CSA CONFERENCE 2017

Roanoke, Virginia

"DJJ Continuum and Service Coordination Model"

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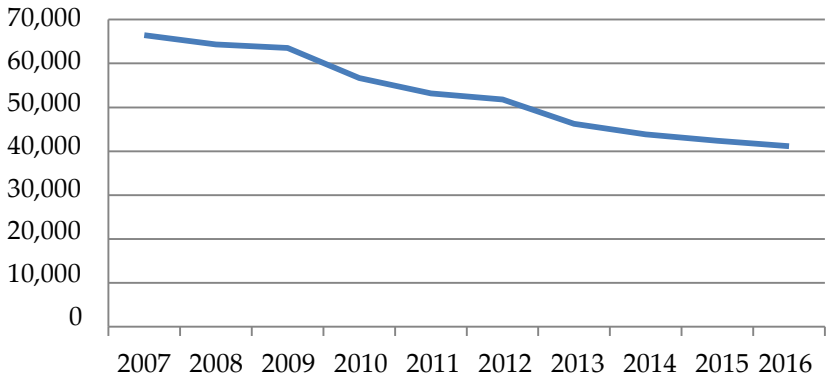
April 20, 2017

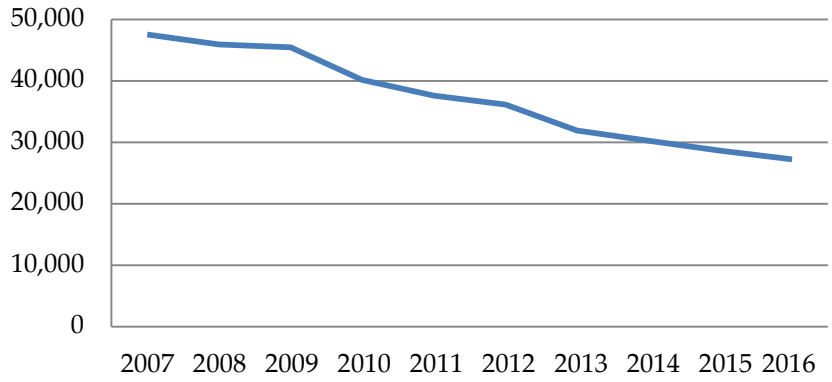
Virginia Department of Juvenile Justice

Juvenile Population Trends, FY 2007-2016

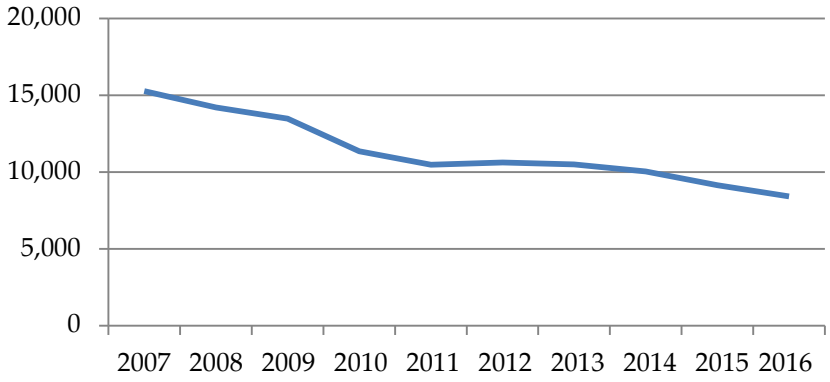
Intake Cases (↓ 38%)



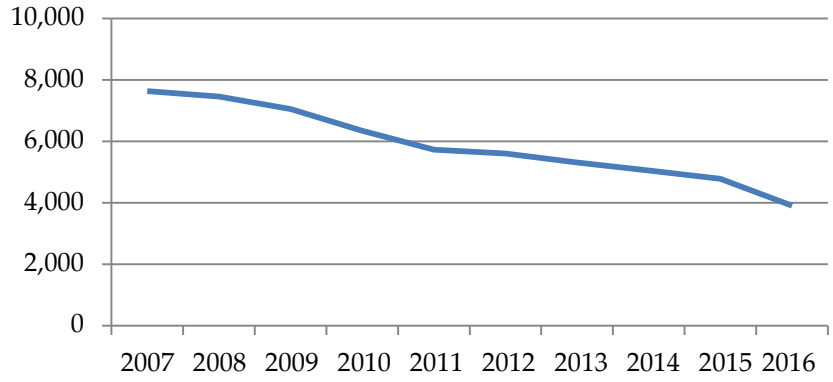
Detention-Eligible Intake Cases (↓ 43%)



Detainments (↓ 45%)

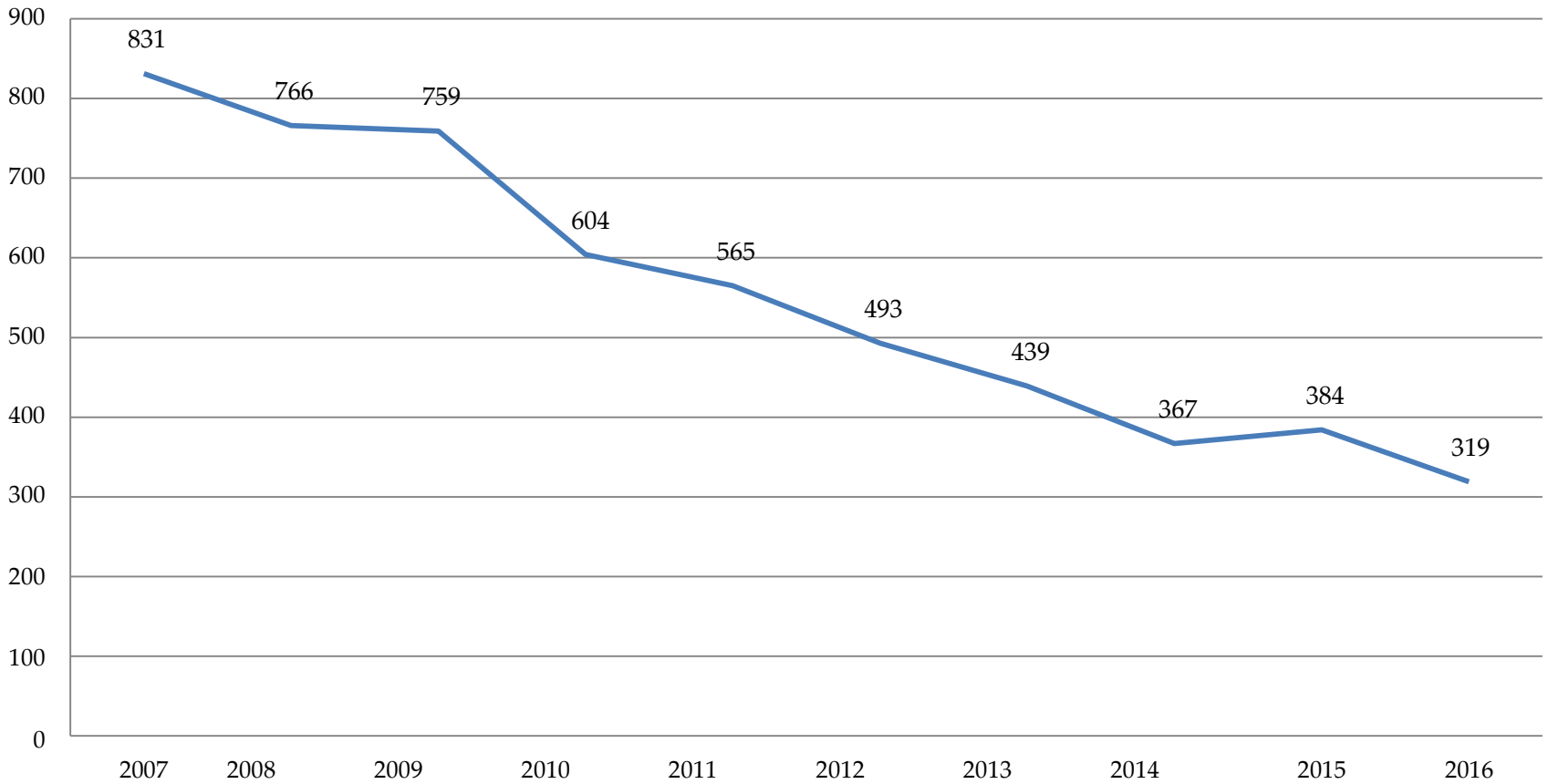


Active Probation ADP (↓ 49%)



* Data generated on July 20, 2016. ADP = Average Daily Population.

