addition of eight new instructors. Of the eight positions that were funded, five are academic positions (GED instructors) located at Limon, Delta, Sterling, Trinidad, and La Vista facilities. Three positions were hired as instructors for the Career and Technical Education Program at Colorado Correctional Center, Territorial, and Trinidad facilities. All positions have been filled, although the vocational position at Trinidad has since been vacated and is currently being advertised.

e. Planning and Analysis Statisticians

The FY 2009 Recidivism Reduction package provided $126,142 to hire two full time statisticians, to provide DOC with enhanced analytical capacity as it targets recidivism as one of its key strategic goals.

The Office of Planning & Analysis has filled both statistician positions, although it should be noted that one has been on leave under worker's compensation since August, 2009. A computer upgrade project was completed in June, 2010 that will improve tracking of offenders who need and receive treatment services. The Department of Corrections Information System (DCIS) currently has a program known as "MPS," or Master Program Scheduling. Originally developed to track inmates' work assignments, MPS was later adopted for tracking program participation. However, there were certain computer program limitations that made it inadequate for tracking treatment participation. The Office of Planning & Analysis collaborated with Business Technologies and Clinical Services in FY 2010 to make a number of improvements to the MPS system. These changes included:

- **Department-wide referrals**. Previously, offenders could only be referred to programs that were offered at their current facility. This presented a challenge for inmates needing programs such as the Sex Offender Treatment and Monitoring program (SOTMP) or TCs that are offered only at certain facilities.
- **Automation/prioritization of referrals.** All of the criteria used to assess inmates' needs and place them in treatment are available in DCIS. Specific criteria were defined to automate and prioritize offenders' placement on a referral list for drug and alcohol treatment and for the SOTMP. Generally these criteria included their needs levels, time to parole eligibility, and sentence type (e.g., lifetime vs. traditional sentence). Because many of the mental health services are individualized, Mental Health Services did not create an automated referral list.
- **Historical Record.** Previously, there was no historical record of offenders who were placed on the referral or waitlists. These programmatic changes will enable tracking of historical referral/waitlist records.
- **Reports.** A new report was built to identify offenders needing treatment based on their prioritization (rather than alphabetical order). This report also enables clinicians to screen the eligible list based on specific criteria and to search system-wide. Additional management reports have been requested but not yet completed.

These efforts will enable the accurate reporting of offenders who receive treatment and re-entry services in the future.

4. Division of Criminal Justice

a. Expansion of Community Corrections Diversion Programs (162 beds)

The FY 2009 Recidivism Reduction package allocated $2.3 million to expand community corrections diversion programs by 162 beds. These additional beds were distributed on July 1, 2009 among the 32 community corrections diversion programs across the state. However, not all of these beds are in use as planned as the number of diversion referrals declined in FY 2009. The reasons for this decline include:

i. Statutory changes reduced a number of felony crimes to misdemeanors, reducing the number of felony filings and convictions.

ii. The number of referrals from probation have declined, due to the reduction in probation technical violations. This reduction is likely due to the efforts on the part of the probation department to implement Evidence-Based Practices in the supervision of probationers.

iii. The overall crime rate in the state of Colorado has declined.

iv. An increase in the number of transition clients has occurred, due to the Department of Correction's response to budgetary constraints. Therefore, some of these beds intended for diversion clients were used for to accommodate the increase in the need for transition beds.

As it is not possible to separate the additional beds from those previously existing for diversion community corrections clients, overall diversion program termination data are presented in Table 21 below.

Table 21. FY 2005-FY 2010 Community Corrections Diversion Clients: Discharge Status

Fiscal Year	Total N Terminations	Success	Escape	Technical Violation	New Crime	Other
FY 2005	2,594	50.7%	19.5%	26.4%	3.4%	0.0%
FY 2006	2,375	54.6%	17.4%	25.1%	2.9%	0.0%
FY 2007	2,460	59.3%	13.5%	24.0%	3.2%	0.0%
FY 2008	2,381	61.3%	12.0%	23.3%	3.3%	0.1%
FY 2009/ 2010 combined	4,869	56.2%	11.7%	29.1%	1.6%	1.4%

Source: Prior to FY 2009: DCJ Office of Research and Statistics analysis of Community Corrections Termination Forms. FY 2009/2010: Community Corrections Information and Billing (CCIB) system.

Recidivism data concerning discharges in the most recent two fiscal years are not yet available, as these terminations have not been in the community for an adequate time to determine recidivism rates. Future

studies will yield a more accurate representation of the impact these additional services have had on the recidivism rates of diversion community corrections clients.

b. Nonresidential (outpatient) therapeutic community beds

The $778,000 appropriation for nonresidential, or outpatient TC services was targeted for program development at the Addition Research and Treatment Services (ARTS) programs Peer 1 and The Haven, and at the Crossroads' Turning Point program in Pueblo. These funds were to provide services to TC graduates only, in the form of rent subsidies, psychiatric services, child care and enhanced case management.

The ARTS allocation has been used as intended. However, some of the funds intended for the Crossroads' Turning Point program in Pueblo have not been used due to a delayed implementation. These funds were transferred to the Peer I and The Haven programs, where they have been fully utilized.

Given that the average length of stay for those who complete the outpatient component of a TC treatment episode is almost 2 years, termination data regarding clients served in these programs will not be available for several more years. Recidivism data will not be available until mid-2012 at the earliest, as terminations must be 'at-risk' in the community for an adequate time to determine recidivism rates. Future studies will yield a more accurate representation of the impact these additional services have had on the outcomes and recidivism rates of those receiving these enhanced services.

FY 2010 Recidivism Reduction and Offender Diversion Package

1. Division of Youth Corrections

a. Prevention Services for Youth

The Division of Youth Corrections in the Department of Human Services received funding to serve 480 juveniles in the Functional Family Therapy (FFT) program. This program was aimed at preventing youth at risk of out-of-home placement from entering or penetrating further into the juvenile justice system. First-year funding totaling $3.3 million was allocated for this program in the FY 2010 Recidivism Reduction package. However, these funds were eliminated during the budget reductions of FY 2010 and this program was never implemented.

2. Division of Criminal Justice

a. Expansion of Community Corrections Diversion Programs (152 beds)

The FY 2010 Recidivism Reduction package allocated $1.6 million to expand community corrections diversion programs by 152 beds. These additional beds were distributed on July 1, 2010 among the 32 community corrections diversion programs across the state. However, as in the case of the FY 2009 diversion bed expansion, not all of these beds are in use as planned as the number of diversion referrals has declined in the past two years. The reasons for this decline include:

a. Statutory changes reduced a number of felony crimes to misdemeanors, reducing the number of felony filings and convictions.

b. The number of referrals from probation have declined, due to the reduction in probation technical violations. This reduction is likely due to the efforts on the part of the probation department to implement Evidence-Based Practices in the supervision of probationers.

c. The overall crime rate in the state of Colorado has declined.

d. An increase in the number of transition clients has occurred, due to the Department of Correction's response to budgetary constraints. Therefore, some of these beds intended for diversion clients were used for to accommodate the increase in the need for transition beds.

As it is not possible to separate the additional beds from those previously existing for diversion community corrections clients, overall diversion program termination data are presented in Table 22 below.

Table 22. FY 2005-FY 2010 Community Corrections Diversion Clients: Discharge Status

Fiscal Year	Total N Terminations	Success %	Escape %	Technical Violation %	New Crime %	Other %
FY 2005	2,594	50.7	19.5	26.4	3.4	0.0
FY 2006	2,375	54.6	17.4	25.1	2.9	0.0
FY 2007	2,460	59.3	13.5	24.0	3.2	0.0
FY 2008	2,381	61.3	12.0	23.3	3.3	0.1
FY 2009/2010 combined	4,869	56.2	11.7	29.1	1.6	1.4

Source: Prior to FY 2009: DCJ Office of Research and Statistics analysis of Community Corrections Termination Forms. FY 2009/2010: Community Corrections Information and Billing (CCIB) system.

Recidivism data concerning clients served under these funds will not be available for several more years, as the average length of stay for successful diversion program terminations is approximately 7.8 months. Additionally, these terminations must be in the community for an adequate time to determine recidivism rates.

b. Therapeutic Community Diversion Beds

The FY 2010 Recidivism Reduction package also allocated $482,000 to add 44 TC diversion beds in southern Colorado. Specifically, these beds were targeted for the Crossroads' Turning Point program in Pueblo, Colorado to augment the 16 TC beds appropriated by the legislature in FY 2009.

The Crossroads TC has now been in existence for 14 months and has a total of 60 beds. In spite of a lengthy start-up due to a slow referral process, these beds are now completely utilized. Table 23 displays the numbers of clients served to date.

Table 23. Crossroads Turning Point Therapeutic Community Clients Served: FY 2010

Legal Status	Total N Admissions	Total N Terminations	Total N Successful Terminations
Diversion	58	31	5
Transition	38	9	2

Source: Community Corrections Information and Billing (CCIB) system

As the length of a successful TC episode averages a year and may last 2 years, the numbers of successful terminations given in Table 23 are not an accurate reflection of future client outcomes. Accurate outcome data regarding the clients served with these funds will not be available for several more years.

c. Accelerated Non-Residential Diversion Community Corrections Pilot Program

The Department of Public Safety also received $197,000 to develop an accelerated non-residential community corrections pilot program for diversion offenders. The implementation of this program is currently in progress and no data are available. Program implementation was delayed due to the potential elimination of these funds in the FY 2010 budget reductions. These funds were not rescinded, and program implementation began in mid-FY 2010.

d. Discharge Planning Services for Transition Community Corrections Clients

The FY 2010 Recidivism Reduction Package included $160,000 to add discharge planning services for community corrections transition clients. These funds were eliminated in the FY 2010 budget reductions and these services were not implemented.

e. Increase Length of Stay in Transition Intensive Residential Treatment Programs

The FY 2010 Recidivism Reduction Package allocated $160,000 to the Department of Public Safety to lengthen the existing Intensive Residential Treatment (IRT) program term of stay. Based on extant research and Evidence-Based Practices, the IRT modality was modified in FY 2010 from a 45-day to a 90-day program. While this program had a slow initial implementation, it was fully subscribed as of the end of FY 2010.

Table 24 gives the number of clients served in the 90-day community corrections intensive residential treatment programs during FY 2010. Recidivism data on these terminations will not be available for another year.

Table 24. Intensive Residential Treatment Clients Served: FY 2010

Program	Legal Status	Total N Admissions	Total N Terminations	Total N Successful Terminations
San Luis Valley Community Corrections	Diversion	22	22	19
	Transition	139	135	93
Larimer County Community Corrections	Diversion	3	0	0
	Transition	8	1	0

Source: Community Corrections Information and Billing (CCIB) system

3. Department of Corrections

The Department of Corrections received funding to begin a pre-release curriculum and planning program to transition offenders from facilities to the community. Funding was also provided to expand TC capacity by 418 beds to serve offenders with co-occurring substance abuse and mental health needs. Additionally, the Department of Corrections received funding to expand academic and vocational education services to more than 2,000 additional offenders.

1. Pre-release curriculum and planning program

The Department of Corrections received funding to begin a pre-release curriculum and planning program to transition offenders from facilities to the community. The addition of multiple transition services costs approximately $340,000 in the first year. The Pre-Release Program targets known barriers to successful community re-entry, utilizing 10 modules designed to increase awareness, self-sufficiency, networks of support and action around critical re-entry components including:

- Identification
- Housing
- Employment
- Transportation
- Money management
- Education
- Healthy Lifestyles
- Family, Relationships & Support Systems
- Victim Awareness and Restorative Justice
- Living under Supervision

All pre-release positions are currently filled. Pre-release services exist at the following facilities: Arkansas Valley, Arrowhead, Four Mile, Skyline, Colorado State Penitentiary, Centennial Correctional Facility, Colorado Territorial, La Vista, San Carlos, Trinidad, Sterling, Buena Vista Complex, Denver Women’s, Colorado Correctional Center, Limon, Rifle, and Delta.

2. In-Prison Offender Treatment Services

The Department of Corrections received $2.9 million to expand TC capacity by 418 beds, serving offenders with co-occurring substance abuse and mental health needs. These funds enabled the addition of five new TCs.

The new sites that have been selected for the TCs are: Buena Vista Minimum Center, La Vista, Trinidad, and Arkansas Valley. Arkansas Valley will be a larger program, using the resources designated for two TCs. When fully operational, the additional TCs will house 418 offenders. Of the 37 annual FTE positions, 5 have been hired. Staff at Buena Vista and La Vista are currently working to identify TC participants, sign treatment contracts, and develop core groups to begin building a positive peer culture. At Arkansas Valley, construction is underway to create treatment group rooms and groups will begin in late August. At Trinidad, hiring is currently underway.

Due to the lengthy expected stay in such a program, an inadequate amount of time has elapsed for any clients served under these funds to be successfully discharged from the program. Therefore, no discharge information or recidivism data are available at this time.

3. Expand academic and vocational education services

The Department of Corrections was allocated funding to expand academic and vocational education services to more than 2,000 additional offenders. The first year cost of these in-prison services was to be approximately $5.0 million, but these funds were eliminated as part of the budget reduction package.

4. Department of Human Services

a. Outpatient substance abuse treatment services

The final allocation of the FY 2010 Recidivism Reduction package was to the Department of Human Services to provide outpatient substance abuse treatment for additional clients using Drug Offender Surcharge Fund moneys. The cost of these additional services is approximately $250,000. These funds were distributed statewide for the delivery of the Strategies for Self Improvement and Change (SSIC) curriculum. SSIC is a manualized intervention based on a cognitive behavioral model of change, an approach that has demonstrated significant advancement in the treatment of individuals with both criminal behaviors and involvement with substance abuse. SSIC is typically 48 - 50 weeks in length and has a comprehensive participant manual, which outlines the goals, objectives and activities for each session. Phase I is entitled “Challenge to Change” and is 18 sessions in length. Phase II is entitled “Commitment to Change” and is 22 sessions in length. Phase III is “Taking Ownership of Change” and is approximately 10-12 sessions in length.

Funds derived from the Drug Offender Surcharge has supported the use of SSIC among public substance abuse treatment agencies for several years. The largest provider of the curriculum is the Signal Behavioral Health Network, who conducted a study of the effectiveness of this intervention on future recidivism. The results of study can be found in Appendix D.

The Division of Behavioral Health contracts with Managed Service Organizations (MSOs) to distribute Federal and State dollars to seven sub-state planning areas. The funds are filtered through the MSO to licensed treatment providers in each of the sub-state planning areas. The distribution of the funds provided by the FY 2010 recidivism reduction package is outlined by sub-state planning area below in Table 25. However, as the designated MSOs receive other funding for delivering the SSIC curriculum, the total amount of funds available for SSIC is $890,328.

Table 25. Distribution of FY 2010 Recidivism Reduction Funds Allocated to the Division of Behavioral Health

Sub-State Planning Area	Funds Allocated	Proportion of Total
1	$32,858	13.0%
2	$120,661	37.6%
3	$35,944	13.3%
4	$14,277	18.2%
5/6	$28,138	12.0%
7	$18,122	5.9%
Total	$250,000	100%

Signal Behavioral Health Network is the MSO for sub-state planning regions 1, 2 and 4. Signal paid the amounts outlined in Table 26 to all 9 of their SSIC providers for FY 2010. These funds distributed by Signal totaled $597,178.79. The research study by Dr. Robert Booth, provided in Appendix D, concerned Signal's network of providers so outcomes are representative of their service delivery.

Table 26. Distribution of DBH Recidivism Reduction Fund Allocation: Sub-State Planning Areas 1, 2 and 4.

Sub-state Planning Area	Provider	Funds Allocated
Region 1	North Range Behavioral Health	$54,690.49
	Larimer Center	$26,820
	Centennial Mental Health	$31,558.50
Region 2	Arapahoe House	$52,175
	ARTS	$267,340.70
	CADREC	$23,007.80
	Sobriety House	$11,580
Region 4	Crossroads Turning Point	$92,412
	San Luis Valley Mental Health Center	$37,594.30

West Slope Casa is the MSO for regions 5 and 6. The SSIC curriculum was delivered to 240 offenders through the 10 providers listed in Table 27 over the past year. These providers received a total of $114,241. While the number of program completions is not available, providers report that the completion rate is "high" due to the fact the clients are involved with the criminal justice system.

Table 27. Distribution of DBH Recidivism Reduction Fund Allocation: Sub-State Planning Areas 5 and 6.

Sub-state Planning Area	Provider	Funds Allocated
Regions 5 and 6	Axis Health (formerly Southwestern Colorado Mental Health)	$114,241
	Balance Counseling	
	Midwestern Colorado Mental Health	
	Colorado West Mental Health	
	White River Counseling (no longer in business)	
	Roaring Fork Counseling*	
	Summit View Counseling	
	Springs Counseling*	
	CARS (Cortez Addiction Recovery Services)	
	Pathfinder Clinic*	

*Denotes providers who delivered SSIC to offenders in STIRRT Continuing Care

Connect Care contracted with 2 providers to deliver SSIC, with a total cost of $118,575 (see Table 28). Of the 176 offenders admitted in FY 2010, 78 offenders were discharged from treatment. Of these, 69 percent completed treatment.

Table 28. Distribution of DBH Recidivism Reduction Fund Allocation: Sub-State Planning Area 3

Sub-state Planning Area	Provider	Funds Allocated
Region 3	Bridge to Awareness	$53,550
	Rocky Mountain Behavioral Health	$65,025

Boulder County Public Health, Addiction Recovery Centers, provides all SSIC services in Region 7 and was allocated $60,333. More complete outcome data were available from Boulder County Public Health than were available from the other MSOs. Table 29 outlines the numbers of clients served and their completion status by program location.

Table 29. Region 7 SSIC program participant outcomes, FY 2010

Location	Successful Completion	Did not Complete	Still Active	Total N
Boulder program	33%	17%	50%	18
Longmont program	52%	12%	36%	25
Combined program totals	44%	14%	42%	43

Summary Matrix: DCJ Report to OSPB
FY 2008, FY 2009 and FY 2010 Recidivism Reduction Packages

FY08	Funding	Description	Status Today	Outcomes Stated in Decision Items	Findings End of FY 2008
DYC	$1.9M	Flexible funding for Continuum of Care Initiative	1,695 youth served with $2,636/youth expended in FY08, 1,715 youth served with $2,761/youth expended in FY09.	Not available	• Fewer youth at risk of reoffending as measured by the CJRA. • Commitment ADP has steadily decreased since implementation, to lowest point observed in 10 years. • Recommitment rates of discharged youth declined by 11.6% over comparison cohort. • Recidivism reduced by 9% over comparison cohort. • Average days in residential placement declined by 9.9% in FY08 and by 5.5% FY09 over the LOS of the comparison cohort.
DBH	$1.3M	Expand Short-Term Intensive Residential Remediation Treatment (STIRRT)	Implemented in 4 sites; 2 new/2 existing: 50 beds for men; 23 beds for women. However, services at the Mesa county site were discontinued in FY 2010. The other three programs are providing ongoing services.	Not available	• 914 total participants FY08. • 892 total participants in FY09. • Between January 2008 and June 2009: o 90.2% successfully completed. o 44.0% went on to continuing care. o 6 month recidivism rate was 14.8%. o 12 month recidivism rate was 24.9%.
DCJ	$1.7M	Expand Community Corrections by: • 20 diversion substance abuse therapeutic community (TC) beds • 65 mental health beds (20 diversion and 45 transition) • 74 transition beds	20 TC beds implemented at Addiction Research and Treatment Services (ARTS) 65 mental health beds implemented in 4 programs. Remainder implemented in transition programs across the state.	Not available	• Between 43.1% and 59.0% of Haven participants successfully terminated between FY05 and FY07. In FY08, successful terminations increased to 70.4%. Of those at risk for 2 years, none recidivated. • 51.4% of Peer I terminations in FY08 were successful, with a 2-year recidivism rate of 12.5%. • Between FY09 and FY10, 394 mental health clients have been discharged with 51.4% successful. Recidivism data are not available as discharged clients have not been at risk for an adequate period of time. • Successful transition program completion rates improved between FY05 and FY08 from 58.8% to 65.9%. In FY09 and FY10, successful completions fell slightly to 62.0% One-year recidivism rates of FY08 terminations declined by 14.0 percent over the previous year. Two-year recidivism rates declined by 7.0%.

FY09	Funding	Description	Status Today	Outcomes Stated in Decision Items	Findings to date
DYC	$359K	Functional Family Treatment parole officer training	These funds were eliminated in FY09 budget reductions and this program was never implemented.	--5 fewer youth recommitted to DYC --reduce pre-discharge recidivism from 38.5% in FY06 to 35% --75% employment /in-school rate at discharge	A parole task force was created and motivational interviewing training underway. However, these funds were eliminated in the FY09 budget reductions and this program was never implemented.
DYC	$666K	Reinstate SB94 funding	Evidence-based programs implemented in 22 judicial districts, statewide implementation of the CJRA.	--No court FTAs --No new charges while in the program --Less duplication of services --Services match youth needs	Statewide implementation of the CJRA to assess juveniles, build case plans, and make placement decisions fulfills the first principle of evidence-based practice. • Over 96 percent of preadjudicated and sentenced youth discharged in FY09 avoided failures to appear in court. • Over 88 percent of the youth discharged in FY09 did not receive new charges while in the program. • Over 89 percent of youth had positive or neutral reasons for leaving SB 94 programs in FY09.

FY09 Continued	Funding	Description	Status Today	Outcomes Stated in Decision Items	Findings to date
DHS	$122K	HB1451—Expands DHS' Collaborative Management Program to 8 new counties	In FY09 there were 24 Colorado counties participating. OMNI Institute retained to conduct ongoing evaluation.	--Reduce duplication /fragmentation of services --encourage cost sharing --better family outcomes	In FY06, 4,752 children were served in 6 counties. First-year implementation costs in these 6 counties were in excess of $600,000. In FY07, 9,557 children were served in 10 counties. Cumulative implementation costs estimated to be in excess of $2 million. In FY08, 10,290 children were served in 17 counties, with an estimated implementation cost of approximately $2.9 million. In FY09, 12,718 children served in 24 counties with implementation costs of $3.4 million. Numerous positive juvenile and family outcomes have been reported.
DOC	$1.8M	Parole wrap-around services	Funds eliminated in budget reductions for both FY 2009 and FY10.	--Reduce recidivism by 1% each calendar year to 47.7% by 2010.	Contracts awarded Oct 1 to 8 service providers. However, funds eliminated in budget reductions for both FY09 and FY10.
DOC	$375K	In-prison substance abuse TC programming	Arrowhead TC to expand to a total of 195 substance abuse beds, an increase of 99 from the previous 96 beds.	--Reduce recidivism by 1% each calendar year to 47.7% by 2010.	Inadequate time has elapsed for any clients served under these funds to be successfully discharged. Therefore, no discharge information or recidivism data are available at this time.

FY09 Continued	Funding	Description	Status Today	Outcomes Stated in Decision Items	Findings to date
DOC	$1.75M	Increase services to mentally ill	All of the 19 positions created have been filled. One clinician has been placed at virtually every DOC facility, and two at facilities with high mental health needs.	--Reduce recidivism by 1% each calendar year to 47.7% by 2010.	None Available.
DOC	$644K	Expand academic/vocational training	All positions have been filled, with 5 GED instructors and 3 technical education program instructors.	--Reduce recidivism by 1% each calendar year to 47.7% by 2010.	None Available.
DCJ	$2.3M	Expand community corrections by 162 diversion beds	Allocated 162 diversion beds on 7/1/09 across the state.	--Improved program outcomes	Discharge rates for FY10 are not available at this time. Additionally, recidivism data for these discharges will not be available for another year.
DCJ	$778K	Provide 40 TC outpatient beds	40 TC outpatient beds implemented at ARTS.	--Improved program outcomes	As the LOS for those completing OP TC treatment is almost 2 years, outcome data will not be available for several more years.

FY10	Funding	Description	Status Today	Outcomes Stated in Decision Items	Findings to date
DYC	$3.3M	Functional Family Therapy services	Funds eliminated in FY10 budget reduction.	Serve 480 juveniles	Not applicable.
DCJ	$1.6M	Expand community corrections by 152 diversion beds	152 beds were distributed across 32 programs statewide. Not all are in use as planned due to decline in diversion referrals	Serve 152 additional clients	Not available at this time.
DCJ	$482K	Add 44 therapeutic community diversion beds in southern Colorado	44 beds added to augment existing 14 beds. All are now completely utilized	Serve 24 people	58 clients have been admitted, with 40 discharges to date. Accurate outcome data will not be available for several years.
DCJ	$197K	Accelerated non-residential pilot program for diversion clients	Implementation in progress	Serve 40 people	Not available a this time.
DCJ	$160K	Add transition discharge planning services	Funds eliminated in FY10 budget reduction and services were not implemented.	Serve 2500 people	Not applicable.
DCJ	$194K	Increase length of stay in transition Intensive Residential Treatment programs	Fully subscribed as of the end of FY10.	Serve 120 people	172 admissions and 158 terminations occurred during FY10.
DOC	$1.1M	Implement pre-release curriculum and planning program	All positions currently filled with services implemented at 17 facilities	Serve 2000 people	Not available.
DOC	$2.0M	Expand Therapeutic Community by 418 beds	Five new TC programs have been added but are not yet fully operational .	Serve 418 people	An inadequate amount of time has elapsed for clients served under these funds to be successfully discharged. Therefore, no discharge information or recidivism data are available at this time.
DOC	$3.0M	Expand academic/vocational training	Funds eliminated as part of the FY10 budget reduction package.	Serve 2,056 people	Not applicable.
DHS	$250K	Outpatient treatment services	Funds allocated statewide to provide SSIC curriculum.	Serve 324 people	While complete data are not available, a minimum of 459 individuals have been served.

APPENDIX A

SCOPE OF WORK

RESIDENTAL DUAL DIAGNOSIS TREATMENT (RDDT) PROGRAM IN COMMUNITY CORRECTIONS

FINAL

SCOPE OF WORK

Residential Dual Diagnosis Treatment (RDDT) Program in Community Corrections

July 2010

Overview

The Residential Dual Diagnosis Treatment (RDDT) program is intended for individuals presenting with serious substance abuse problems, chronic mental illness, and a history of felony criminal conduct. The purpose of RDDT is to provide an intense treatment intervention with the intention of providing continuing care after completion of the residential intervention.

Residential treatment programs are professionally supervised therapeutic environments geared toward drug and alcohol abstinence, improved mental health and abstinence from continued criminal conduct. Generally, the treatment program is aimed at offenders with both significant substance abuse and mental illness, including those whose previous treatment failures necessitate more intensive measures. For the transitional client, these programs offer structure, guidance, a range of therapy options and the opportunity to re-enter society at a gradual pace. For the direct sentence offender, these programs offer structure, guidance, a range of therapy options and the opportunity to divert the offender from incarceration.

Standards for the operation of a community corrections program can be found in the *Colorado Community Corrections Standards* (*CCCS*), Colorado Department of Public Safety, Division of Criminal Justice (effective August 1, 2010). The RDDT provider must, at minimum, conform to all applicable *Standards* in that publication, or any revised version. The standards and regulations set out in the *CCCS* are attached and incorporated by reference into this contract as ***Exhibit A***.

Regulations for residential substance abuse treatment programs can be found in *Substance Use Disorder Treatment Rules,* Colorado Department of Human Services, Alcohol and Drug Abuse Division (March 1, 2006), which are attached and incorporated by reference as ***Exhibit B***. The provider must, at a minimum, conform to all licensing requirements and policies and procedures included in that publication, or any revised version.

In addition to the *CCCS* and *Substance Use Disorder Treatment Rules*, the provider must comply with all contract terms and conditions. Where this *Scope of Work* establishes requirements that are more stringent than the *CCCS* and *Substance Use Disorder Treatment Rules*, the *Scope of Work* shall be controlling.

This *Scope of Work* is structured as though the provider is the sole or primary source for all clinical services. If any services are provided by an agency that is external to the contracted provider, it is the responsibility of the provider to assure that all requirements set forth herein are met, including those in ***Exhibit A*** and ***Exhibit B***. The provider shall notify the Division of Criminal Justice and the Division of Behavioral Health if any external provider is unwilling or unable to meet the requirements of the *Scope of Work*.

Offender Populations Served/Admission Criteria

Adult felons with histories of substance abuse and mental illness are eligible for services from the RDDT program. This treatment is intended for clients who are transitioning to lower-intensity levels of care and/or are re-integrating into the community and whose history of criminal behavior, chronic substance use disorder, lack of functional and supportive living situation, possible unemployment, levels of social or psychological dysfunction and lack of housing necessitate residential treatment. Offenders accepted into the program must have been specifically assessed as appropriate for RDDT placement according to the Adult Standardized Offender Assessment (as revised) and mental health screens and assessments. Offenders will be referred from the courts, community-based correctional agencies, parole or the Department of Corrections for residential care and treatment services.

Transition Clients - The clients served in the RDDT program shall be limited to:

- Transition offenders regressed for treatment from adult other community corrections programs due to behavioral problems related to substance abuse and mental illness.
- DOC inmates meeting pre-release criteria and eligible for community corrections placement.
- Transition inmates placed in a specialized treatment and release-planning program before transferring to another facility.
- Parolees receiving a technical violation for problems related to substance abuse and mental illness whose risk and needs necessitate RDDT treatment.

Direct Sentence/Diversion Clients – The clients served in the RDDT program shall be limited to:

- Felony offenders referred by a state-funded adult community corrections program.
- Felony offenders required to successfully complete an RDDT program as a condition of their community corrections sentence.
- Felony offenders at risk of regression or technical violation of a community-based correctional sentence due to behavioral problems related to substance abuse and mental illness.
- Felony offenders required by a community corrections board to successfully complete an RDDT program prior to placement in a community corrections program.

Evidence-Based Programming

The Colorado Commission on Criminal and Juvenile Justice (CCCJJ) has identified eight (8) evidence-based principles and practices upon which the RDDT program shall be based. The provider shall use programming that is consistent with the evidence-based practices outlined herein and shall measure adherence to these practices with well-documented internal audit practices and file reviews.

The provider will be audited at least once during the contract period for quality and compliance by a team from the Division of Criminal Justice that may include officials from the Division of Behavioral Health, the Department of Corrections, the Division of Probation Services, and local referral and oversight agencies. Quality assessment will be based on the contract, *Scope of Work*, *Colorado Community Corrections Standards* (Division of Criminal Justice), the *Substance Use Disorder Treatment Rules* (Division of Behavioral Health) and local standards imposed by the community corrections board pursuant to C.R.S. 17-27-103.

Section 1: RISK/NEEDS ASSESSMENT

Principle: Assess offender risk and need levels using actuarial instruments being used by the institutions, parole, and community corrections.

A) Admission Criteria: The provider shall have updated written admission criteria and procedures that are consistent with the contract and *Scope of Work.* Such criteria shall specify types of clients treated and types of clients not admitted into the program. Equal application of the criteria is required across all referrals. The admission criteria shall be consistent with state guidelines including the *Substance Use Disorder Treatment Rules* Colorado Department of Human Services, Alcohol and Drug Abuse Division (hereinafter referred to as *Substance Use Disorder Treatment Rules*).

B) Acceptance: The provider shall only accept clients who meet the following criteria:

1. Clients approved for community corrections placement according to local board and program criteria AND
2. Clients rated by the Department of Corrections at Level P3 or P4 (DOC clients) or formally diagnosed in writing by a licensed mental health professional as having a chronic and persistent Axis I disorder (Diversion clients) AND
3. Clients who have been assessed, within 6 months prior to admission, by the Standardized Offender Assessment – Revised at any of the following treatment levels:
   i. Level 4a – Enhanced Outpatient Therapy
   ii. Level 4b – Intensive Outpatient Therapy
   iii. Level 4c – Intensive Residential Treatment
   iv. Level 4d – Therapeutic Community
   v. (ASAM Level III-1 – Transitional Residential Treatment if assessed with a ASAM instrument or process)

The provider shall reject cases that do not meet these criteria and shall work with referral agencies to recommend alternative treatment placement for inappropriately referred clients. Under no circumstances shall the provider admit or treat clients who are clinically inappropriate for RDDT.

C) Referral Documentation: As part of their admission criteria, the provider shall require referring agencies to submit updated copies of the Standardized Offender Assessment - Revised (SOA-R) instruments and all copies of mental health screening, assessment, and diagnostic records. The provider shall also access the *Mental Health Transition Form* and should access the *Discharge Referral Form* via the DOC Information System for DOC clients. The provider shall assure that proper confidentiality and privacy procedures are followed when requiring and accessing the referral documentation.