Direct Care Admissions, FY 2007-2016



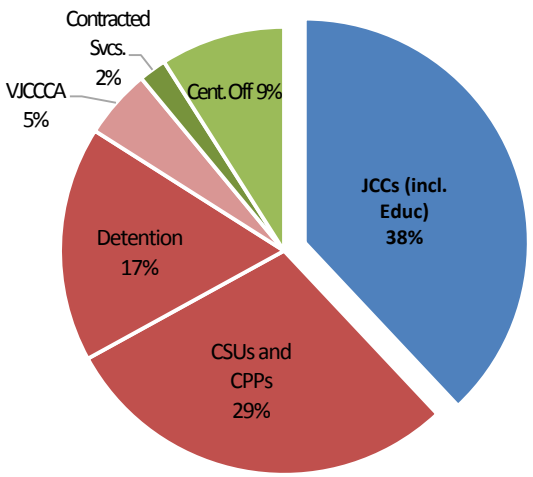
- Direct care admissions decreased 62% (512 juveniles) since FY 2007.

* Data generated on July 20, 2016.

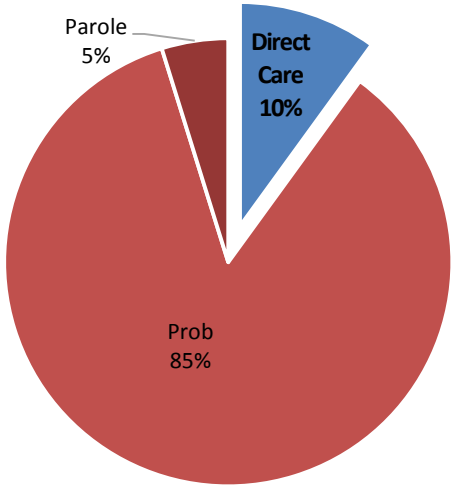
Negative Return on Investment

38% of our General Fund Budget was used to confine less than 10% of the youth we serve, of whom 75% were rearrested within 3 years of release from commitment.

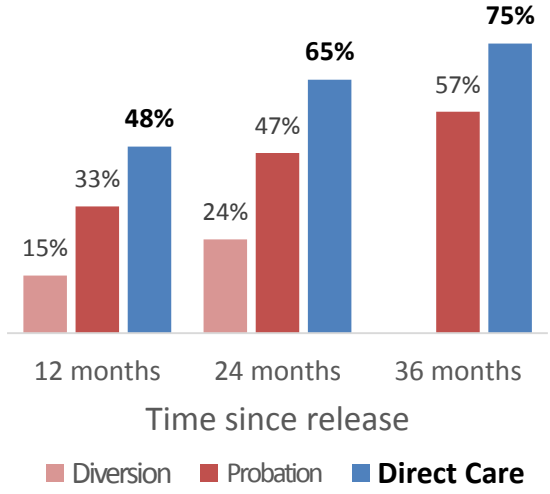
DJJ Budget



DJJ Population



Recidivism



DJJ Releases Reincarcerated with DOC

- Of the 6,365 unique juveniles released from DJJ between FYs 2005 and 2014, 23.7% were reincarcerated in a DOC facility on December 31, 2015.*

DJJ Release Cohort	Unique DJJ Releases	Number Reincarcerated with DOC	Percentage Reincarcerated with DOC
FY 2005	793	188	23.7%
FY 2006	766	182	23.8%
FY 2007	734	197	26.8%
FY 2008	755	173	22.9%
FY 2009	716	180	25.1%
FY 2010	580	149	25.7%
FY 2011	528	131	24.8%
FY 2012	526	140	26.6%
FY 2013	482	105	21.8%
FY 2014	485	61	12.6%
Total	*6,365*	*1,506*	*23.7%*

- More than **$150,000,000** spent to rehabilitate the reincarcerated youth.
- Annual costs to taxpayers of more than **$42,000,000** for reincarcerated youth.

- Data are a snapshot of the DOC population on December 31, 2015 and do not count those persons reincarcerated with DOC and released prior to that date.
- Reincarceration rates for persons in more recent release cohorts (e.g., FY 2013 and FY 2014) may be lower due to them having less follow-up time than persons released in earlier cohorts.
- Persons released from DJJ in multiple FYs were only counted in the most recent FY.

Negative Outcomes

- High recidivism (36-month re-arrest rates of direct care releases = 78%)
- Racial disproportionality
- 1,500 juveniles (approx. 23%) released from direct care in last 10 years were serving a Department of Corrections (DOC) sentence as of December 31, 2015.

1,500 = > $150,000,000 in juvenile rehabilitation

1,500 = $42,000,000 in DOC annual expense*

* 36-month recidivism sample from FY 2010
* Virginia DOC Management Information Summary Annual Report, 2015, p.14

Consequences of Budget Cuts

FY 2005

Culpeper Max Security Closed 2014	Bon Air Max Security	Beaumont Max Security
Hanover Mid Security Repurposed 2013	Reception & Diagnostic Center Closed 2015	Barrett Mid Security Closed 2005
Oak Ridge Special Placement Consolidated 2013	Transition Living Program Closed 2010	Natural Bridge Min Security Closed 2009
Hampton Place Halfway House Closed 2013	Abraxas House Halfway House Closed 2013	Discovery House Halfway House Closed 2010
20 Community Placement Slots	Camp New Hope Special Placement Closed 2009	VA Wilderness Inst. Special Placement Closed 2009

FY 2015

Bon Air Max Security	Beaumont Max Security
Reception & Diagnostic Center Closed 2015	
43+ Community Placement Slots	

FY 2017

Bon Air Max Security	Beaumont Max Security
76+ Community Placement Slots	

Capacity (FY 2005)
1,278 beds
Maximum Security: 662 beds (52% of total)

Capacity (FY 2017)
596+ beds
Maximum Security: 520 beds (87% of total)

DJJ Transformation Plan

Reduce

Use data and evidence to modify Length of Stay (LOS) policy

Uniform, effective, and data-driven probation practices

Develop more alternative placements for committed juveniles

Reform

Convert juvenile correctional center (JCC) units to Community Treatment Model (CTM)