D) Risk/Needs Assessment: In cases where a current and complete SOA-R battery is not made available by a referral agency, the provider shall administer the SOA-R within 10 business days of admission and shall be done consistently with the remainder of section 6-090 of the *CCCS*.

Section 2: MOTIVATIONAL ENHANCEMENT

Principle: Enhance offender motivation

A) Motivational Assessment: The provider shall assess for levels of motivation upon intake/referral and every 60 days thereafter. Initial assessments shall be instrument-driven and shall be chosen from instruments approved by the Division of Behavioral Health. Follow up assessments of motivation shall be documented in treatment plan updates and progress reports. Assessment of client motivation should be behavior-specific with respect to the clients assessed criminogenic needs and related behaviors.

B) Curriculum: The provider shall incorporate motivational enhancement into the group and individual therapy components of the RDDT program. Clinicians should incorporate formal and structured motivational interviewing techniques into group facilitation settings and in individual therapy sessions.

C) Reporting and Application: Results of the initial motivational assessment shall be incorporated into the initial treatment plan. Results of reassessments shall be documented in client files on treatment plan updates/reviews. Results of the final motivational assessment shall also be documented on discharge summaries in a cumulative form that describes the progress of levels of motivation throughout the RDDT services. Reporting of the levels of motivation shall be behavior-specific for criminal conduct and specific to the client's substance use preferences and compliance with psychotropic medications (if applicable).

D) Feedback: Clinical staff shall provide documented and regular feedback to offenders regarding their levels of motivation and their progress towards treatment goals. Feedback should be behavior-specific for criminal conduct and specific to the client's substance use preferences and compliance with psychotropic medications (if applicable).

Section 3: PROGRAM DOSE AND DURATION

Principle: Target interventions: Act on risk/need/responsivity principles and ensure adequate program dose and duration

A) Intake Assessment – Mental Health: The provider shall complete a formal intake assessment within 10 business days of the client's admission. The intake assessment should be instrument-driven, shall be administered by an appropriately qualified staff member, and shall incorporate use of a semi-structured BioPsychoSocial interview. The intake assessment should incorporate the client's past psychological evaluations from referral agencies. The provider shall complete a written report of the intake assessment that covers, at a minimum, the following domains:

- Demographic Information
- Legal/Criminal History
- Current Diagnosis/Symptoms/Presenting Problem
- Past Psychiatric Treatments
- Mental Status and Cognitive Functioning
- Trauma/History of Abuse
- Significant Life Events
- Medications
- Family Situation and History
- Leisure/Recreation
- Companions/Friends
- Living Situation/Accommodation
- Medical Problems
- Work History and Status
- Education Status
- Daily Functioning
- Suicide Ideation
- Homicide Ideation
- Self Injury Risk
- Substance Use
- Attitude/Orientation
- Strengths/Interests
- Cultural Factors

B) Initial Clinical Assessment – Mental Health: The provider shall complete an initial clinical assessment for mental health within 30 calendar days of the client's admission. The clinical assessment for mental health shall be instrument-driven and shall use instruments that are approved by the Division of Behavioral Health. The clinical assessment shall be administered by an appropriately qualified staff member who is (or who is clinically supervised by) a licensed mental health professional. The initial clinical assessment shall indicate whether or not the client needs further symptom-specific/psychological testing.

C) Initial Clinical Assessment – Substance Abuse (Differential Assessment): The provider shall administer clinical assessments for substance abuse (differential assessments) to all clients who have been accepted into RDDT placement. Clinical assessments must be instrument-driven based on the list of instruments approved by the Division of Behavioral Health. Clinical assessments shall be completed within 30 calendar days of the client's admission. Clinical assessments shall consider referral agency information, interviews, prior treatment histories, any manifestations of drug or alcohol problems or use, observations and ongoing interaction throughout the program period, results of screening and assessment tools, authorized by the State of Colorado pursuant to CRS 16-11.5-102 (a) including provisions within CRS 18-1.3-209 and related sections, and other available relevant diagnostic information. Identified problem areas may be wide-ranging. Written criteria and procedures for all treatment components must be applied.

D) Psychiatric Evaluations and Medication Adjustments: The provider shall complete a thorough psychiatric evaluation, when clinically indicated, within 30 calendar days of the client's admission. Ongoing psychiatric evaluation and medication adjustments should be completed monthly, or as needed, at the professional discretion of the psychiatric services provider.

E) Ongoing Clinical Assessment: The provider shall conduct ongoing clinical assessment for substance abuse and mental health. Ongoing clinical assessments should incorporate daily clinical observations of clients in all therapeutic activities. Results of ongoing clinical assessments shall be summarized in treatment progress reports, treatment plan updates, discharge plans, and discharge summaries.

F) Initial Supervision Plan: The provider shall develop an individualized supervision plan consistently with the requirements of *CCCS* 6-100. The supervision plan shall be a separate document from the individualized treatment plan.

G) Initial Individualized Treatment Planning: The provider shall develop an individualized and comprehensive treatment plan that addresses the offender's immediate needs and establishes treatment objectives during the foreseeable transition or rehabilitation period. The treatment plan shall cover substance abuse, mental health, and criminal thinking/behavior. The initial treatment plan shall be developed jointly with the client and shall be completed within 30 calendar days of client admission. Treatment plans shall be based on the results of clinical assessments in accordance with the *Substance Use Disorder Treatment Rules*. Treatment plans goals and objectives shall be specific, measureable, achievable, realistic, and time-bound. Treatment plans shall also incorporate client strengths and shall identify strategies to sustain and develop the strengths in daily therapeutic activities.

H) Treatment Plan Updates: The provider shall complete treatment plan reviews at all clinical decision points or other critical stages, and also at 30-day intervals for all clients. At minimum, reviews shall occur at admission, transfer, discharge, unsuccessful termination or escape; upon any significant change in mental, physical or social conditions; and, whenever new information regarding previous or concurrent treatment is received. Unless specified differently herein, treatment plan reviews shall be performed consistently with the requirements of section 15.219.53 of the *Substance Use Disorder Rules*. Treatment plan updates shall be based on the results of ongoing clinical assessment and treatment progress reports.

I) Detoxification Services: The provider shall be able to access detoxification treatment services. If the provider cannot supply such services, then a comprehensive and practicable contingency plan shall be required. The plan must identify the proposed treatment facility, its usual course of detoxification treatment, the safety and security precautions used by the treatment facility, the proximity of the facility in relation to the program site (time and distance), plans for transportation to and from the facility, the estimated costs associated with such treatment at the facility, and what portion of detoxification costs shall be the offenders responsibility.

J) Supervision Services: Unless otherwise specified in this section, supervision of offenders in RDDT programs shall be in accordance with applicable *Standards* within Sections 4-000 and 6-000 of the *Colorado Community Corrections Standards*.

K) Substance Abuse Testing: The provider shall be capable of testing for drug use with a system that complies with appropriate standards for accuracy and proper evidence handling. One urine drug screen will be required upon admission as specified in *CCCS* 4-100. Interim urinalysis testing shall be completed consistently with *CCCS* 4-110. Unless specified differently herein, substance abuse testing procedures shall comply with sections 4-080, 4-090, and 4-120 of the *CCCS*.

L) Alcohol Abuse Monitoring: The provider shall be capable of testing for alcohol use with breathalyzer testing process that complies with appropriate standards for accuracy and proper evidence handling. Alcohol abuse monitoring shall comply with *CCCS* 4-130.

M) Treatment Services – Eight (8) Hours Per Week: The provider shall provide at least eight (8) hours per week of general treatment activities for all clients. The 8 hours of treatment activities shall encompass individual and group therapeutic sessions (direct therapeutic contact), didactic or educational services, self-help groups, vocational counseling, life skills training, structured recreation, or other support or wrap-around services. General treatment activities shall be provided at least 5 days per week for all clients.

N) Direct Therapeutic Contact: No less than five (5) hours per week shall be comprised of direct individual and group therapeutic contact. At least one (1) hour of individual psychotherapy shall be completed within the first week of admission. Additional individual psychotherapy shall be delivered when clinically indicated via initial and ongoing assessments. The need for individual psychotherapy and the plan to deliver individual sessions shall be assessment driven, and shall be documented in initial and follow-up treatment plans. Group therapy sessions shall last no less than 90 minutes each. . Psycho-educational, educational, 12-step support services and structured recreation shall not count towards hours required for direct therapeutic contact. Direct therapeutic contact shall be delivered pursuant to section 15.218.5 of the *Substance Use Disorder Rules*.

O) Curricula: The provider shall use curricula that is approved by the Division of Behavioral Health. Curricula shall include that which is manualized, cognitive-behavioral, and evidence-based. Curricula should also include that which is gender sensitive or specific and ethnically sensitive. Curricula shall address substance abuse, mental health and criminal conduct in an integrated manner. The curricula used shall incorporate symptoms management, emotions management and medication management as part of the mental health or dual diagnosis treatment.

P) Security and Case Management Staffing: Staffing of the RDDT program shall be in accordance with the *Colorado Community Corrections Standards*. Additionally, overnight RDDT client/staff ratios shall not exceed 20:1 pursuant to section 15.218.5 of the *Substance Use Disorder Rules*.

Q) Clinical Staffing: Clinical staffing shall be in accordance with section 15.216 and 15.219.3 of the *Substance Use Disorder Rules* such that clinical staff to client ratios shall not exceed 1:12. The provider shall maintain staffing levels in accordance with the requirements of this contract.

R) Clinical Staff Credentials and Qualifications: The provider shall maintain or use a level of substance abuse clinical staff with credentials, qualifications, and competencies that are consistent with 15.216.2 of the *Substance Use Disorder Rules.* Clinical staff providing mental health or dual diagnosis therapeutic services shall be (or shall be clinically supervised by) a licensed mental health professional with the minimum of a master's degree in a behavioral health field.

S) Qualified Treatment Providers: If the provider utilizes external treatment agencies to provide clinical, educational, or support services, the provider shall use qualified treatment providers consistently with sections 6-160, 6-161, 6-162, 6-163, 6-164, and 6-165 of the *CCCS*. The provider should have a written agreement with external providers that clearly articulates that the clinical records are subject to review by the Division of Criminal Justice, the Department of Corrections, and the Division of Behavioral Health.

T) Crisis Intervention: The provider shall have a written policy, procedure, and practices that clearly outline the actions taken to manage crisis incidents. The policies and procedures shall identify which services are accessed (parole officer, mental health center, mental health crisis line, mental health on call, law enforcement, etc). The crisis intervention policy should be consistent with the Crisis Intervention Training (CIT) model, when appropriate.

Section 4: SKILL TRAINING

Principle: Provide skill training for staff and monitor their delivery of services

A) Program-Specific Training: Staff shall be formally trained in program curricula and structured interventions used. Training for specific interventions and curricula should be formalized and structured and shall be from an original or formally authorized source. Clinical staff shall be trained in all screening and assessments used in the program, all manualized and structured curricula, and motivational interviewing techniques. Documentation of training records shall be subject to audit/review and shall be maintained in personnel files.

B) Crisis Intervention Training: The provider shall maintain at least one full time staff member who has successfully completed a formal Crisis Intervention Training (CIT) or Mental Health First Aid (MHFA) from a certified trainer. The provider should schedule staff such that at least one CIT or MHFA-trained staff member is on duty at all times.

C) Ongoing Training: Staff training shall be consistent with the requirements of relevant provisions of section 2.000 of the *CCCS*. Clinical staff training shall be consistent with the *Substance Use Disorder Rules*.

D) Staff Qualification and Competencies: The program shall recruit and maintain clinical staff members who meet the requirements of section 15.216.2 of the *Substance Use Disorder Rules*.

E) Clinical Supervision: The provider shall be responsible for documenting compliance with clinical supervision and/or consultation of all substance abuse clinical staff as required and defined by the *Addiction Counselor and Licensure Standards* of the Division of Regulatory Agencies (6CCR 1008-3). Mental health or dual diagnosis staff shall be given clinical supervision as determined by the clinical supervisor. The frequency of clinical supervision shall be based on the education, experience, and skill level of the clinician.

F) Case Management and Clinical Staff Roles: The provider shall use clearly defined staff members who are responsible for case management/supervision apart from those who provide clinical services. The provider shall employ staff members who serve exclusively in case management/supervision roles and who do not serve in clinical roles for their clients. The provider shall employ or use clinical staff members who serve only in a therapeutic role with the clients and who do not have direct authority over clients' supervision plans. The case management and clinical staff, although separate, shall work collaboratively in order to effectively supervise clients while assisting them in reaching their treatment goals and objectives.

Section 5: POSITIVE REINFORCMENT AND STRENGTH-BASED TREATMENT

Principle: Increase positive reinforcement

A) Ratio of Rewards to Punishments: The program should incorporate a formal system of using a rewards-to-punishments ratio of 4:1 in order to manage offender behavior. Positive reinforcement techniques should be modeled by program staff in daily actions with clients.

B) Staff Training: Staff should be formally trained in the importance and use of a system of rewards and punishments and how it affects offender outcomes and treatment progress.

C) Program Policies and Procedures: Program policies and procedures should support the use of the required rewards-to-punishments ratio.

D) Feedback to Clients: The provider shall incorporate a measurement of client strengths into the individualized treatment plans and treatment plan reviews and updates. Strengths shall be regularly monitored and reported with feedback given to clients in individual sessions.

E) Documentation: Both rewards and punishments should be equally recorded in client files. Client records should clearly document client strengths throughout the program duration. Feedback shall be exchanged between program administrators and staff regarding compliance with rewards to punishments procedures and policies.

F) Strength-Based Treatment: The provider shall incorporate strength-based treatment into the curriculum for the RDDT program. The strength-based treatment shall focus on client strengths, including the capacity to cope with difficult situations; maintaining functioning under stress; rebounding from significant trauma; using external challenges as opportunities for growth; and using support systems as a basis for resilience.

Section 6: CONTINUING CARE

Principle: Engage ongoing support in natural communities

A) Discharge Criteria: The provider shall develop and utilize discharge criteria that are consistent with section 15.219.54 of the *Substance Use Disorder Rules*. Discharge criteria shall be applied consistently for all clients.

B) Discharge Planning: In order for the client to receive appropriate treatment services after completing the program, the provider shall develop a written discharge plan that prescribes post-program treatments and support services. Discharge planning should commence at least 30 days prior to the clients planned release from residential services. A specific referral for follow-up treatment services shall be recommended by the provider in the written plan. Client education regarding the need for follow-up and support services shall be addressed in the residential treatment component as the client progresses towards treatment goals. Discharge planning shall be conducted consistently with section 15.219.54 of the *Substance Use Disorder Rules*.

C) Support Services: Support services for continuing care should be developed consistently with section 15.219.6 of the *Substance Use Disorder Rules*.

D) Discharge Summary: The provider shall create a discharge summary (for both successful and unsuccessful terminations) that includes a review of the supervision plan, individual treatment plan, objectives, progress, and problems demonstrated by the offender. The summary shall also describe the reason for termination and recommendations for continued supervision and treatment by the referring agency.

Section 7: PROGRAM QUALITY ASSURANCE

Principle: Measure relevant processes and practices

A) Statistical Summaries: The provider shall use the DCJ Community Corrections Information Billing System (CCIB) to report data regarding offenders served by the RDDT. Statistical summaries maintained by the provider should include sources of referrals, services delivered, length of placement, reasons for termination and similar descriptive information. The provider should provide specific information regarding management information systems, databases and the formats and frequency of reports to be generated regarding the RDDT.

B) Quality Assurance: The program shall use structured methods to assure quality in treatment and supervision services. This shall include reviews and coaching of motivational interviewing practices; quality checks for the use of manualized curricula and assessment instruments; and internal auditing of program operations consistent with sections 3-180 and 3-190 of the *CCCS*.

Section 8: PROGRAM FEEDBACK

Principle: Provider measurement feedback

A) Daily Contact Note and Weekly Summary Notes: The provider shall clearly document each offender's treatment-related activities on a daily basis for each mental health or dual diagnosis contact. Weekly summary notes shall be completed and shall be consistent with section 15.219.52 (B)(3) of the *Substance Use Disorder Rules*. Weekly summary notes shall contain information regarding progress towards treatment goals. Documentation shall also include the following: a description of the treatment activity (i.e., group contact, individual contact, skill-building exercise); duration of time to complete the activity; date of the activity; and staff contact. Records of treatment-related activities shall be maintained in each offender's treatment file.