Improve educational and vocational programming

Improve family engagement

Enhance reentry planning and parole services

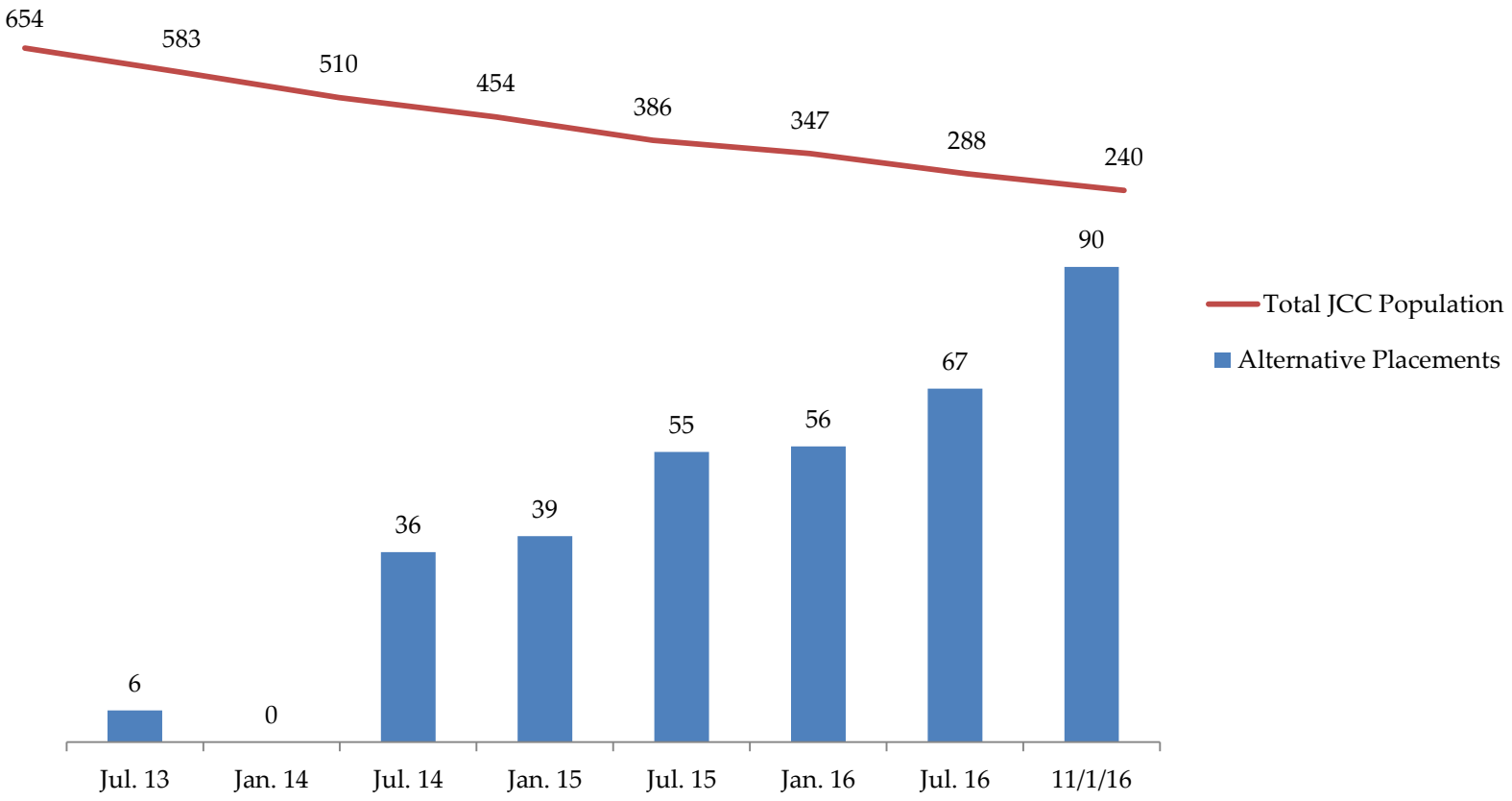
Replace

Expand the array of commitment placement alternatives by reinvesting correctional savings

Develop a statewide continuum of services

Build new facilities that are safer, closer, smaller in scale, and designed for treatment to replace current JCCs

Alternative Placements and JCCs



*Data are not displayed on the same scale.

- The JCC population has decreased 63% since the beginning of FY 2014; the population in alternative placements has increased more than ten-fold.

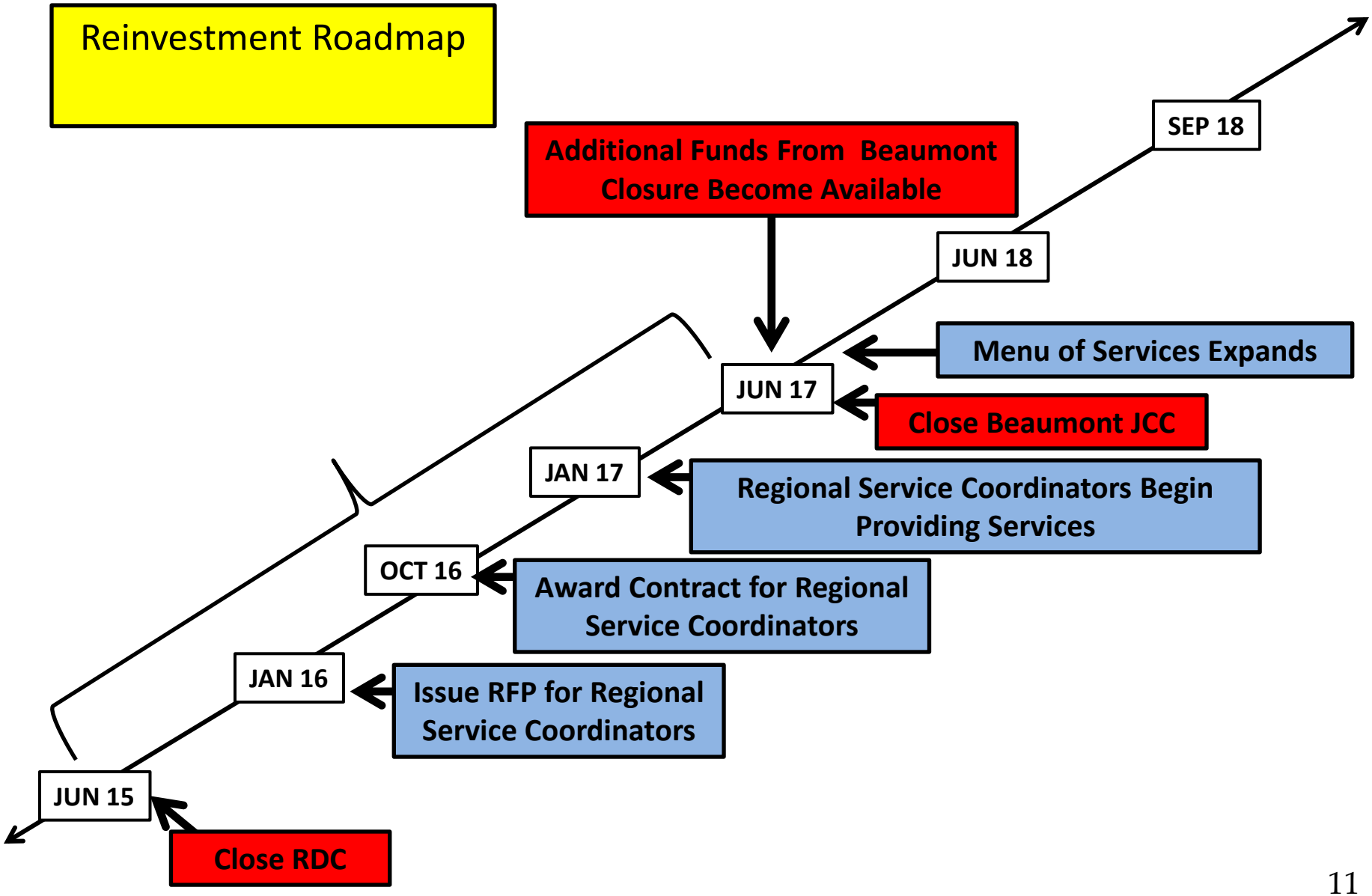
* Counts are monthly ADPs except for the most recent date.

2016 General Assembly DJJ Budget

- New reinvestment authority for savings from JCC downsizing
- Authority to close a Juvenile Correctional Center (Beaumont)
- Funding for new facility in Chesapeake and planning $$ for second

Reinvestment Authority: New Regional Service Contracts

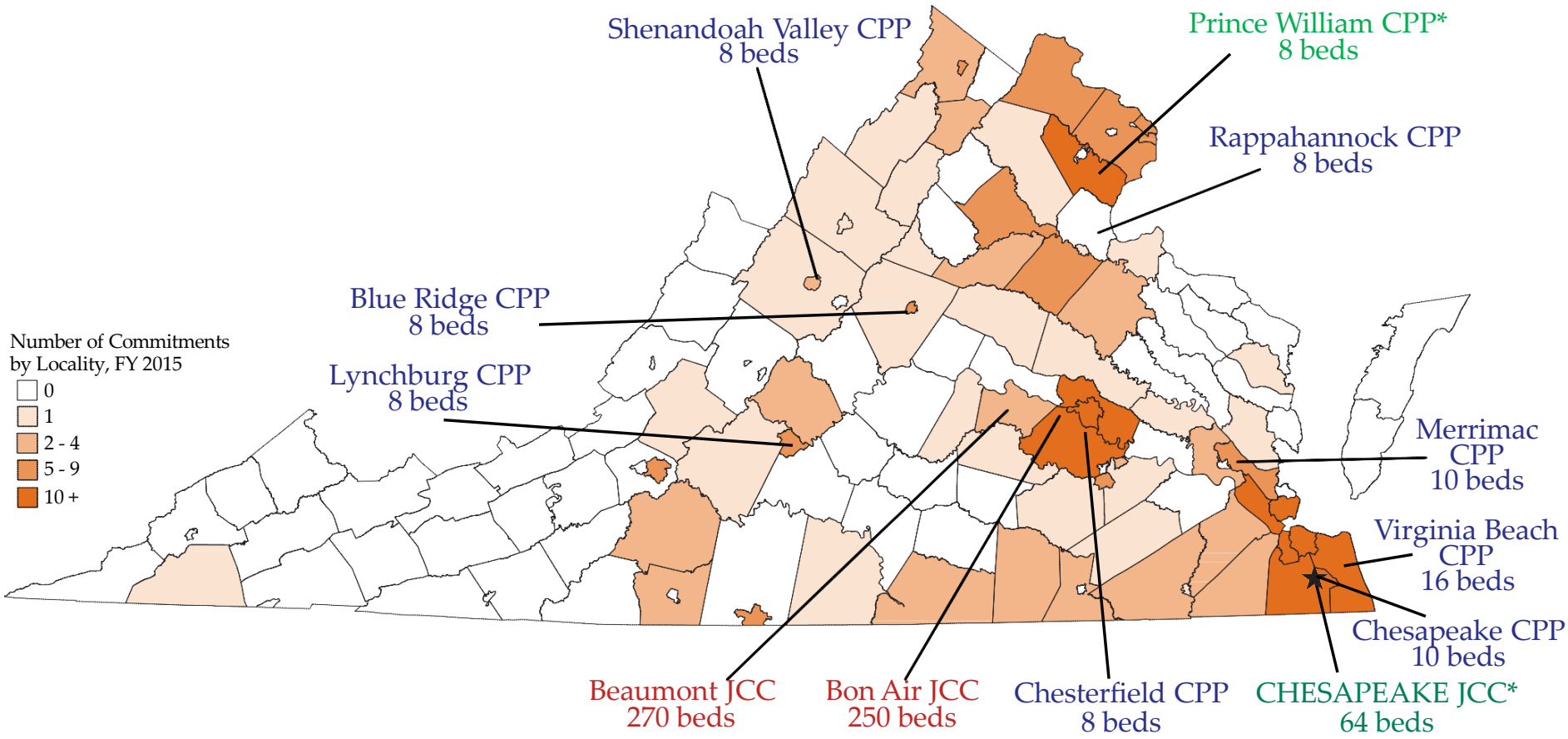
- Primary goal: Build a statewide continuum of services
  - Provide alternatives to placement in JCCs
  - Increase array of services for all regions
  - Provide more evidence-based services
  - Improve accessibility
  - Monitor effectiveness
- Contracts awarded: October 2016
- Service initiation: January 1, 2017
- Initial Award period: Until October 2018


Reinvestment Roadmap
Additional Funds From Beaumont Closure Become Available
SEP 18
JUN 18
Menu of Services Expands
JUN 17
Close Beaumont JCC
JAN 17
Regional Service Coordinators Begin Providing Services
OCT 16
Award Contract for Regional Service Coordinators
JAN 16
Issue RFP for Regional Service Coordinators
JUN 15
Close RDC

New JCC's

- Interagency Taskforce Establishing and Working
  - Submitted Interim Report in August, 2016
  - Final Report Due 6/30/17
- Funds for Chesapeake Planning Received by DJJ
- Procurement Process Underway
- Planning Money Available for 2nd JCC no earlier than July 1, 2017

Current/Future Direct Care Placement Options



* Proposed facility or program

Transformation Progress: Reform

- CTM expansion
- Strengthen educational programming
- Reentry reform
- Family engagement (e.g., visitation, transportation, community-based services)

CTM Unit Transformation

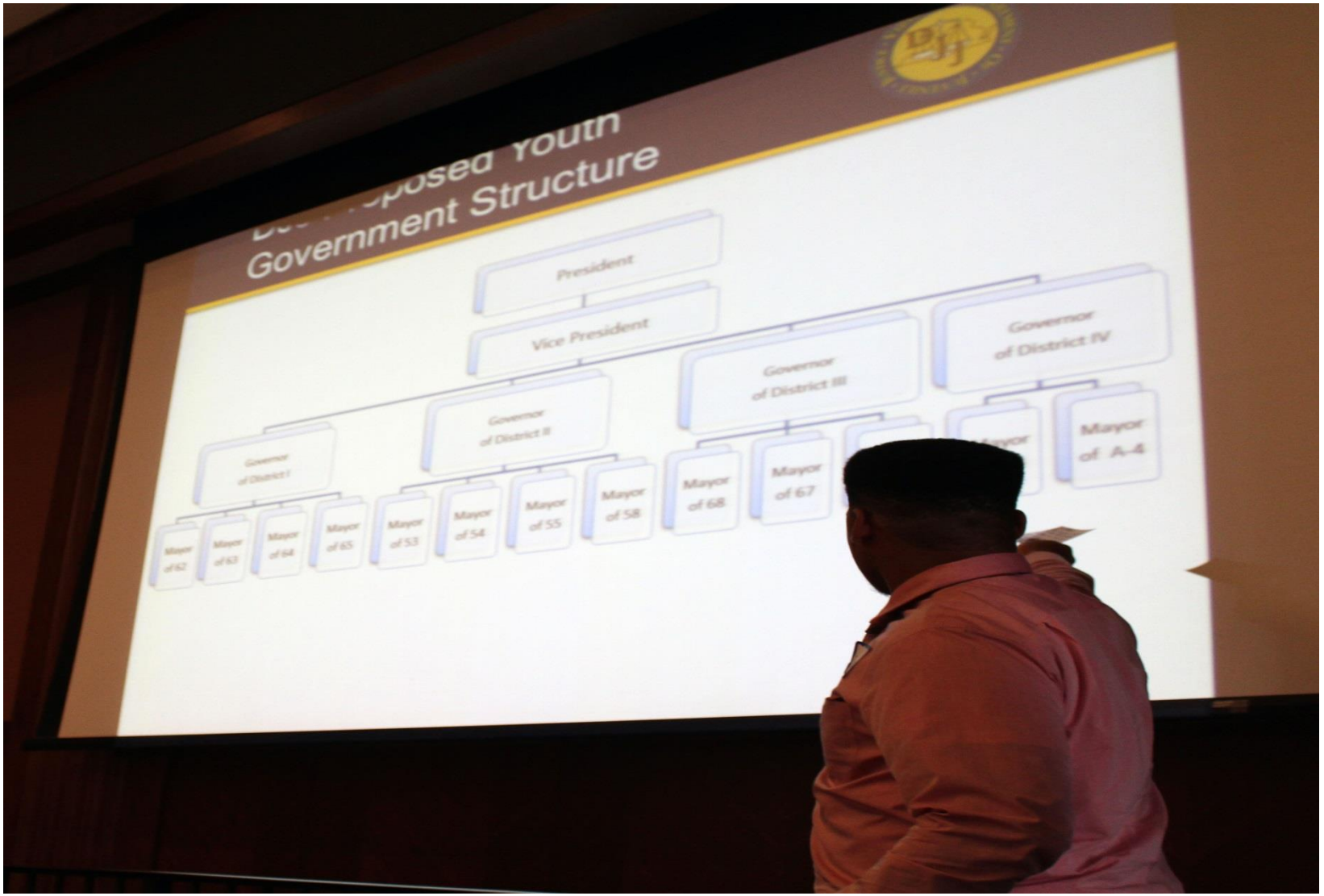
Old Correctional Model

New CTM

Governor's Quilt

JCC Residents with Governor and Staff

JCC Residents with Governor and Staff (*cont'd*)



Visitation Transportation

What's Next?