B) Treatment Progress Reporting: The provider shall create a written progress report every 30 days regarding the client's behavior and progress toward case plan goals and therapeutic goals and objectives. The progress report shall be based on the ongoing clinical assessment, daily contact notes, and weekly summary notes.

C) Information Sharing with Referral Sources: The provider shall provide the referring agency with the initial written plans and program objectives if requested. The provider shall prepare monthly written summaries of progress and problems of offenders. These shall be shared with referral agencies by fax, mail or electronically upon request by the referring agency. The provider shall provide the referring agency with immediate notification, followed by written reports, within 24 hours, of significant problems that would jeopardize public safety or the offender's continuation in the RDDT program. Such problems include, but are not limited to, failure to report and follow daily schedules, failure to participate in required activities, new arrests, alcohol or drug usage or other behaviors that pose a risk to public safety. Such reports are in addition to any notifications required by the *Colorado Community Corrections Standards* or by contract.

APPENDIX B

EFFECTIVE PRACTICES THAT CONTRIBUTE TO EFFECTIVE COMMUNITY CORRECTIONS PROGRAMS

SUMMARY of ADMINISTRATOR and UNIT DIRECTOR COMMENTS and RESEARCH STAFF OBSERVATIONS

SUMMARY of COMMUNITY CORRECTIONS PROGRAM ADMINISTRATOR and UNIT DIRECTOR COMMENTS and RESEARCH STAFF OBSERVATIONS

EFFECTIVE PRACTICES THAT CONTRIBUTE TO EFFECTIVE COMMUNITY CORRECTIONS PROGRAMS

Prepared for the Office of Research and Statistics at the Division of Criminal Justice of the Colorado Department of Public Safety by the Health Resources Consortium

January 2009

SUMMARY of ADMINISTRATOR and UNIT DIRECTOR COMMENTS and RESEARCH STAFF OBSERVATIONS

EFFECTIVE PRACTICES THAT CONTRIBUTE TO EFFECTIVE COMMUNITY CORRECTIONS PROGRAMS

Introduction

Therapeutic community (TC) programs operating as community corrections programs in Colorado tend to have better long-term recidivism rates when compared to non TC programs, despite admitting more serious offenders, on average (See Table A below). This finding, combined with the ongoing controversy and debate about the daily reimbursement rate paid by the state to community corrections providers, led the Office of Research and Statistics in DCJ to contract with Health Resources Consortium to conduct interviews with program administrators and staff in three programs: Peer 1 and The Haven run by Addition Research and Treatment Services (ARTS), and Independence House at Fillmore Street. The intent of this effort was to better understand how these specific programs operated in terms of funding and services provided.

Table A: Outcomes for three community corrections programs, FY00-FY04 (most recent data available)

Outcome	Peer 1	The Haven	Independence House Fillmore
Program Success	61.8%	43.4%	63.7%
New Court Filing, 12 months	8.8	4.0	8.2
New Court Filing, 24 months	20.7	10.1	15.0
AVERAGE CRIMINAL HISTORY SCORE (Range 0-4)	***2.9***	***3.0***	***2.7***

NOTE: Successful program completion rates ranged from 39.6% to 72.8% across 30 programs in FY00-FY04. Independence House only takes offenders transitioning from prison; the average program success rate for transition offenders was 60.1%. The average 24 month recidivism rate was 25.2% across all programs. The average criminal history score across all programs was 2.59.

Using the National Registry of Effective Programs and Practices (NREPP) and Treatment Improvement Protocol (TIP) principles, the assessment effort identified policies, procedures, practices, and philosophies that distinguish the selected two effective programs from those that seem less beneficial. An important limitation of the inquiry is the reliance on interview data alone. Nevertheless, the effort to better understand these programs resulted in two important findings:

1. **These programs prioritize assessment and reassessment. Staff "know" the bio-psychosocial characteristics of the targeted populations very well. The programs are based upon a history of what administrators consider to be successful interventions with the target population, and they rarely deviate from established practice. Any program deviations are intended to better match individual client requirements.**

2. **Successful programs leverage funding from multiple sources. No single funding stream or source is adequate to provide for the needed services or supervision. Programs "braided and leveraged" funding to provide adequate resources for their client populations.**

The latter finding requires further study. The success of these programs suggests that the current per diem reimbursement rate alone may be inadequate. Historically community corrections analysts and administrators have emphasized the fact that this placement is less expensive than prison. However, prison provides minimal, if any, services whereas these programs prioritize assessing and delivering needed services for each individual. A complete discussion of cost analyses should include the cost of program failures and long-term recidivism.

Findings

DCJ selected ARTS (Addiction Research & Treatment Services), a modified Therapeutic Community model, and Independence House, Inc., a population-specific halfway house model. ARTS serves offenders with multiple disorders through a wide range of holistic treatment and support services. Many of these services are delivered on-site during client residential stays and continued into outpatient treatment. ARTS can be called an "Integrated Therapy Program." Independence House services more criminally sophisticated offenders who present with specific treatment requirements. As such, it can be labeled a "Specific Therapy Program." These designations are used in the findings to assist the reader in understanding the observations and comments that follow.

PROJECT SPECIALIZATION - Successful community corrections projects demand a thorough understanding of the nature, seriousness, and treatment requirements of the population they serve. The nature and range of services provided either on-site or through referral into community-based services are as complex as the bio-psychosocial characteristics of the client population. Clients present with a wide range of strengths and problems.

ARTS' integrated therapy program attempts to address the nature, seriousness, and treatment requirements as individually as possible while still adhering to basic therapeutic principles; great effort is made to provide each client with personal treatment and support. The ultimate goal is to treat the client holistically, producing an overall better functioning individual.

Specific therapy programs are more apt to completely concentrate on the specific disorders (e.g. chronic mental difficulties or sex offending) and only occasionally provide ancillary services. The effort is primarily to place clients back in the community, employed and controlling their disorders.

Successful programs fully understand the treatment and accountability requirements of their target populations and they strictly adhere to proven treatment and supervision principles. The more serious the offender population, the lower is the likelihood that the program will deviate from the chosen therapies and supervision under any circumstance.

AFFILIATIONS - Successful integrated therapy programs greatly benefits from an affiliation with a larger institution. The University of Colorado at Denver, University Health Services Center, Department of Psychiatry, Division of Substance Dependence is the sponsoring agency for ARTS. The benefits of this affiliation include program access to psychiatrists, psychologists and other mental health and substance abuse professionals. ARTS can participate in and has access to University research endeavors thus creating a close relationship between research, the science of additions, and clinical practice. The research and evaluation orientation produces an environment that allows ARTS to build effective practices and assess client level outcomes.

Specific therapy programs, such as Independence House, tend to keep a low profile in the community and rely on government funding sources. There are few community champions for the client groups served and remarkably few affiliations.

CONTINUUM OF CLIENT SERVICES – ARTS' successful integrated therapy program gains from being a part of a parent organization that can provide a wide range of services which supplement one another and provide a continuum of treatment and supervision alternatives. Successful programs strive to provide seamless integration for clients from residential into outpatient settings. This continuum of services, ranging from the most restrictive environment (ARTS residential therapeutic community) to the least restrictive environment (outpatient), significantly benefits clients. Clients can slowly move from a residential structure into transition housing and then into non-residential treatment. Movement of clients between services and treatment phases is based on client engagement, compliance, and progress.

Aftercare or a post graduate/maintenance phase appears to be an important final stage to the continuum. These latter stages are supplemented by holistic treatment services that include: (a) alcohol abuse counseling; (b) peer/support groups; (c) peer resistance counseling; (d) relapse prevention; (e) 12-Step programs (e.g., AA, NA); and, (f) social and interpersonal relationship skills training.

Great efforts are made to retain clients and treat them for the expected treatment duration. Relapsing clients can be admitted more than once during any 12 month period.

The specific therapy programs occasionally make additional specialized services available to clients. Programming is very focused on controlling the specific client disorder and on providing the client with life skills.

MULTIPLE FUNDING SOURCES - Successful integrated and specific community corrections programs are part of parent organizations that have been highly effective in developing multiple funding sources that benefit all clients. No single funding source is adequate to operate these programs;

successful programs develop supplemental funding sources to adequately provide client services. State funds reimbursement ranges from $36 to $70 per client day, depending on the seriousness of client mental difficulties and substance dependence. For the integrated therapy program, costs per day per client vary between $89 and $200. At the specific therapy program, the state funds reimbursement rate comprises 75 percent of the actual program costs.

The ARTS parent agency, as a governmental organization which has relationships with non-profit organizations such as the CU Foundation and the Friends of the Haven, is able to compete for external funds from a wide range of sources. This integrated therapy program aggressively seeks funds from such diverse sources as:

- Substance Abuse and Mental Health Services Administration (SAMHSA);
- Byrne Memorial Funds;
- Ryan White Awards;
- SIGNAL substance abuse treatment contracts (through DHS);
- U.S. Department of Education and Health and Human Services (Medicaid);
- city, county and state agency contracts (including DCJ);
- client fees and insurance;
- the Daniels Fund;
- State and County Social Services;
- the Colorado AIDS Project;
- the Rose Community Foundation;
- TANF;
- the Mayor's Office of Early Childhood Education; and,
- the Colorado Childcare Assistance.

Each funding stream generally designates a specific type of activity or treatment for the monies. ARTS "braids" the funding streams together, thus providing crucial services to residential and outpatient clients. By creating this blend of funding to supplement community corrections monies, the integrated therapy program can offer evidence-based and best practice therapies. As an example of "braiding" funds, ARTS Outpatient Services combines funds from the aforementioned sources with monies from the Governor's Recidivism package (through CDPS/DCJ), forfeiture funds from Denver County Court, Arapahoe/Douglas Mental Health monies, and Senate Bill #97 Tobacco monies. ARTS Outpatient Services also secured a contract with Denver Office of Workforce Development to serve individuals on TANF. Further, ARTS Outpatient Services works with five county child welfare departments and various local and state criminal justice entities.

The specific therapy program, Independence House, Inc., at Fillmore, is in a much less advantageous position when it comes to leveraging funds and soliciting monies from varied sources. The nature and seriousness of the client disorders and crimes do not lend themselves to community fundraising or publicity. Therefore, they are very dependent upon official government sources for funding. For these reasons, it is much more difficult for a for-profit entity, such as Independence House, Inc., to obtain external funding from foundations or organizations.

EVIDENCE-BASED TREATMENT and SUPPORT SERVICES – ARTS' uses, either in-house or through referral, SAMHSA-approved evidence - based programs and practices. For example, The Haven (women's residential modified therapeutic community at ARTS) uses the **MATRIX** model, developed at UCLA by Dr. Richard Rawson, **Seeking Safety,** and **Partners in Parenting Education.** Individualized treatment of clients (with different activities matching client disorders and needs), supportive group therapy, individual psychotherapy, individual behavioral therapy, cognitive behavioral therapy, reality therapy, and aggressive case management are also used in treatment**.** These interventions use peer influences to guide client treatment and contingency management to motivate clients. Clients also attend 12 Step self-help group meetings (both on-site and off-site). Pro-social activities and excursions occur frequently. Client family activities are common.

The Haven has unique services for mothers in treatment who have their babies with them. The Harris Infant Mental Health Technique is used to integrate the mother's treatment with parenting skills; it also includes the Infant Mental Health (IMH) program. Pregnant clients have access to DOULA staff care (labor assistant from the same community): ARTS is the only DOULA program in the country where community is defined as "the recovering community." To become DOULA staff, the person must have at least three years of continuous sobriety and the ability to serve as an effective role model for client mothers. DOULA staff work directly with the client from pregnancy, through childbirth, and up until the child is 18 months old.

The specific therapy program produces successful results by concentrating on providing a residential experience for clients, offering specialized treatment in-house, and making extensive use of other community-based programs to provide supplemental services. The in-house services are most frequently targeted towards client mental functioning (including sexual predation). Treatment

efforts to stabilize or control client behaviors are supplemented through training to improve life skills and financial management.

RESPECTFUL INTERAGENCY RELATIONSHIPS - The importance of maintaining high-quality working relationships with the few sources of referrals used by community corrections programs (such as the DOC, DCJ and local judicial staff) is important if not essential. Both types of community corrections programs need to maintain good working relationships with their sources of referrals. Because there are more potential clients than available bed spaces, a positive relationship with the referral source helps insure that the most appropriate type of client enters the appropriate treatment and supervisory modality.

It is paramount to the success of clients considered for community corrections programs that referral sources know the strengths of each program; matching the client to the program that has the best potential to treat the client's disorders. It is also crucial that referral sources have sufficient confidence in community corrections programs to allow them to conduct day-to-day decision-making in regard to clients and their treatment and supervision. There are currently some tensions in these relationships where performance objectives of referral agencies contradict treatment program protocols, especially regarding retention of clients for expected treatment durations.

REFERRAL TO SPECIALIZED SERVICES – When and where on-site program services are not available for client treatment, program staff refers clients to community resources to obtain specialized services. In the integrated therapy program, a team of counselors review the individual case and determine if a referral to an external treatment resource is needed. Staff consistently monitors these referrals to determine whether the client actually used the service and the effectiveness of the service. The most frequently used referral services include: (a) specialized medical care; (b) legal assistance; (c) specialized psychological care; (d) family counseling; (e) continuing care; and, (f) pro-social activities.

Within the specific therapy program, the majority of decisions are made by unit directors. The specific therapy program seems much more autocratic, which is not surprising given the serious nature of the client population and the more focused approach to controlling client behaviors. Therefore, the use of external treatment or support services is greatly diminished.

STAFFING DIVERSITY, LOW CASELOADS, AND HIGH STAFF MORALE – The integrated therapy program uses a combination of academic, professional and ex-consumer staff. The specific therapy program staff includes fewer ex-offenders and academics. High staff morale contributes to program efficiency and effectiveness. Staff routinely receives pay raises, bonuses, and/or promotions. Salaries for the integrated therapy program counseling staff are generally comparable to most public and private agencies in the area. This is not true among specific therapy program staff. Both programs also motivate staff through incentives such as attendance at conferences or special meetings, greater involvement in determining responsibilities, and recognition in staff meetings (e.g. staff member of the week, gift certificates or baskets). After-hours crisis counseling time is compensated with overtime staff pay and compensatory time.

In the integrated therapy program, a significant proportion (59 percent) of treatment staff is comprised of recovering substance abusers or ex-offenders; this proportion is 2 percent in the specific therapy program. When peers and former service consumers are used, they are tasked with inducing clients to conform to program rules and goals to facilitate recovery. Recovering or ex-offender staff also participates in individual peer counseling, leading group sessions, and milieu treatment. The integrated therapy program attempts to systematically match clients with specific counselors according to different characteristics, strengths, or problems. Client/staff matching is based on major areas such as racial or ethnic characteristics, gender, pregnancy status, and the culture of recovery (clients matched with counselors who are in recovery). The specific therapy program tries to match clients to counselors based on client mental health needs and therapist style.

A team approach is used by ARTS for decision making at intake for admission decisions, decisions regarding client movement between specific programs and phases within programs, decisions regarding external treatment or support, and decisions at discharge to determine readiness for program completion. The final decisions of program entrance or discharge are frequently made by the program director, especially where the client population has special needs.

Average caseloads are low; full-time primary counselors or supervisory staff can have caseloads as low as eleven (11) clients per counselor. In outpatient programs, the average caseload for each full-time primary counselor or supervisory staff is thirty (30) clients per counselor.

FAMILY PARTICIPATION IN TREATMENT – The extent of family participation depends upon the seriousness of the client population's disorders and crimes; specialized male participants have greatly reduced family involvement. Family members participate in treatment plan development and help with release plan involvement.

To a great extent, The Haven focuses on family involvement in the treatment of the clients. Eighty to ninety (80 – 90%) percent of The Haven's clients have at least one family member or representative actively involved in their treatment. The types of family interventions offered by the program include family therapy, family meetings, substance abuse education, referrals for family members, multifamily therapy, and group therapy.

At Peer 1, family members do not routinely participate in development of the treatment plan. However, family involvement is encouraged in the treatment of the clients; thirty (30%) percent of the program's clients have at least one family member or representative actively involved in their treatment. Types of family interventions offered by the program include family therapy, family meetings, and multifamily therapy-education.

At Independence House Fillmore, family participation is much less prominent. Family involvement ranges between two (2%) and fifteen (15%) percent of the program's clients (at least one family member or representative actively involved in treatment). Family interventions include family meetings regarding transition into the community and exit interviews with family members.

TREATMENT RETENTION - Great efforts are made by staff to retain clients in treatment for the expected duration. Retention is a priority for both types of programs. The definition or criteria for successful completion or graduation from these programs is that all phases

of the client's prescribed treatment plan are finished and the client is actively employment. In order to graduate from the Haven and Peer I programs, clients are required to complete the residential treatment program and live successfully in the community while attending the Outpatient Therapeutic Community for 12 months.

For client cases regarded as failures, the key contributing factors are that the client was not ready for treatment, not motivated to change, or did not comply with treatment. Major reasons for discharging clients from the programs before client completion of their treatment include: involvement in illegal activities other than using illicit drugs; being arrested for a crime; violent behavior on-site; and, sexual activity on-site. Clients are not discharged from treatment as a result of having positive urine unless there are other reasons for discharge. In the event that clients have positive urine testing, the following actions are frequently used to sanction clients: loss of privileges; potential revisions to the client treatment plan; and court hearings.

The integrated therapy program allows for readmissions, if space is available. Policy regarding readmissions for clients discharged due to rule infractions allows for return after a specified period of time, usually six months. The policy also allows clients who are not discharged for rule infractions to return after a specified period of time, again usually six months.

*CLEAR CLIENT EXPECTATIONS AND ACCOUNTABILITY– **Both program types require clients to become unequivocally involved in their own recovery.*** Prior to a client's admission, these programs provide written information to clients about the program and the treatment services offered. A formal, written, individual pre-release service or treatment plan is also frequently developed for the clients prior to their admission into the program. The following elements are covered in the pre-release services plan: (a) housing; (b) employment and vocational training needs; (c) needed official papers and identification; (d) education; (e) substance abuse treatment; (f) finances including benefits acquisition; (g) mental functioning and treatment; and, (h) physical health requirements.

An initial plan is usually developed one to fourteen days after admission; a long-term treatment plan is written 15 to 30 days after admission. These treatment plans are usually generated by the client's primary program counselor or case manager. Clients participate in developing the prerelease treatment plan by reviewing and signing the treatment plan, thus acknowledging that the plan reflects their content suggestions and timeline for completion of tasks. Discharge goals and objectives are reviewed and revised on a weekly and monthly basis.

To a great extent, the integrated therapy program's initial orientation emphasizes development of trust, self-confidence, and understanding. The program strongly encourages clients to change their previous lifestyle (i.e., daily habits) and their environment (i.e., friends, living situations, and location) that supported drug taking, criminal behavior, related negative behaviors, and attitudes. Clients are encouraged to improve, where necessary, their physical health, mental well-being, and practical life skills. The latter includes developing the capacity to be self-supporting, improving personal functioning, and coping better with life problems.

The goal of abstinence works with this client population, in this setting, and with this philosophy that realizes that inevitably progress will occasionally result in relapse. These programs insist that clients must directly focus on abstinence from marijuana, alcohol, cocaine,

heroin, and any other illicit drugs. Coupled with this philosophy are program efforts to train clients on relapse prevention and to identify relapse triggers. Peer pressure is used intentionally to induce clients to conform to the program's rules and goals.

In both types of programs, clients who have an extensive treatment history are likely to succeed. In both program types, clients who seek treatment voluntarily do best. Integrated therapy program clients who do not have pronounced mental difficulties progress well; specific therapy program clients whose mental health difficulties are under control through medications and therapy are likely to improve. The specific therapy program also does well with clients in which poly-drug use is a problem (including cocaine or meth-amphetamine) and who relied upon criminal friends and acquaintances for the drug supply. Clients with extensive criminal histories do well in the specific therapy programs as do clients with some history of successfully obtaining and keeping employment. Most clients, however, arrive at the program with no employment skills and on-going financial problems.

Experienced, motivated, and cognitively clear clients do best at the integrated therapy program. Clients also do well in the integrated therapy program when faced with termination of parental rights or other social services interventions to correct family functioning problems.

ON-GOING CLIENT ASSESSMENTS - These programs use an extensive array of standardized differential and specific assessment instruments to diagnose client functioning and to develop treatment plans. These programs use similar assessment and screening tools, although funding sources prescribe some specific instruments. Instruments used consistently within both types of programs include: (a) the Level of Service Inventory; (b) the Adult Substance Use Survey; (c) the ASAM; (d) the Simple Screening Instrument Revised; (e) the Drug Abuse Screening Tool; (f) the Standardized Offender Assessment Revised-Supplement; (g) the Colorado Criminal Justice Mental Health Screen/Adult; (h) the Addiction Severity Index; and, (i) Beck's Depression Inventory (BDI).

It is critical that program staff have a wide range of screening and assessment results available to them, starting with selection for program participation. Staff must also continuously re-assess client functioning during program participation. The following domains are routinely and repetitively assessed by staff: (a) health; (b) vocational, educational, psychological, and mental functioning; (c) drug and alcohol use; (d) criminal activity and thinking; (e)social support; (f) family functioning; and(g) living situation.

SELF-EVALUATION OF SERVICES – The integrated therapy program uses a relatively extensive program evaluation that includes supervisory agency audits (e.g. DCJ, ADAD) coupled with internal data collection and analysis. Client satisfaction and follow-up information from clients is also collected once treatment is ended. The integrated therapy program also uses NIATx (Network for Improvement of Addiction Treatment) methodology, focusing on retention in treatment.

The specific therapy program uses some self-audit reports. However, these reports do not include client satisfaction surveys, family satisfaction surveys, or follow-up information from clients after treatment ends. Limited information is collected from clients through exit interviews.

APPENDIX C

HOUSE BILL 1451
COLLABORATIVEMANAGEMENT PROGRAM
Evaluation Progress Report

HOUSE BILL 1451

COLLABORATIVE MANAGEMENT PROGRAM

Evaluation Progress Report

FEBRUARY 15, 2010
OMNI INSTITUTE

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Background: The Collaborative Management Program in Colorado

In *Tales of a New America* Robert Reich, former Secretary of Labor, identifies several conditions that require new strategies for dealing with old problems. These conditions include the increasing complexity of social issues and the diversity of perspectives that require integration in order to find acceptable solutions to these issues[1]. Collaboration is among the most widely supported new strategies for changing the way we work together on common problems. Collaboration, in the social arena, is a method of collective decision-making where public agencies and non-state stakeholders engage in consensus-oriented efforts to develop and implement public policies and procedures designed to manage public resources and solve problems. Collaboration is the strategy chosen by the Colorado General Assembly to reduce costs and duplication of efforts and to improve the quality of services for children and families in the child welfare system.

House Bill 04-1451 was passed by the Colorado General Assembly in 2004, reflecting the idea that the "development of a uniform system of collaborative management is necessary for agencies at the state and county levels to effectively and efficiently collaborate to share resources or to manage and integrate the treatment and services provided to children and families who benefit from multi-agency services." Participating partners include county departments of human/social services, local judicial districts, health department, school district(s), community mental health centers and Behavioral Health Organizations, parent or family advocacy organizations, community agencies, and other state agencies. Local collaboratives may request waivers of rules, can receive earned incentive money for meeting identified outcomes, and can reinvest any general fund savings into additional services to children and families that would benefit from multi-agency services.

House Bill 1451 Program Goals and Outcomes

The goals of the legislation are to create Collaborative Management Programs that seek to accomplish the following:

1. Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent advocacy or family advocacy organizations;
2. Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi-agency services;
3. Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services;
4. Encourage cost sharing among service providers; and
5. Lead to better outcomes and cost-reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado.

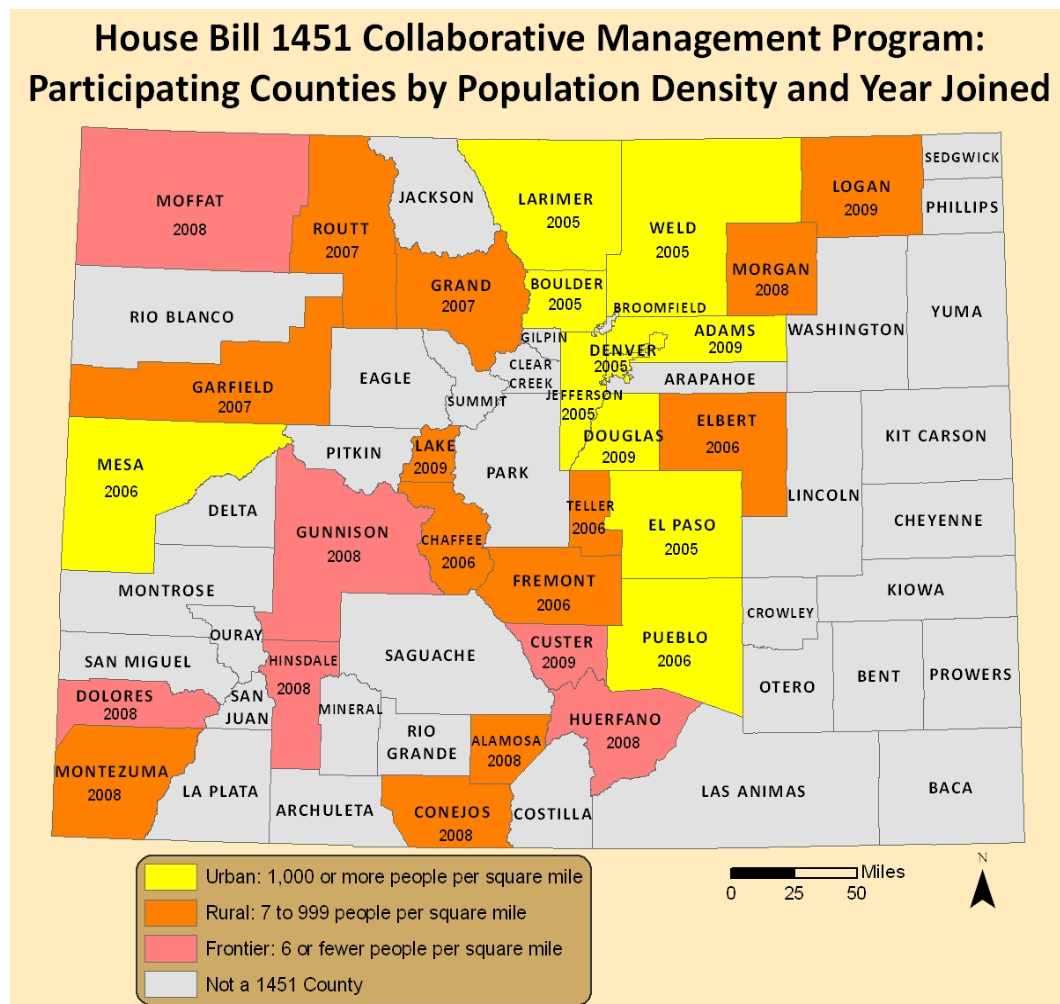
Performance based measures are developed by a County Interagency Oversight Group (IOG) in four areas:

[1] Reich, Robert B. Tales of a New America. New York: Times Books, 1987.

- Child Welfare
- Juvenile Justice System
- Education
- Health/Mental Health/Other Health Services (e.g., Substance abuse)

Performance based incentive money is made available based on impacts to these area and in accordance with a formula approved by the State Board of Human Services. Counties are required to set specific targets in all four outcome areas and to describe how they plan to meet these targets. Incentive funding is to be used for a variety of purposes including: facilitation of collaborative processes (including hiring trained facilitators and family support staff); project coordination; filling gaps in services that are not available through other sources; and start-up funds for new programs identified by the Interagency Oversight Group as needed in the community.

The Reach and Growth of Collaborative Management in Colorado
As illustrated in the map below, Collaborative Management Programs have developed throughout Colorado in urban, rural, and frontier counties. While the structure of programs varies by community, the goals remain the same. Additional counties have consistently joined the program each year since its inception which may speak to the popularity of the initiative. However, the total amount made available for incentives has not increased from the original amount, resulting in less incentive funding per county as additional CMPs are added.



Statewide Evaluation of House Bill 1451: History and Status

HB08-1005 authorizes an annual external evaluation of the Collaborative Management Program (CMP). In July 2009 the Colorado Department of Human Services hired the OMNI Institute (OMNI) to conduct a statewide evaluation of the CMP for FY2009-10. The contract was received and work began in October of 2009. This progress report covers a four month period, from October 1 through January 31, 2010 and thus represents very early and inconclusive results. More summary results will be available after the completion of a full year of evaluation activities.

The evaluation is focused on examining the relationship between collaborative management efforts as expressed in CMP practices and processes and impacts on performance measures in child welfare; juvenile justice, education, and health. The evaluation design also includes a formative component that explores areas such as barriers to implementation, resource allocation conflicts, and IOG performance issues, as well as observed success in the implementation of local plans. Taken together, quantitative and qualitative findings will be used to assess overall CMP effects, describe best practices, and develop recommendations in the area of effective collaboration approaches.

OMNI has been working in partnership with the CMP State Steering Committee and the CMP Evaluation Committee to select areas of measurement for collaborative management practices and processes as well as performance measures. OMNI identified ten common outcomes across the CMP sites based on local performance measures. These outcomes serve as the basis for information gathering across the sites and work is ongoing to identify the performance measures related to these common outcomes.

From November 2009 to January 2010, OMNI conducted site visits with each CMP, including an interview with each IOG Coordinator and focus groups with IOG members, to document unique and common service and system models implemented by projects. To support the evaluation, OMNI developed and implemented a web-based data collection system in January 2010. The system is designed to collect standardized information on a quarterly basis reflective of statutorily defined intermediate outcomes (e.g., reducing duplication of services). The system also collects information on successes, barriers, and key learnings realized by the CMPs that will help to identify best practices.

To assess the quality of CMP collaborative practices, Dr. Carl Larson and Dr. Darrin Hicks, members of the OMNI evaluation team, created data collection tools to measure collaborative quality and effectiveness across sites. This work is in progress and will be completed in two phases, detailed in the next section of this report. These data will be used to explore the relationship between collaborative efforts and observed outcomes.

Finally, OMNI developed a dedicated 1451 Portal site to help support the creation of collective knowledge, the further development of best practices, identification of major barriers and successes, and an efficient means for sharing project information across participants.

Evaluation of Collaborative Practices

Dr. Carl Larson and Dr. Darrin Hicks of the University of Denver are members of the OMNI evaluation team. They both have extensive experience studying collaboration and its relationship to program outcomes. Past research has shown that when collaboration is successful it can lead to increased governmental accountability, greater civic engagement, consistent downstream implementation, and, most importantly, higher levels of program success[2]. But successful collaboration is difficult to achieve; it depends on creating a deliberative climate that fosters trust, shared commitment, mutual accountability, and a willingness to share risk. The CMP evaluation seeks to measure collaboration effectiveness in order to explore and assess its relationship to observed project outcomes. The first step in evaluating CMP collaboration is to identify the key variables that differentiate the ways in which collaboration has evolved across the 27 HB1451 sites. After these variables are identified, measurement strategies can be developed for quantifying and examining the degree to which different forms and aspects of collaboration are present in the different sites.

To date, the evaluation has focused on identifying key variables related to collaboration. To collect data on these variables, a sample of nine sites, ranging from high-performing to average, was selected with the assistance of Mr. Norm Kirsch, Director of the HB1451 Initiative at the Colorado Department of Human Services. Data collection included interviews of key stakeholders, Interagency Oversight Group (IOG) coordinators, members of the evaluation subcommittee, and key state department officials identified by Mr. Kirsch. Areas of inquiry included perceptions of the collaborative climate in respective counties, descriptions of the process used to establish and implement the Collaborative Management Program, reflections on the practices of inclusion and decision-making, processes used to determine target outcomes, perceptions of community support, and reflection on the practices used to ensure collaborative success.

The preliminary findings from the interviews are listed below. Constant refining of these variables and practices will be required as the analysis proceeds.

Key variables: The following variables were identified by stakeholders as important dimensions of their collaborative processes.