- Beaumont JCC closure
- Chesapeake JCC design
- Continued expansion of statewide continuum
- Practice improvements in communities and facilities

New Model of Service Coordination

- Regional Service Coordination Model Contract (RFP) DJJ-16-034 www.eva.virginia.gov

  AMIkids (AMI)
  Evidence-Based Associates (EBA)

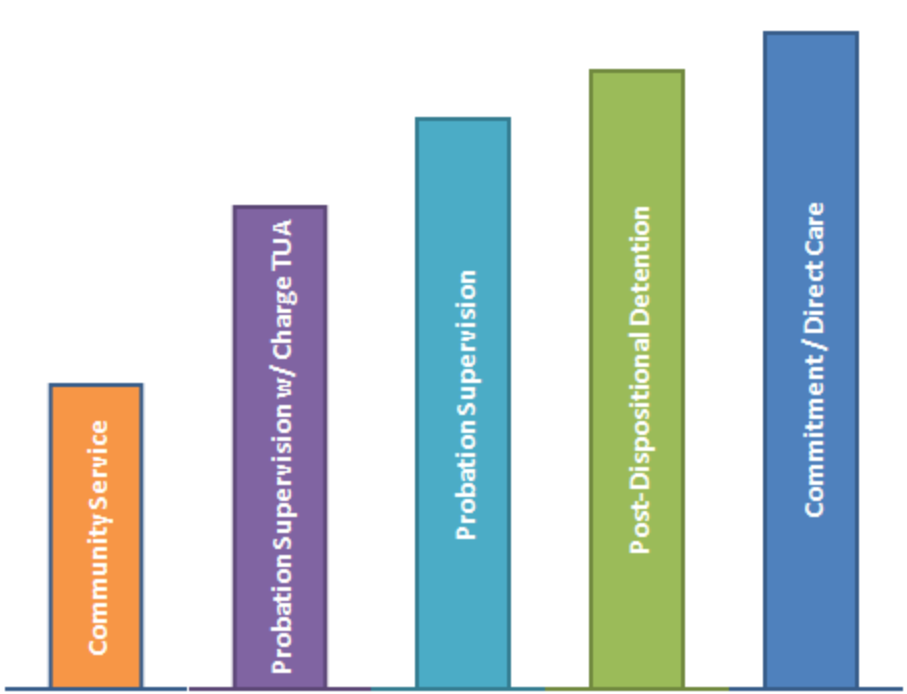
- The initial work under the contracts includes:

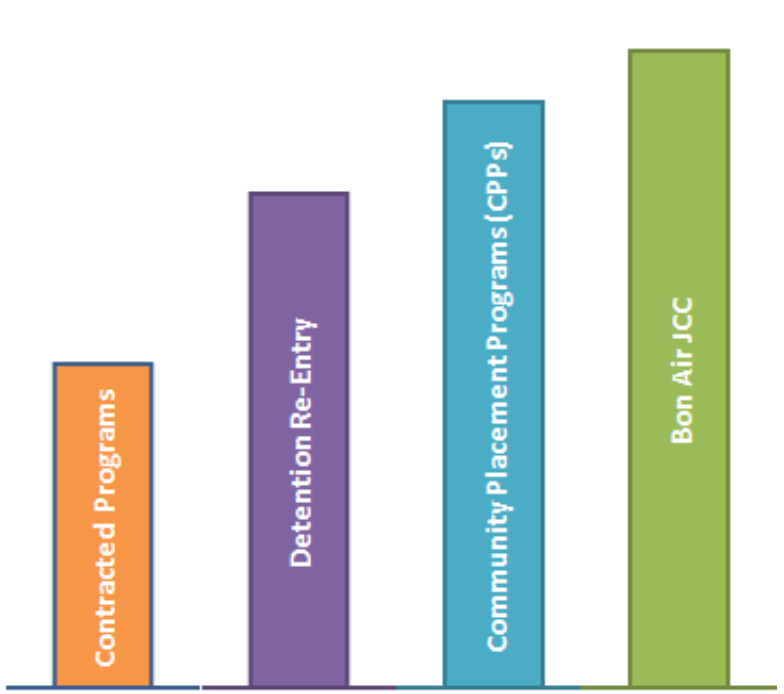
  - Third party management of
    - service coordination / centralized referrals
    - centralized billing
    - centralized reporting
    - performance measurement and quality assurance

  - Development of a statewide continuum of evidence-based services and alternatives to placement in juvenile correctional centers.

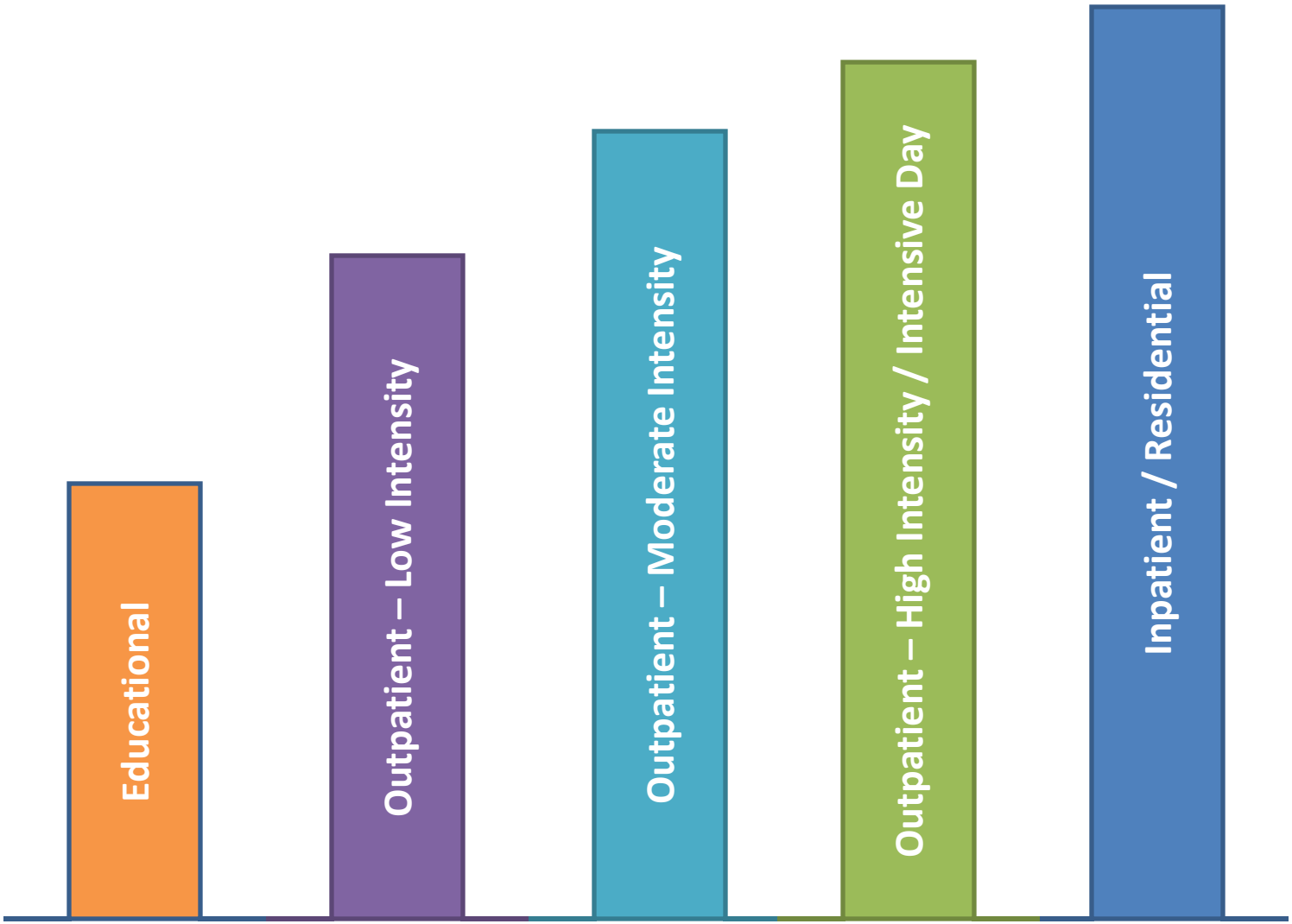
Types of Continuums

- **Intake Options**
- **Legal Responses / Supervision Levels**
- **Direct Care Placement Options**
- **EB Service / Intervention Options**