- The **authenticity** of the process was secured by bringing those with decision-making authority to the table rather than their representatives: Those in high-performing sites discussed the importance of being able to maintain a commitment to the process by having those who could make decisions and commitments on behalf of their agency to the collaborative at the table.

[2] Hicks, Darrin; Larson, Carl; Nelson, Christopher; Olds, David L.; Johnston, Erik. "The Influence of Collaboration on Program Outcomes: The Colorado Nurse-Family Partnership." *Evaluation Review*, Vol. 32. No.5, 2008.

- The **inclusion** of stakeholders outside the professional agency culture was seen as critical to the success of the collaborative effort: Those in high-performing sites discussed the importance of including law enforcement, magistrates, school officials, parents, and family advocates in their collaborative processes.

- The presence of strong, engaged **leadership** dedicated to fostering a genuinely collaborative process was seen as critical to the success of the collaborative effort: Those in high-performing sites discussed the need for process-oriented leadership. Several stakeholders said that the turning point in their collaborative efforts was the emergence of strong facilitative leadership.

- The history of collaborative **working relationships** among stakeholders was seen as critical to the success of the CMP: Those in high-performing sites discussed the prior history of collaboration as a precondition for their success.

- Each of the stakeholders having an equal **investment** in the process was identified as critical to the success of the CMP: Those in high-performing sites discussed the importance of all stakeholders demonstrating their commitment to the process by being willing to share resources and risks.

- The ability to devote resources to **process management** was seen as a critical condition of success. Those in high-performing sites discussed the importance of having an IOG coordinator who had the time and resources necessary to manage the process.

These and other variables will be measured in the coming months through use of an online survey completed by all IOG members in each site. These data will be supplemented with existing measures of collaboration process and structure as reflected in the *Process Quality Scale* and the *Working Together* instrument, formerly developed by Dr. Carl Larson.

<u>Best Practices</u>: In addition, a goal for this evaluation is to assist sites in improving the quality of their collaborative process so they can increase the success of their services to children and families. To this end, work is underway to create an account of the best practices used by sites to secure and sustain high-quality collaboration. In the interviews each of the stakeholders were asked to identify what concrete steps they had taken to secure collaborative success. A preliminary list of these "best practices" is presented below:

- Establishing *open lines of communication* between all stakeholders

- Ensuring that the process was *transparent* to both stakeholders and the public

- Reaching out for *expert advice* when possible

- Having a process for the *identification of real felt needs* in the community

- *Seeking public recognition* when possible as a means of securing community support

- Devoting time and effort to *building relationships* between stakeholders

- Ensuring that stakeholders are given *timely, accurate and comprehensive information*

- *Being data-driven* when making decisions about what efforts to continue and which to terminate.

The evaluation will continue to identify and refine the best practices used to foster high-quality collaboration and the final report will contain a comprehensive list of these practices along with suggestions for implementing them across all of the Collaborative Management Program sites.

Evaluation of Program Goals and Outcomes

This progress report covers a four month period, from October 1 through January 31, 2010 and thus represents limited data and very preliminary results. More summary results will be available after the completion of a full year of evaluation activities.

OMNI researchers visited all HB1451 Interagency Oversight Groups in the winter of 2010. While the data from these visits is still being organized, communities overall reported positive results as a result of their involvement in the initiative. The researchers recorded stories of successes, progress, and challenges across all Collaborative Management sites. Some preliminary learnings are presented below followed by plans for the evaluation moving forward.

Early Findings

a. Preliminary Collaboration Findings

All CMP sites are engaged in collaborative planning to build on existing services; leverage resources; identify gaps and needs; and develop new and ongoing formalized relationships. Some of the themes that emerged across multiple counties related to IOG collaborative efforts are presented below:

Agencies are working together more closely through Collaborative Management
Many communities expressed that the broad and formalized nature of the CMP initiative has resulted in better communication, teamwork, and shared responsibility for accomplishing common outcomes, including more agency-level accountability and ownership for broad goals. It was also reported that the diverse and narrow missions of the various IOG members can make commitment and true partnerships challenging, despite

best intentions. Attempting to emerge the "common good" amongst all of the mandates, requirements and agendas of various agencies can be daunting. Many reported that working together more closely results in enhanced mutual respect and increased knowledge of existing supports and services as well as better sharing of information and creation of informal networks.

"The network of people has created access resources that were not there previously. There was a situation with a foster kid placement where the biological father found out where his kid was and was making noise about going over there. You want to notify law enforcement but you want someone familiar with child welfare. Having contacts in the Police Department that you know have knowledge is helpful.

-Tracy Neely, Youth Services Administrator, Denver Human Services

CMPs are balancing direct service to families with broader systems-change efforts

The IOGs are working on multiple levels and balancing intensive work with a defined set of multi-system youth and their families, while also working on broader systems changes across their agencies and communities to have a longer-term impact.

Many of the IOGs have developed "wraparound teams" that focus on family-driven and integrated services to address the most challenging cases. These teams can be costly to manage in terms of staff time, and the value of prevention is difficult for many CMPs to quantify. Anecdotally the teams are producing better results through integrated care, but the true costs and benefits of this approach are difficult for communities to measure.

Larimer County IOG members visited Hampton County Virginia to learn more about their successful Family Assessment and Planning Team (FAPT) model. Upon returning they worked to create a similar team that has been successfully operating for the past year to divert youth from costly residential treatment.

Urban, Rural, and Frontier Counties' CMPs face different challenges

The challenges and opportunities inherent in Collaborative Management Programs are different for urban, rural, and frontier communities. Urban counties are managing collaboration at multiple levels to determine appropriate roles and infrastructure, which tends to be more complex than in smaller county systems. They also tend to have more services available to work with. In rural areas with IOGs that cover broad geographic regions (frontier counties and two-county Collaborative Management Programs) the services tend to be centralized in one geographic location, requiring extra effort to reach out to the surrounding region and ensure coverage of services and supports. Smaller counties also tend to have fewer services overall for families.

Staff and Leadership are key components to the success of CMPs

Leadership and consistent staff support are reported as critical components to the success of all projects. IOG coordinators play a central role in creating and managing coherent processes for the IOG, Wraparound or Individualized Service and Support Teams (ISSTs), as well as other committees and groups; tracking outcomes; and facilitating strategic

planning and goal setting. The leadership and support from key agencies was also reported as critical to the overall success of collaboration. This was noted particularly in cases where it was clearly absent (e.g., due to an indifferent school district superintendent, non-engaged mental health agency director, or magistrate who is not bought in to the process).

b. Preliminary Outcome Findings

This section provides highlights and examples of successes from selected communities for each outcome area of the legislation. A systematic review of all of the data collected in the quarterly progress reports, as well as site visits, is currently underway and findings will be included in the final evaluation report. The case examples presented here show how the goals of the legislation are working in practice across different settings. All of the communities highlighted below have been engaged in the Collaborative Management Program for at least four years.

Legislative Goal #1: Develop a more uniform system of collaborative management that includes the input, expertise, and active participation of parent advocacy or family advocacy organizations

Case Example

Chaffee County has successfully broadened their CMP to include additional partners. In addition to mandated agencies, the following partners are also signed onto the MOU in Chaffee County: Family Youth Initiative, Chaffee County High School, Family Representative, and a Youth Representative. There are other partners who regularly participate in IOG meetings but are not partners on the MOU. These include, but are not limited to Restorative Justice, Build a Generation of Buena Vista, and the Early Childhood Council. Currently a member of the faith community and a police officer are becoming actively involved in the CMP.

On one of the wraparound teams in Chaffee County, the child's school teacher was able to participate in regular meetings to help support the child and family.

Case Example

Collaboration with the School Districts has made a big difference for kids and families in El Paso County. Many at-risk families change schools frequently and thus the El Paso IOG worked on improving communication between the schools, including the transfer of school records and relevant information in a timely way. They also educated mental health therapists and other professionals working with youth not to set therapy appointments for youth during the school day since this practice leads to an increase in truancy rates.

El Paso County recently approved the addition of youth representatives to serve as voting members on the Interagency Oversight Group. Beginning in July 2010, two youth will begin a term of service on the IOG to provide a client perspective at the governance level.

Legislative Goal #2: Reduce duplication and eliminate fragmentation of services provided to children or families who would benefit from integrated multi-agency services

Case Example

A DHS Supervisor in El Paso County describes a family with five children in which three were in out-of-home placements. There were a total of 21 professionals providing services to the family: eight therapists, three Guardians Ad Litem, two caseworkers, two probation officers, four different schools, and two placement providers. After becoming involved in the wraparound team, two of the three open dependency/neglect cases were closed within five months and the family now works with one probation officer, one Guardian Ad Litem, and one caseworker.

El Paso County has also developed a crisis planning process through the collaboration of multiple agencies: when a youth in placement returns home, the plan ensures that the youth, family, and agencies know what to do if things become difficult. Often the plans include anger management and conflict resolution strategies. As reported by a DHS supervisor, the crisis plans have made reunifications more successful.

Legislative Goal #3: Increase the quality, appropriateness, and effectiveness of services delivered to children or families who would benefit from integrated multi-agency services

Case Example

An IOG and Wraparound Coordinator for Chaffee County, describes a family who was not accessing any supports despite multiple and complex needs. Without intervention, members of the family were on a path to institutionalization. Through the support of the wraparound team and an individual Family Support Partner assigned to the family, tremendous growth occurred in the mother's self-esteem and confidence; stability in a difficult school situation for the child; and housing as well as ongoing supportive disability services were secured for the family.

The IOG in Chaffee County identified a gap in services and now financially supports a therapeutic mentoring program. "MentorsPlus" serves Chaffee County youth considered at risk of correctional involvement. The youth receive one-on-one mentoring with trained adults, group life-skills activities, and individual therapy. Reports indicate that positive role models are making a big difference.

In another instance, services were coordinated for a preschool child with developmental disabilities: the therapists, school teacher, and mother met regularly, sharing strategies and building on one another's approaches with the child. As a result of these coordinated efforts, the child is making tremendous growth.

Case Example

In a similar case in Jefferson County, one father shares his experience of how agencies coming together impacted his family, struggling to cope with autism and bi-polar disorder:

"Our experience with Jefferson County Collaborative Management (HB1451) partners has:

- Kept our family together; It got Z. out of the residential program he was in, and safely back home with me and his younger brother; It has kept Z. out of possible further residential care or a group home; it kept him home with us
- It kept me employed (in the same job) and kept me from going bankrupt
- Z. and his brother A. are doing well in school Z is now is getting green days in school and has a grade point average above a 3 point. This program has saved my job, without the after-school autism care I would not be able to keep a full-time job."

The grandmother in the family writes:

> "My greatest wish is that our story will help the decision makers see that there is a better way to design a 'system' that is both functional and cost effective. Families in crisis often are overwhelmed with the responsibilities of daily life and they do not have the time, the expertise, or the energy to find the help they so desperately need. My son, D., and both his boys are diagnosed bipolar. Z., the oldest son, is also diagnosed with autism (high functioning). D. is a single Dad with a degree in engineering and has a good paying job. However, the cost for the kind of services Z. requires is far and above his ability to pay. A., the younger son, also requires special services… This team of professionals [Jefferson County Collaborative Management Partners], each with their own agenda and funds, were able to come together, to pool their resources, and ultimately give the family what it needs to make them successful citizens. Z. was able to finish his residential treatment, and then safely return home with virtual residential services… As of today, D., Z., and A. appear to be doing much better managing a most difficult life. They are growing and developing skills that give them more independence and more control over their lives."

Legislative Goal #4: Encourage cost sharing among service providers

Case Example

Weld County's Truancy Response and Intervention Program (TRIP) was recently added to the list of best practices by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in Washington D.C. The TRIP program was developed through a CMP strategic planning session several years ago when the District Attorney's office was unable to continue supporting the existing truancy intervention program. The CMP took it on as a goal and began working to build a multi-agency truancy intervention program.

In December of 2009, the U.S. House of Representatives approved H.R. 3288, which includes roughly $245,000 for the Weld County Juvenile Assessment Center (JAC) to expand its Truancy Response and Intervention Program to school districts throughout the southern and rural parts of Weld County. The TRIP provides multi-level intervention support and assistance to truant youth and their parent(s),

Through the work of their CMP, Weld County is set to receive federal funding to expand its Truancy Response and Intervention Program to school districts throughout Weld County.

enabling them to remain engaged or to re-engage in the education process.

Case Example

Larimer County has successfully blended funding to provide seamless services to children and families. DHS Core Services funding for families with a child at imminent risk of out-of-home placement is blended with 1451 funding, which includes money from multiple agencies. This funding can fill a critical gap for families who are eligible for Medicaid when their child(ren) are in out-of-home placement but often no longer qualify for Medicaid when the child returns home. The 1451 funding (including Core Services dollars) can kick-in right away when Medicaid coverage ceases in order to provide seamless services for families as their child(ren) are reunified, enabling them to continue working with the same therapist. In another case, funding from the Probation Department was able to cover a needed therapy to avoid placing the family on a waiting list for funding from DHS Core Services.

One of the IOG members in Larimer describes their deliberate cost-sharing structure this way: "everyone truly pushes money into the middle of the table and we decide how to allocate it as a group." These allocation decisions are made through a partnership with researchers at CSU in which outcomes are reviewed annually and priorities are set accordingly.

Legislative Goal #5: Lead to better outcomes and cost-reduction for the services provided to children and families in the child welfare system, including the foster care system, in the state of Colorado

Case Example

In El Paso County, the wraparound team became involved in a case that had been open since 1985. The team was able to link the family to their natural supports, such as extended family, helping to mend relationships and mediate conflict. The children became involved in Boys and Girls Club and Big Brothers Big Sisters, allowing the parents to work, and the case was successfully closed within 4 months.

Case Example

In Larimer County, the Family Assessment and Support Team (FAPT) targets families with children at imminent risk of placement in the Treatment Residential Child Care Facility (TRCCF). A core team of multi-agency representatives meets weekly to review cases and develop integrated service plans with families. When the team began meeting in January 2008 there were 35 children in the TRCCF. One year later that number has decreased to 12. The majority of these youth were reunified with their family of origin, while approximately one third were placed in specialized foster care settings. The cost of caring for a child for one month in TRCCF is approximately $4500. The cost for specialized foster is roughly $2400 each month.

When the Larimer County Family Assessment and Planning Team began meeting in January 2009, there were 35 youth placed in the Treatment Residential Child Care Facility, at a cost of appx. $4500/month. One year later, there are 12 youth in TRCCF.

The Larimer County IOG spent one year developing a program for Juvenile Sex Offenders, who were often remaining in TRCCF for more than two years. The program finds creative solutions to keep the child in the community safely. Since its inception they have seen a reduction in outcomes for the offenders, such as school dropout and successful probation completion, as well as a decrease in new charges and moves into more intensive placement.

Future of the Evaluation Effort

Over the last four months (October 2009 – January 2010) OMNI has been building the infrastructure needed to conduct a statewide evaluation of the HB1451 initiative. This foundation and the overall multi-method evaluation approach, which includes formative, process and outcome components, will allow for the assessment of project outcomes, a determination of the importance of collaborative efforts, and the identification of best practices and lessons learned to help improve the functioning of all CMP projects.

The overall evaluation infrastructure will include the following components:

1. Finalization of the web-based quarterly reporting system

This reporting system is designed to collect key information that can inform the legislature, existing CMP projects and new 1451 counties about the significant work CMPs are doing. It captures information on lessons learned, as well as successes, and barriers encountered and will help to identify best practices to share with CMPs across the state. The system is set up on a quarterly cycle in order to gather information about progress made and changes over time. Additional sections will be available for Quarter 3-4 reporting which help fulfill all statutory reporting requirements.

2. Development and implementation of multiple tools to assess collaboration

In addition to the key informant interviews with selected counties and state-level stakeholders, two survey instruments will be collected from all IOG members in all 27 sites. The *Process Quality* and *Working Together* instruments, developed previously by Dr. Carl Larson, will be combined with additional questions developed for this evaluation and distributed in March of 2010. The second survey is designed to measure members' perceptions of the overall success of their CMP and will include open-ended questions along with survey questions. This will be collected in April of 2010. Both surveys will be analyzed and results presented in the final evaluation report.

3. Descriptions of project process models to identify structural approaches to local program implementation

Process data collected through these efforts will be linked to information related to collaborative practices and service models being implemented across the state as identified through the focus groups with each CMP site. As a complement to this work, OMNI developed a set of common process-related performance measures, or intermediate outcomes, related to the overarching goals of HB 1451 (e.g., reduction in fragmentation of

services). The first round of data collection has been completed and counties will continue submitting these data via an on-line quarterly reporting system.

4. Development of data sets related to the 10 common outcome areas

In the coming months OMNI will complete work identifying standardized performance measures in each outcome area and trend data related to the common outcomes (outcomes identified by at least 5 of the 27 sites) will be compiled and compared across CMP and non-CMP sites to gain an understanding of how CMPs impact outcomes over time and emerge any differences between CMP and non-CMP counties. These data can also help communities to set priorities as they continue to refine the focus of their Collaborative Management programs.

5. Full implementation of the 1451 portal

A Portal is a web-based system designed to assist communities in working in a collaborative environment. The 1451 collaborative portal will allow communities to access common documents, calendars, and resources in a centralized location. Communities will be able to improve efficiencies for their work from utilizing shared knowledge and experience of others through the portal[3]. The internet portal is expected to support inter-project communication; disseminate information of project efforts to help projects learn from each other; and support the development of a knowledge base to continue to inform local efforts.

6. Development of a cost model

Another area for exploration in the evaluation is a comparison of costs savings to collaborative practices and processes with the inclusion of CMP support costs. This is a highly complex area given the lack of standardized collection of cost information. The cost model will be specified by the end of year one of the evaluation and implemented, given available funds, in subsequent years of the evaluation. Future analyses will explore variation in the predictive relevance of practices and processes as they relate to costs saving achievements.

All together the data collected on practices, processes, intermediate outcomes, and performance measures will be connected to explore whether enhanced collaborative management is associated with program outcomes. These analyses will also be useful in identifying the most salient practice and process elements to help focus local efforts and improve the overall effectiveness of the initiative. These elements will be summarized as a set of best practices that can be used to help refine local practices and disseminate findings to future CMP communities.

[3] http://clientportal.omni.org

APPENDIX D

STRATEGIES FOR SELF-IMPROVEMENT AND CHANGE AND RECIDIVISM FOLLOWING TREATMENT

Strategies for Self-Improvement and Change and Recidivism Following Treatment

October 27th, 2009

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Wayne E.K. Lehman, Ph.D.

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Executive Summary

A total of 685 clients who participated in substance abuse treatment using the Strategies for Self-Improvement and Change (SSC) model from July 2004 through June 2006 were included in this assessment of recidivism. Overall, 425 clients were involved with the Colorado Department of Corrections; 260 were involved with other portions of the criminal justice system such as drug courts, diversion programs, or municipal courts. Recidivism was operationally defined as involvement in DOC following SSC treatment, measured both by incarceration for technical violations and incarceration as a result of committing a new offense. Nine treatment agencies throughout the state were involved in providing SSC services for this evaluation.

At one year post treatment, 79% had not committed new offenses and 62% were not returned due to technical violations; at two years, these figures were 73% and 50%, respectively. While these rates are generally the same as those the DOC routinely reports, it is noteworthy that all of the clients in this study had issues of substance abuse, placing them at much more risk of relapse than non-substance abusing DOC clients. Additionally, a series of analyses were conducted on the DOC clients to assess predictors of recidivism at year one. Findings revealed that economic indicators including education, employment and income were significantly associated with lower rates of recidivism, as was older age, suggesting a possible maturation effect in terms of further involvement with the DOC.

Perhaps most importantly, lower recidivism was also associated with treatment duration (i.e., more days in treatment) and completing treatment. Overall, 47% of non-recidivists completed treatment compared to 18% of recidivists who completed treatment.

Other predictors on lower recidivism included having a moderate or high treatment achievement assessment rating and paying $100 or more for treatment (payment is defined as services billed and paid for by Signal Behavioral Health Network, the Division of Behavioral Health Designated Managed Service Organization). As reflected in numerous prior studies, substance abuse treatment has been linked to reduced drug use and HIV drug and sex-related risk behaviors, as well as HIV seroconversion, productivity, criminal activity and psychological functioning. This evaluation supports these earlier investigations.

The Authors

Robert E. Booth, Ph.D. and Wayne E. K. Lehman, Ph.D. were hired as independent contractors by Signal Behavioral Health Network to conduct this assessment. Dr. Booth is a Social Psychologist who has conducted evaluations of human service programs for over 35 years. For the past 22 years this work has focused on interventions designed to prevent the spread of HIV among drug users, including testing interventions to increase treatment entry and retention among injection drug users (IDUs). He has served on numerous study sections for the National Institutes of Health and from 1998-2002 was a member of the Office of AIDS Research Advisory Council. He has more than 200 publications to date. Dr. Lehman is also a Social psychologist. For more than 20 years he has assessed interventions designed to address substance abuse, in particular substance abuse treatment. He has numerous publications in this area.

Introduction

Funds derived from the Drug Offender Surcharge, a cash fund that is supported by fines levied on persons convicted of drug offenses, has supported the use of the Strategies for Self-Improvement and Change [SSC] among public substance abuse treatment agencies for several years. SSC is a manualized intervention based on a cognitive behavioral model of change, an approach that has demonstrated significant advancement in the treatment of individuals with both criminal behaviors and involvement with substance abuse. SSC is typically 48 - 50 weeks in length and has a comprehensive participant manual, which outlines the goals, objectives and activities for each session. Phase I is entitled “Challenge to Change” and is 18 sessions in length. Phase II is entitled “Commitment to Change” and is 22 sessions in length. Phase III is “Taking Ownership of Change” and is approximately 10-12 sessions in length. Substance abuse treatment providers who receive funding from Signal to offer SSC must be licensed to treat offenders with these funds. SSC has achieved considerable success in affording providers a standardized protocol for changing the thinking and behavior of offenders with substance abuse disorders. It is the most widely used protocol for offenders in the public treatment system in Colorado.

The purpose of this report is to assess the effectiveness of SSC based upon measures of recidivism, operationally defined as return to the Department of Corrections (DOC) following SSC treatment. The eight SSC treatment programs included in this assessment were: Denver metro area - Arapahoe House; Addiction, Research, and Treatment Services (ARTS); Community Alcohol Drug Rehabilitation and Education Center (CADREC); and Sobriety House; Northeast Colorado – Island Grove Regional Treatment Center and Centennial Mental Health; Southern Colorado – Crossroads’ Turning Points and San Luis Valley Mental Health Center. All eight programs received funding from Signal Behavioral Health Network, the managed service organization disbursing SSC funds in these areas, for delivery of outpatient services to offenders using the SSC curriculum. Included in this assessment were all clients discharged from these programs between July 2004 and June 2006, for whom Signal paid for at least one SSC service.

A focus group of staff from the eight providers was held to learn more about how the SSC curriculum was used. All providers reported having received training on use of the curriculum and using the curriculum to conduct group counseling for all clients. However, there was considerable variation in how providers used the curriculum. Only one provider reported having all clients participate in all three SSC phases. More commonly, providers reported that clients completed only a portion of the full SSC curriculum, usually at the request of the referral source or because the client had already completed a portion of SSC prior to admission. Similar variation was found in use of specific SSC sessions. Some providers reported rigidly adhering to the SSC manual; others reported modification of SSC content to address individual client needs. Additionally, providers reported a wide range of clients referred for SSC. All clients

were involved in the criminal justice in some way and were in need of treatment that addressed both substance abuse and criminal thinking. Many clients had extensive criminal histories with lengthy prison stays; others were not involved with the Department of Corrections and were referred directly by probation officers, diversion programs, or municipal courts.

Specific aims are:

1. To calculate recidivism rates for a sample of DOC clients after substance abuse treatment in the SSC program at one and two years.
2. To identify predictors of recidivism at one year.

Methods

Data Files Utilized. Three data sets were merged for the analyses file. These included –

DOCRecid	N = 465
DOCProfile	N = 429
SignalData	N = 748

The DOCRecid file included DOC number, a date variable (stat_strt_dtd) and two variables that described the type of DOC contact or status (10 = NEW CT COM; 21 = PAR RET; 22 = NC/PAR RET; 30 = PROB RET; 40 = CO DIS RET). The file included 465 records. Of these, 36 were duplicates which were eliminated for a total of 429 unique DOC numbers.

The DOCProfile file included DOC number, a date variable KEYDATE, and variables representing demographics and background and DOC assessment information, including dates for the various assessments. The file included 429 records, all of which had unique DOC numbers. These DOC numbers matched the 429 unique DOC numbers in the DOCRecid file. In addition, the dates in the variable, stat_strt_dtd in the DOCRecid file were identical to the dates in the KEYDATE variable in the DOCProfile file. The stat_strt_dtd will be referred to as the DOC date.

The SignalData file included DOC number, admission and discharge dates, dates of first and last service, demographic and background variables, and various "treatment" variables. The file included 748 records of which 18 were duplicates in terms of DOC number and admission and discharge date. These records were eliminated. Of the remaining 730 records, 45 DOC numbers had two different admissions. Because recidivism was based on the individual and not the treatment admission, only the record with the first treatment admission was retained for analysis, leaving a total of 685 records with Signal data.

The three files were merged using the DOC number. The resulting file had 685 cases – 425 cases had DOC data and 260 cases did not. The 260 cases were clients involved with

parts of the criminal justice system other than DOC. Such clients were referred to SSC from agencies such as drug courts, diversion programs, and municipal courts. The 425 cases involved with DOC is the final number utilized in the remaining analyses.

Date Issues. Four key date variables from the SignalData file were examined. These included admission date, first service date, last service date, and discharge date. The typical sequence was admission followed by first service, last service and finally discharge. However, there were a number of records where first service date preceded admission date and last service date preceded the discharge date, sometimes by very large differences. Overall, the first service date preceded the admission date for 58 cases; the last service date preceded the discharge date for 23 cases. When calculating days of treatment (from admission to discharge date) and days of service (from first to last service dates), 28 cases had more days of service than days in treatment. In addition, 2 cases had a DOC date occurring prior to the Signal admission date (but after the first service date) and 8 cases had the DOC date occurring before the last service date.

The following table gives the earliest and latest dates for several key date variables in the files. Note that the latest "first service date" is more than six months past the latest discharge date and that the latest "last service date" is more than two years past the latest discharge date.

Ranges for Date Variables

Date Variable	**File**	**Earliest date**	**Latest Date**
admitdate	SignalData	May 8 2002	Jun 2 2006
dischargedate	SignalData	Jul 1 2004	Jun 30 2006
first service date	SignalData	Jun 7 2002	Jan 9 2007
last service date	SignalData	Dec 16 2003	Sep 27 2008
stat_satrt_dtd	DOCRecid	Mar 14 2003	May 15 2009

In order to further understand the nature of the DOC date, the DOC date was compared to 12 other dates included in the DOCProfile file. These included an offense date, a classification date, and dates of various assessments including, Level of Severity (LSI), gang code, mental health, sex offender, substance abuse, medical academic/vocational anger, developmental disability, and self destruction. All but a few cases had some of these dates preceding the DOC date and some that occurred after the DOC date.

Recidivism Further Defined. Recidivism was defined as any contact with the DOC (as indicated by the DOC date) in the first year (365 days) and second year (730 days) following the last SSC service date. The last service date was chosen rather than the discharge date because there were a number of cases (N = 48) where the DOC date was later than the last service date but before the discharge date. It was assumed that for these cases, the client had client with the DOC and was then discharged from the SSC program.

The type of DOC contact was also considered in defining recidivism. The DOCRecid file included variables indicating type of DOC contact or status. Of these, NEW CT COM (new court commitment; stat_strt_typ code 10) and NC/PAR RET (parole return

for a new crime; stat_strt_typ code of 22) indicated new offenses committed. The other categories: PAR RET (parole return, technical violation; stat_strt_typ code 21), PROB RET (probation return; stat_strt_typ code 30) and CO DIS RET (court discharged return; stat_strt_typ code 40) represented parole or probation revocations or returns. Recidivism was assessed both in terms of returning to the DOC, regardless of the reason, and according to new offenses only (NEW CT COM or NC/PAR RET).

Predictors of Recidivism. Predictor variables were selected from the SignalData file to represent personal demographic and background information and additional variables to represent SSC treatment.

Personal and background variables included gender (male), race (separate dummy coded variables: White, Black, Hispanic); age (coded as 17 to 29 and 30 or older); education (coded as less than a H.S. diploma vs. H.S. diploma or more); employment status (coded as not employed, part-time employment and full-time employment); monthly income (coded as none, \$1-\$800, \$801-\$1200 and \$1201 or more); primary drug of use (separate dummy coded variables: alcohol, cocaine, methamphetamine, heroin/opiates and marijuana), number of prior treatment episodes (coded as none, 1, 2, and 3 or more); arrested for DUI last 30 days; and other arrests last 30 days.

Treatment variables included: days in treatment (days from admission to discharge, coded as 0-89 days, 90-179 days, 180-364 days and 365 or more days); type of discharge (separate dummy coded variables - completed treatment, left against professional advice, terminated by facility, transferred or referred to another SA treatment program or facility and incarcerated); progress at discharge (coded as assessment only, minimal achievement, moderate achievement and high achievement); dollars paid by Signal for treatment (coded as \$0 to \$99 and \$100 or more); and dollars cost (coded as \$0 to \$149 and \$150 or more). (Signal receives a specific amount of funds for SSC each year. These funds typically are exhausted quickly, leaving providers to use other sources of funds to pay for SSC treatment. The dollar cost variable reflects what the cost would be if all the client's services were paid by Signal using SSC funds.)

<u>Analyses</u>**.** Two measures of recidivism were examined. The first measure defined recidivism as returning to the DOC (DOC date) within one-year of last SSC service date regardless of the reason. Results using this measure of recidivism are included in Tables 1-4. A second measure of recidivism is based on new offenses (NEW CT COM and NC/PAR RET) within one-year of the last SSC service date. Results are shown in Tables 5-8.

Bivariate contingency tables were computed between each of the predictor variables and two measures of recidivism. Chi-square statistics and associated probability levels are reported. Predictor variables that had a chi-square probability of $p < 0.10$ were then entered into sets of logistic regressions for each of the two recidivism measures. One set entered all significant predictor variables into an overall logistic regression and a second set used a stepwise selection procedure to select a subset of the best predictors.

Results

<u>Recidivism Rates</u>. For one-year recidivism, measured by any further contact with the DOC, there were 259 recidivists (38%); for two-year recidivism, there were 339 recidivists (49.5%). The table below shows the status description breakdowns of the one-year and two-year recidivists.

	One-Year (from Last Service)		Two-Year (from Last Service)		Total	
	N	Pct.	N	Pct.	N	Pct.
Total	259	37.8%	339	49.5%	425	62.0%
Status						
New Offenses	141	20.6%	185	27.0%	248	36.2%
NEW CT COM	*110*	*16.1%*	*145*	*21.2%*	*202*	*29.5%*
NC/PAR RET	*31*	*4.5%*	*40*	*5.8%*	*46*	*6.7%*
Prob/Parole Returns	118	17.2%	153	22.3%	177	25.8%
PAR RET	*114*	*16.6%*	*149*	*21.8%*	*172*	*25.1%*
PROB RET	*3*	*0.4%*	*4*	*0.6%*	*4*	*0.6%*
CO DIS RET	*1*	*0.1%*	*1*	*0.1%*	*1*	*0.1%*

Note: Percentages shown are out of a baseline of 685 clients.

Overall, 36% of clients committed a new offense following SSC treatment **-** 21% committed new offenses in the first year and 27% in the two years following SSC treatment. In addition, 26% returned to DOC as probation/parole returns with 17% in the first year following SSC treatment and 22% in the first two years.

<u>One-Year Recidivism – Bivariate Results</u>. Table 1 shows demographic and background predictors for One-year Recidivism and Table 2 shows treatment predictors. These results indicated that recidivists within the first year were: more likely than non-recidivists to be non-white and more likely to be Hispanic; more likely to be under 30 years of age; less likely to have a high school education; less likely to be employed full-time (and more likely to be unemployed); more likely to have no income; and, less likely to have a primary drug of methamphetamine. Table 2 shows relationships between treatment variables and one-year recidivism. One-year recidivists were: more likely to have had less than 180 days in SSC treatment; less likely to have completed treatment and more likely to have left treatment against professional advice or because of incarceration; more likely to have had minimal achievement in treatment (and less likely to have had high achievement); and, less likely to have paid at least $100 for treatment.