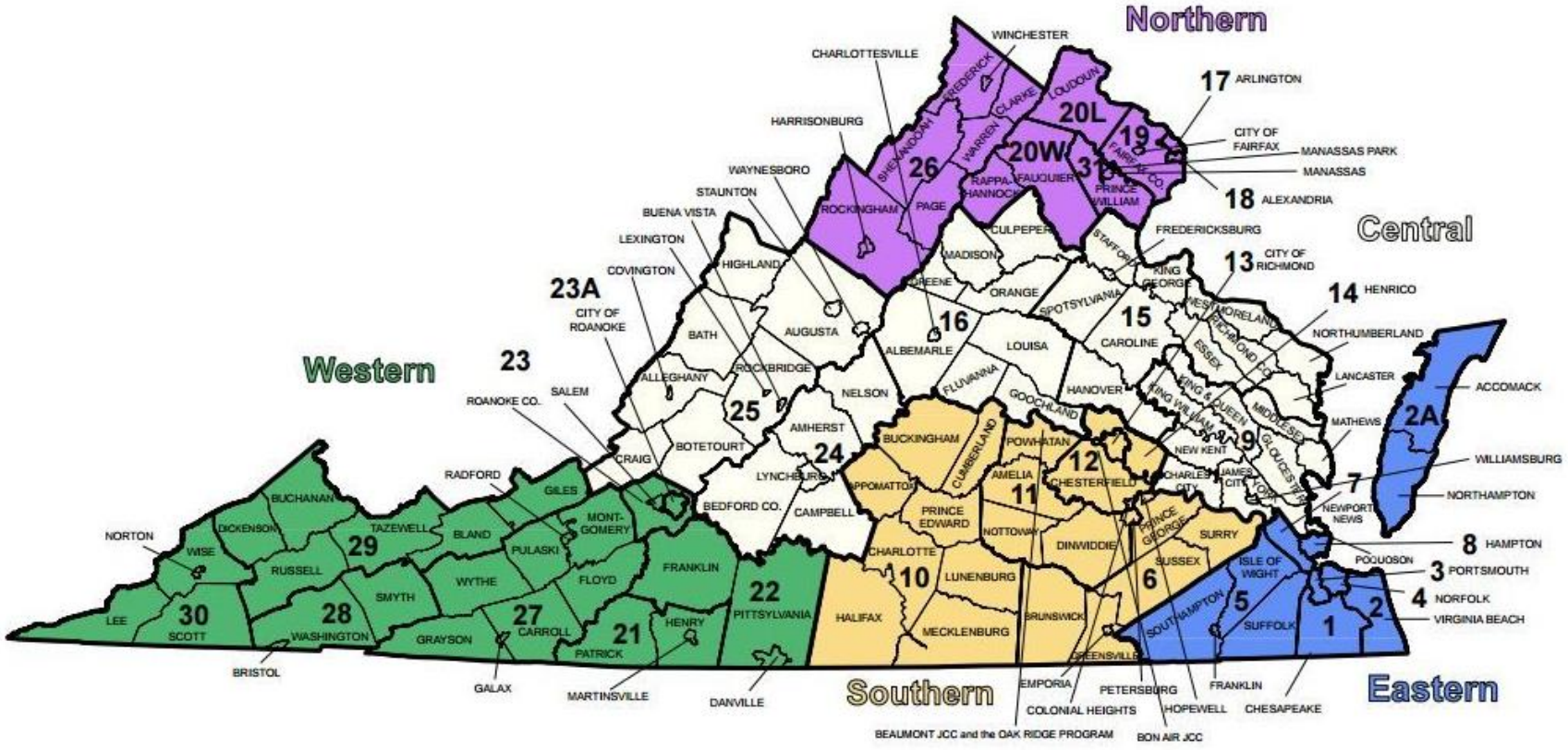


Continuum of Service Options

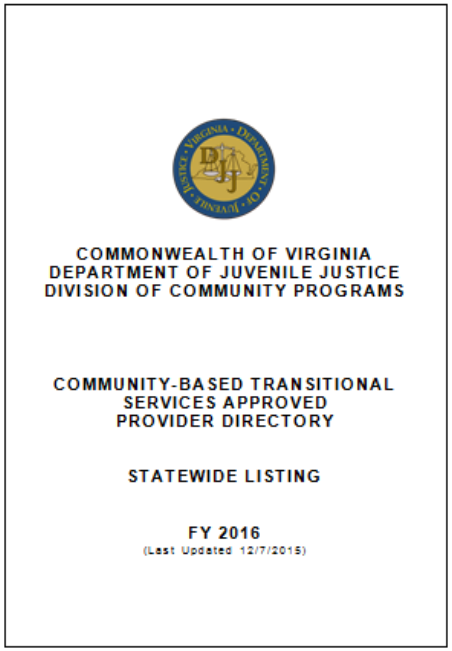


New Service Coordinator Agencies and Service Regions

Western Region – Evidence Based Associates (EBA)
Northern Region - Evidence Based Associates (EBA)
Central Region - Evidence Based Associates (EBA)
Southern Region – AMIkids (AMI)
Eastern Region – AMIkids (AMI)



Traditional Services Available


COMMONWEALTH OF VIRGINIA
DEPARTMENT OF JUVENILE JUSTICE
DIVISION OF COMMUNITY PROGRAMS

COMMUNITY-BASED TRANSITIONAL SERVICES APPROVED PROVIDER DIRECTORY

STATEWIDE LISTING

FY 2016
(Last Updated 12/7/2015)

Clinical / Behavioral Health Services

Assessments, Mental Health Counseling, Substance Abuse Treatment, Sex Offender Treatment

Life Skills Coaching

Surveillance / Monitoring

Independent Living (Residential)

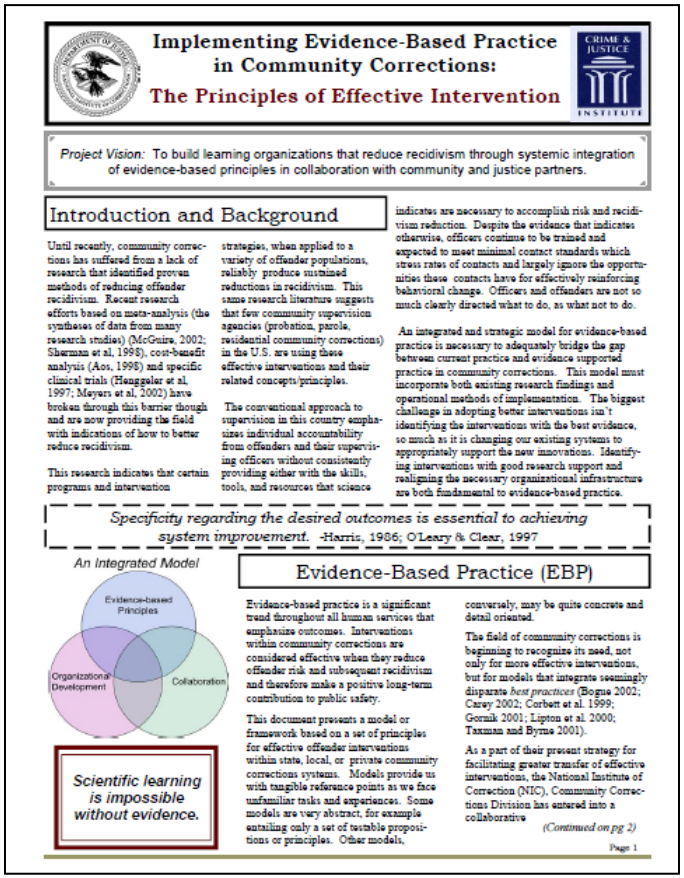
Goals of the New Model

GOALS:

- Efficiency of Processes
- Service Availability
  - Basic Services in Every Region / Fill Service Gaps
  - No "Justice By Geography"
- Introduction of Evidence-Based Models of Family Focused Interventions (e.g. MST® / FFT®)
  - Group based interventions (e.g. ART®)

Goals of the New Model (Cont.)

- Adherence to 8 Evidence-Based Practices and Principles



Implementing Evidence-Based Practice in Community Corrections:
The Principles of Effective Intervention

CRIME & JUSTICE INSTITUTE

Project Vision: To build learning organizations that reduce recidivism through systemic integration of evidence-based principles in collaboration with community and justice partners.

Introduction and Background

Until recently, community corrections has suffered from a lack of research that identified proven methods of reducing offender recidivism. Recent research efforts based on meta-analysis (the syntheses of data from many research studies) (McGuire, 2002; Sherman et al, 1998), cost-benefit analysis (Aos, 1998) and specific clinical trials (Henggeler et al, 1997; Meyers et al, 2002) have broken through this barrier though and are now providing the field with indications of how to better reduce recidivism.

This research indicates that certain programs and intervention strategies, when applied to a variety of offender populations, reliably produce sustained reductions in recidivism. This same research literature suggests that few community supervision agencies (probation, parole, residential community corrections) in the U.S. are using these effective interventions and their related concepts/principles.

The conventional approach to supervision in this country emphasizes individual accountability from offenders and their supervising officers without consistently providing either with the skills, tools, and resources that science indicates are necessary to accomplish risk and recidivism reduction. Despite the evidence that indicates otherwise, officers continue to be trained and expected to meet minimal contact standards which stress rates of contacts and largely ignore the opportunities these contacts have for effectively reinforcing behavioral change. Officers and offenders are not so much clearly directed what to do, as what not to do.

An integrated and strategic model for evidence-based practice is necessary to adequately bridge the gap between current practice and evidence supported practice in community corrections. This model must incorporate both existing research findings and operational methods of implementation. The biggest challenge in adopting better interventions isn't identifying the interventions with the best evidence, so much as it is changing our existing systems to appropriately support the new innovations. Identifying interventions with good research support and realigning the necessary organizational infrastructure are both fundamental to evidence-based practice.

Specificity regarding the desired outcomes is essential to achieving system improvement. -Harris, 1986; O'Leary & Clear, 1997

An Integrated Model

Scientific learning is impossible without evidence.

Evidence-Based Practice (EBP)

Evidence-based practice is a significant trend throughout all human services that emphasize outcomes. Interventions within community corrections are considered effective when they reduce offender risk and subsequent recidivism and therefore make a positive long-term contribution to public safety.

This document presents a model or framework based on a set of principles for effective offender interventions within state, local, or private community corrections systems. Models provide us with tangible reference points as we face unfamiliar tasks and experiences. Some models are very abstract, for example entailing only a set of testable propositions or principles. Other models, conversely, may be quite concrete and detail oriented.

The field of community corrections is beginning to recognize its need, not only for more effective interventions, but for models that integrate seemingly disparate *best practices* (Bogue 2002; Carey 2002; Corbett et al. 1999; Gornik 2001; Lipton et al. 2000; Taxman and Byrne 2001).

As a part of their present strategy for facilitating greater transfer of effective interventions, the National Institute of Correction (NIC), Community Corrections Division has entered into a collaborative

(Continued on pg 2)

Goals of the New Model (Cont.)

GOALS:

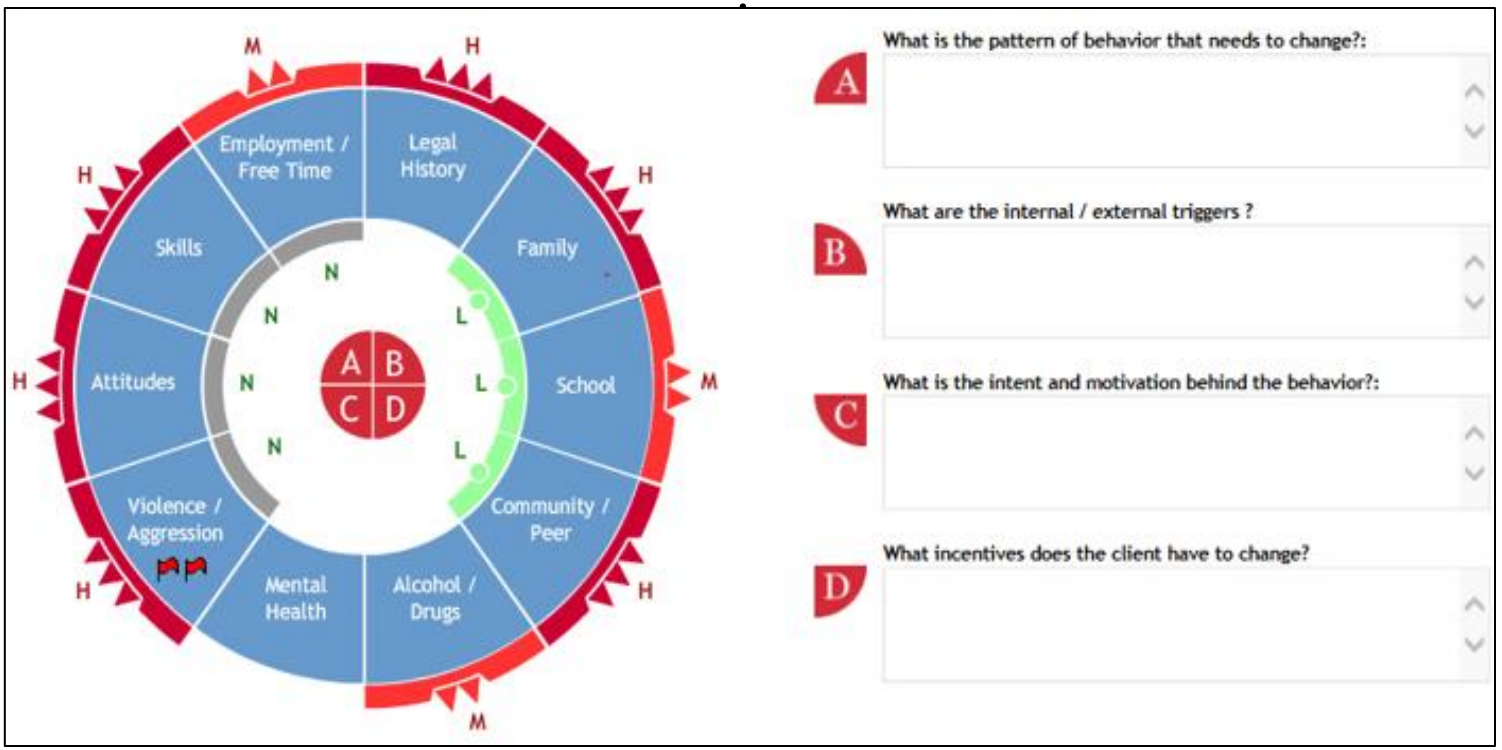
- Family Inclusion and Family Engagement in Treatment
- Reduce Barriers to Treatment Success
  - Language
  - Transportation
- Continuity of Services Across Agencies
- Quality Assurance and Program Fidelity