<u>One-Year Recidivism – Logistic Results</u>. Table 3 presents overall logistic regression results for one-year recidivism. None of the personal background variables were statistically significant (although the O.R. for income was marginal, indicating that lower income was related to recidivism). However, a number of treatment variables were

significantly related to recidivism. Completing treatment and paying at least $100 toward treatment were associated with lower recidivism, whereas leaving treatment against professional advice or due to incarceration were associated with a greater likelihood of one-year recidivism.

In the stepwise logistic regression (Table 4), higher income, completing treatment, and paying at least $100 for treatment predicted a lower likelihood of recidivism, while leaving against professional advice or discharged due to incarceration predicted a greater likelihood of recidivism.

<u>One-Year New Offenses – Bivariate Results</u>. Table 5 shows bivariate results for One-year Recidivism – New Offenses and demographic and background variables. Being over the age of 30, having a high school education or more, full-time employment, higher income, having 3 or more prior treatment episodes, and not having a DUI or other arrests were associated with lower recidivism rates for new offenses. Table 6 shows results for the treatment variables. Completing treatment, showing better progress at discharge and paying at least $100 for treatment were associated with a lower likelihood of new offenses in the first year, whereas transferring to complete treatment elsewhere or being incarcerated were associated with a higher likelihood of being charged for a new offense.

<u>One-Year New Offenses – Logistic Results</u>. Table 7 presents logistic regression results for all significant ($p < 0.10$) predictors. In terms of demographic/background predictors with statistically significant O.Rs for new offenses, a lower likelihood of new offenses was associated with being 30 years of age or older, having at least a high school education, and not getting arrested for a DUI. A lower likelihood of new offenses in the first year following SSC treatment was also associated with completing treatment and not leaving treatment due to incarceration.

Stepwise logistic regression results for new offenses are shown in Table 8. Being over the age of 30, having a high school education or more and higher income were associated with a lower probability of new offenses, while having a DUI arrest was associated with a higher likelihood. One treatment variable was selected in the logistic regression equation – completing treatment was associated with a smaller likelihood of being charged for a new offense.

Discussion

For both overall recidivism, defined as any incarceration in the DOC following SSC treatment, and new charges, including a new court commitment and return to incarceration for a new crime, older age (i.e., 30 or older), completing treatment, number of days in treatment, having achieved a high school education or more, full-time employment and earning a higher income were significantly associated with lower rates of recidivism. These variables reflect that not only are economic indicators important in whether or not further DOC action is required, but that the population assessed in this study may have matured in terms of criminal activity.

According to treatment variables, again for both overall recidivism and new charges, lower recidivism was associated with treatment duration (i.e., more days in treatment), completing treatment, having a moderate or high achievement assessment rating and paying $100 or more for treatment. Substance abuse treatment is important for a wide variety of reasons. Treatment has been associated with decreased drug use (Hubbard et al. 1988; Yancovitz et al. 1991), reduced HIV-related drug risk behaviors (Ball et al. 1988; Woods et al. 1991) and sex risk behaviors (Watkins et al. 1992; Comacho et al. 1997), lower HIV seroconversion (Woody et al. 1992; Moss et al. 1994; Metzger et al. 1993), as well as increased productivity (Milby et al. 1996; Maddux & Desmond 1997), reduced criminal activity (McLellan et al. 1986; Booth et al. 1996) and improved psychological functioning (McLellan et al. 1982; McLellan et al. 1996).

Central to the effectiveness of treatment is its duration (Stimmel et al. 1978; DeLeon et al. 1979). Outcomes for patients receiving less than 90 days of treatment are not significantly different from those receiving no treatment (Simpson 1979; Simpson 1981). The findings observed in this evaluation support the critical role treatment plays in further involvement in the criminal justice system.

It needs to be stressed that the individuals assessed in this report had issues of substance abuse, otherwise they would not have been referred to SSC. They differ in this regard from non-substance abusing DOC clients, yet their rates of recidivism were comparable. It is also important to note that lower recidivism was associated with completing treatment.

Table 1 - Demographic and Background by One Year Recidivism*

	Non-Recidivist (N=426)	Recidivist (N=259)	Chi-square	Prob
Male	84.7%	88.4%	1.82	0.177
White	50.7%	41.7%	**5.24**	**0.022**
Black	11.3%	11.6%	0.02	0.900
Hispanic	35.5%	44.8%	**5.91**	**0.015**
Age 30 or older	67.8%	57.9%	**6.89**	**0.009**
H.S. educ. or more	74.1%	66.4%	**4.58**	**0.032**
Employ			**8.14**	**0.017**
Not employed	28.3%	37.8%		
Part-time	15.6%	16.6%		
Full-time	56.1%	45.6%		
Income			**15.55**	**0.001**
None	24.1%	37.1%		
$1-$800	25.7%	25.9%		
$801-$1200	25.0%	18.5%		
$1200 or more	25.2%	18.5%		
Primary Drug				
Alcohol	27.8%	29.7%	0.28	0.594
Cocaine	21.5%	27.8%	3.55	0.059
Methamphetamine	24.8%	17.4%	**5.12**	**0.024**
Heroin/opiates	5.9%	3.9%	1.37	0.242
Marijuana	18.6%	18.9%	0.01	0.926
Prior Treatment			0.62	0.891
None	21.2%	18.9%		
1	29.0%	29.3%		
2	22.6%	22.8%		
3 or more	27.1%	29.0%		
DUI arrest	13.2%	17.0%	1.84	0.175
Other arrests	39.9%	42.5%	0.45	0.500

* Recidivism is defined as involvement with DOC (having a record in the DOC_RECID file) with a DOC start date that was within one year of the Signal last service date.

Table 2 -Treatment Variables by One Year Recidivism*

	Non-Recidivist (N=426)	Recidivist (N=259)	Chi-square	Prob
Days in treatment			**22.67**	**<0.001**
0-89	17.8%	27.0%		
90-179	26.1%	35.5%		
180-364	41.8%	27.8%		
365 or more	14.3%	9.7%		
Type of discharge				
Completed treatment	47.4%	18.2%	**59.65**	**<0.001**
Left against professional advice	12.7%	24.3%	**15.43**	**<0.001**
Terminated	12.2%	12.7%	0.04	0.847
Transfer	11.0%	12.7%	0.46	0.500
Incarcerated	10.6%	27.0%	**31.25**	**<0.001**
Progress at Discharge			**36.86**	**<0.001**
Assessment only	0.9%	1.9%		
Minimal achievement	30.5%	51.7%		
Moderate achievement	37.1%	30.1%		
High achievement	31.5%	16.2%		
Dollars paid ($100 or more)	52.1%	35.5%	**17.86**	**<0.001**
Dollars cost ($150 or more)	45.5%	49.0%	0.79	0.374

* Recidivism is defined as involvement with DOC (having a record in the DOC_RECID file) with a DOC start date that was within one year of the Signal last service date.

Table 3 -Logistic Regression on One Year Recidivism

	O.R.	Prob	95% C.I.	
White	1.03	0.924	0.60	1.77
Hispanic	1.14	0.644	0.66	1.94
Age 30 or more	0.75	0.119	0.52	1.08
H.S. Education or more	0.82	0.313	0.56	1.20
Employment	0.86	0.251	0.67	1.11
Income	0.82	0.054	0.67	1.00
Primary drug cocaine	1.32	0.191	0.87	2.01
Primary drug methamphetamine	0.75	0.230	0.48	1.20
Days in treatment	1.12	0.297	0.91	1.37
Completed treatment	**0.56**	**0.031**	**0.33**	**0.95**
Left against professional advice	**2.19**	**0.002**	**1.34**	**3.58**
Discharged due to incarceration	**2.82**	**<.0001**	**1.72**	**4.63**
Progress at discharge	0.80	0.110	0.61	1.05
Dollars paid (> $100)	**0.61**	**0.006**	**0.42**	**0.86**

Table 4 -Stepwise Logistic Regression on One Year Recidivism

	O.R.	Prob	95% C.I.	
Income	**0.76**	**<0.001**	**0.65**	**0.88**
Completed treatment	**0.43**	**<0.001**	**0.28**	**0.66**
Left against professional advice	**2.07**	**0.003**	**1.29**	**3.32**
Discharged due to incarceration	**2.56**	**<0.001**	**1.59**	**4.13**
Dollars paid (> $100)	**0.63**	**0.009**	**0.45**	**0.89**

Table 5 -Demographic and Background by One Year Recidivism -- New Offenses*

	Non Recidivist (N=544)	Recidivist (N=141)	Chi-square	Prob
Male	85.9%	87.2%	0.18	0.671
White	47.4%	46.8%	0.02	0.896
Black	11.8%	9.9%	0.37	0.541
Hispanic	38.4%	41.1%	0.34	0.556
Age 30 or older	68.0%	48.9%	**17.7**	**<0.001**
HS Education or more	74.0%	60.3%	**10.2**	**0.001**
Employment			**7.67**	**0.022**
Not employed	29.9%	39.7%		
Part-time	15.3%	18.4%		
Full-time	54.8%	41.8%		
Income			**18.47**	**<0.001**
None	25.3%	43.3%		
$1-$800	26.4%	23.4%		
$801-$1200	24.0%	17.0%		
$1200 or more	24.4%	16.3%		
Primary Drug				
Alcohol	28.4%	29.1%	0.02	0.876
Cocaine	23.3%	26.2%	0.55	0.458
Methamphetamine	22.9%	18.4%	1.29	0.257
Heroin/opiates	5.0%	5.7%	0.11	0.740
Marijuana	19.2%	17.0%	0.35	0.557
Prior Treatments			**8.33**	**0.040**
None	20.1%	21.3%		
1	29.5%	27.7%		
2	20.7%	30.5%		
3 or more	29.7%	20.6%		
DUI arrests	12.4%	23.4%	**10.92**	**0.001**
Other arrests	37.3%	54.6%	**13.92**	**<0.001**

* Recidivism is defined as committing a new offense (the variable stat_trt_sdesc from the DOC_RECID file equal to “NEW CT COM” or “NC/PAR RET”) within the first year after the Signal last service date.

Table 6 -Treatment Variables by One Year Recidivism – New Offenses*

	Non-Recidivist (N=544)	Recidivist (N=141)	Chi-square	Prob
Days in treatment			4.82	0.185
0-89	21.1%	22.0%		
90-179	27.9%	36.2%		
180-364	38.2%	29.8%		
365 or more	12.7%	12.1%		
Type of discharge				
Completed treatment	41.5%	16.3%	**30.81**	**<0.001**
Left against professional advice	16.0%	21.3%	2.21	0.137
Terminated	12.1%	13.5%	0.19	0.667
Transferred	10.1%	17.7%	**6.30**	**0.012**
Incarcerated	14.2%	27.0%	**13.12**	**<0.001**
Progress at Discharge			**14.98**	**0.002**
Assessment only	1.1%	2.1%		
Minimal achievement	35.1%	51.8%		
Moderate achievement	36.2%	27.7%		
High achievement	27.8%	18.4%		
Dollars paid ($100 or more)	48.7%	34.8	**8.79**	**0.003**
Dollar cost ($150 or more)	45.2%	53.2	2.86	0.091

* Recidivism is defined as committing a new offense (the variable stat_trt_sdesc from the DOC_RECID file equal to “NEW CT COM” or “NC/PAR RET”) within the first year after the Signal last service date.

Table 7 – Logistic Regression on One Year Recidivism – New Offenses

	O.R.	Prob	95% C.I.	
Age 30 or more	**0.58**	**0.012**	**0.38**	**0.89**
H.S. Education or more	**0.64**	**0.038**	**0.42**	**0.98**
Employment	1.00	0.983	0.74	1.35
Income	0.81	0.097	0.63	1.04
Prior treatments	0.93	0.468	0.77	1.13
DUI arrests	**1.85**	**0.024**	**1.08**	**3.14**
Other arrests	1.46	0.080	0.96	2.23
Completed treatment	**0.37**	**0.003**	**0.19**	**0.72**
Transferred	1.28	0.417	0.71	2.32
Incarcerated	**1.71**	**0.041**	**1.02**	**2.87**
Progress at discharge	1.02	0.924	0.74	1.39
Dollars paid (> $100)	0.80	0.323	0.51	1.25
Dollar cost (> $150)	1.17	0.492	0.75	1.80

Table 8 -Stepwise Logistic Regression on One Year Recidivism – New Offenses

	O.R.	Prob	95% C.I.	
Age 30 or more	**0.541**	**0.003**	**0.363**	**0.809**
H.S. Education or more	**0.653**	**0.044**	**0.431**	**0.988**
Income	**0.787**	**0.010**	**0.656**	**0.945**
DUI arrests	**2.074**	**0.004**	**1.257**	**3.423**
Completed treatment	**0.299**	**<0.001**	**0.183**	**0.488**

References

Ball JC, Lange WR, Myers CP, Friedman SR. Reducing the risk of AIDS through methadone maintenance treatment. *J Health Soc Beh* 1988;29:214-226.

Booth RE, Crowley TJ, Zhang Y. Substance abuse treatment entry, retention, and effectiveness: out-of-treatment opiate injection drug users. *Drug Alc Dep* 1996; 42:11-20.

Comacho LM, Bartholomew GW, Simpson DD. Maintenance of HIV risk reduction among injection opioid users: a 12 month post treatment follow-up. *Drug Alc Dep* 1997;47:11-18.

DeLeon G, Andrews MPA, Wexler HK, Jaffee J, Rosenthal MS. Therapeutic community dropouts: criminal behavior five years after treatment. *Am J Drug Alcohol Treatment* 1979;6:253-271.

Hubbard RL, Marsden ME, Cavanaugh E, Rachal JV, Ginzberg HM. Role of drug abuse treatment in limiting the spread of AIDS. *Rev Infect Dis* 1988;10:377-384.

McLellan AT, Luborsky L, O'Brien CP. Alcohol and drug abuse treatment in three different populations: is there improvement and is it predictable? *Am J Drug Alcohol Abuse* 1986;12:101-120.

McLellan AT, Luborsky L, O'Brien CP, Woody GE, Druley KA. Is treatment for substance abuse effective? *JAMA* 1982;247:1423-1428.

McLellan AT, Woody GE, Metzger D, et al. Evaluating the effectiveness of addiction treatments: reasonable expectations, appropriate comparisons. *Milbank Quarterly* 1996;74:51-83.

Metzger DS, Woody GE, McLellan AT, et al. Human immunodeficiency virus seroconversion among intravenous drug users in- and out-of-treatment: an 18-month prospective follow-up. *JAIDS* 1993;6:1049-1056.

Milby JB Schumacher JE, Raczynski JM, Caldwell E, Engle M, Michael M, Carr J. Sufficient conditions for effective treatment of substance abusing homeless persons. *Drug Alcohol Dep* 1996;43:39-47.

Moss AR, Vranizan K, Gorter R, Bacchetti P, Watters J, Osmond D. HIV seroconversion in intravenous drug users in San Francisco, 1985-1990. *AIDS* 1994;8:223-231.

Simpson, D.D. The relation of time spent in drug abuse treatment to post-treatment outcome. *Am. J. Psychiatry* 1979;136, 1449-1453.

Simpson DD. Treatment for drug abuse: follow-up outcomes and length of time spent. *Arch Gen Psychiatry* 1981;38:875-880.

Stimmel B, Goldberg J, Cohen M, Rotkopf E. Detoxification from methadone maintenance: risk factors associated with relapse to narcotic use. *Ann NY Acad Sci* 1978;311:173-180.

Watkins KE, Metzger D, Woody G, McLellan AT. High-risk sexual behaviors of intravenous drug users in- and out-of-treatment: implications for the spread of HIV infection. *Am J Drug Alcohol Abuse* 1992;18:389-398.

Woods WJ, Guydish J, Abramowitz A, Clark W, Hearst N, Kiefer R. Treatment helps reduce needle sharing in San Francisco. Presented at the *VII International Conference on AIDS* Milan, Italy, Abstract MC 3007; June 1991.

Woody GE, Metzger DS, McLellan AT, et al. Two year incidence rates for HIV and HTLV-I/II among IDUs in- and out-of-treatment. Presented at the *54th Annual Meeting of the College on Problems of Drug Dependence* Keystone, Colorado, June 1992.

Yancovitz S, Des Jarlais DC, Peyser N, et al. A randomized trial of an interim methadone clinic. *Am J Public Health* 1991;81:1185-1191.