Services Under New Model

- **Individual Clinical Services**
  - Must provide individual therapy, individual substance abuse treatment, individual substance abuse relapse prevention, individual sex offender treatment, and individual sex offender relapse prevention
- **Family Focused Interventions**
  - Must provide Functional Family Therapy (FFT) and/or Multi-Systemic Therapy (MST);
- **Individual Cognitive Skills Training**
  - Must provide Life Skill Coaching and Gang Intervention Services
- **Group-Based Cognitive Skills Training**
  - Must provide at least one cognitive skills group (Aggression Replacement Training (ART) or Thinking for a Change (T4C) groups
- **Group Based Clinical Services**
  - Must provide substance abuse treatment groups and sex offender treatment groups when there are 6 or more referrals within a 90 day period
- **Assessment and Evaluations**
  - Must provide Psychological Evaluations, Psychosexual Evaluations, Psychiatric Evaluations, Substance Abuse Assessments, Mental Health Assessments, Trauma Assessments, Sex Trafficking Evaluations, Sex Offender Polygraph Evaluations, Sex Offender Plethysmograph Evaluations
- **Monitoring Services**
  - Must provide Surveillance, Electronic Monitoring, and GPS.
- **Residential Services**
  - Must facilitate Mental Health Inpatient Treatment, Inpatient Substance Abuse Treatment, Inpatient Sex Offender Services, Independent Living Beds, Group Home Beds, Treatment Foster Care, and Emergency Respite / Shelter Care Beds; when services do not exist within the region, services should be sought that are within close proximity; must provide reentry services for youth upon release from a residential setting

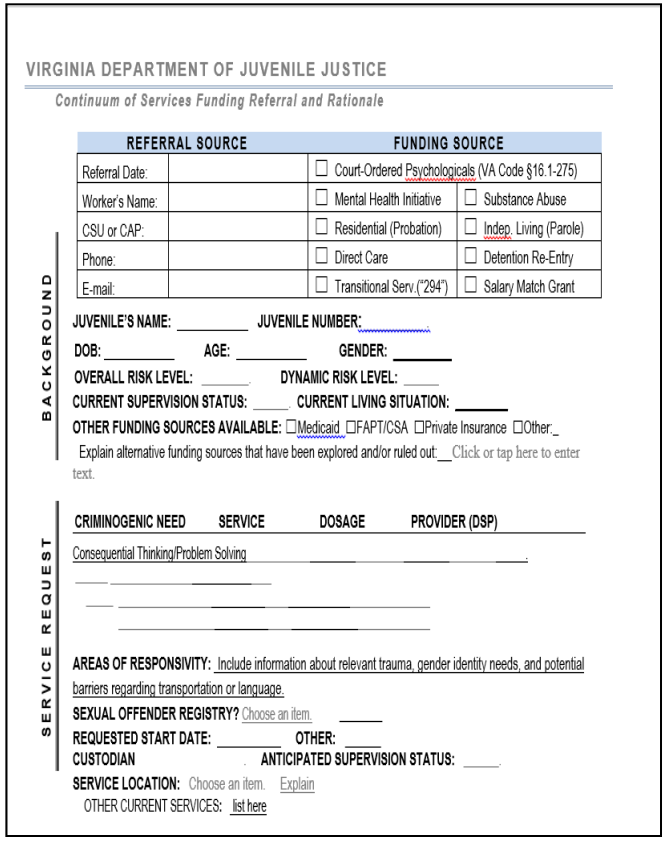
Centralized Referral Process

STEP ONE – Probation/Parole Officer conducts a case staffing with his/her Supervisor and identifies a potential service need for his/her client. We use a risk / needs tool, the Youth Assessment & Screening instrument (YASI) to assess needs.



Centralized Referral Process

STEP TWO – Probation / Parole Officer prepare and forwards a referral packet to the Regional Service Coordinator (RSC).



VIRGINIA DEPARTMENT OF JUVENILE JUSTICE

Continuum of Services Funding Referral and Rationale

REFERRAL SOURCE		FUNDING SOURCE	
Referral Date:		☐ Court-Ordered Psychologicals (VA Code §16.1-275)	
Worker's Name:		☐ Mental Health Initiative	☐ Substance Abuse
CSU or CAP:		☐ Residential (Probation)	☐ Indep. Living (Parole)
Phone:		☐ Direct Care	☐ Detention Re-Entry
E-mail:		☐ Transitional Serv.("294")	☐ Salary Match Grant

BACKGROUND

JUVENILE'S NAME: _____ JUVENILE NUMBER: _____

DOB: _____ AGE: _____ GENDER: _____

OVERALL RISK LEVEL: _____ DYNAMIC RISK LEVEL: _____

CURRENT SUPERVISION STATUS: _____ CURRENT LIVING SITUATION: _____

OTHER FUNDING SOURCES AVAILABLE: ☐Medicaid ☐FAPT/CSA ☐Private Insurance ☐Other:_

Explain alternative funding sources that have been explored and/or ruled out: Click or tap here to enter text.

SERVICE REQUEST

CRIMINOGENIC NEED	SERVICE	DOSAGE	PROVIDER (DSP)
Consequential Thinking/Problem Solving			

AREAS OF RESPONSIVITY: Include information about relevant trauma, gender identity needs, and potential barriers regarding transportation or language.

SEXUAL OFFENDER REGISTRY? Choose an item. _____

REQUESTED START DATE: _____ OTHER: _____

CUSTODIAN ANTICIPATED SUPERVISION STATUS: _____

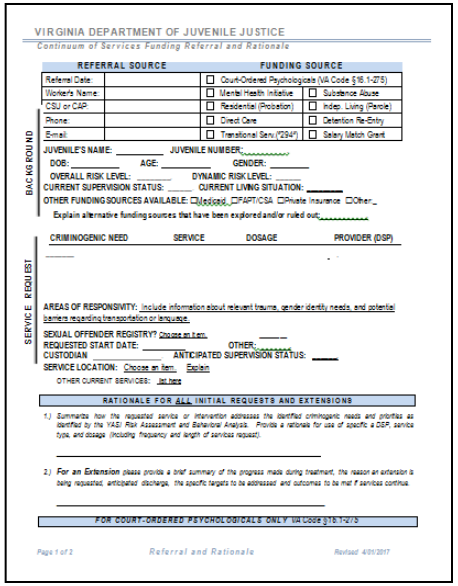
SERVICE LOCATION: Choose an item. Explain

OTHER CURRENT SERVICES: list here

Referral Packet Attachments:

- VADJJ Referral Form / Rationale Form
- Universal Release of Information Form
- BADGE – Generated Face Sheet
- YASI Wheel
- YASI Behavioral Analysis
- Current Social History
- Court Order (when applicable)
- Case Plan

Continuum of Services Referral Form



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Phone:		☐ Direct Care	☐ Detention Re-Entry
E-mail:		☐ Transitional Serv.("294")	☐ Salary Match Grant

BACKGROUND

JUVENILE'S NAME: _____ **JUVENILE NUMBER:**_____

DOB: _____ **AGE:** _____ **GENDER:** _____

OVERALL RISK LEVEL: _____ **DYNAMIC RISK LEVEL:** _____

CURRENT SUPERVISION STATUS: _____ **CURRENT LIVING SITUATION:** _____

OTHER FUNDING SOURCES AVAILABLE: ☐Medicaid ☐FAPT/CSA ☐Private Insurance ☐Other:_

Explain alternative funding sources that have been explored and/or ruled out:_____

SERVICE REQUEST

CRIMINOGENIC NEED	SERVICE	DOSAGE	PROVIDER (DSP)

Choose an item.
Attitudes/Values/Beliefs
Consequential Thinking/Problem Solving
Constructive Leisure Time
Education
Employment/ Vocational
Family
Peer Associations
Self-Control/ Emotional Regulation
Substance Abuse

tion about relevant trauma, gender identity needs, and potential

Example of Drop-Down Box

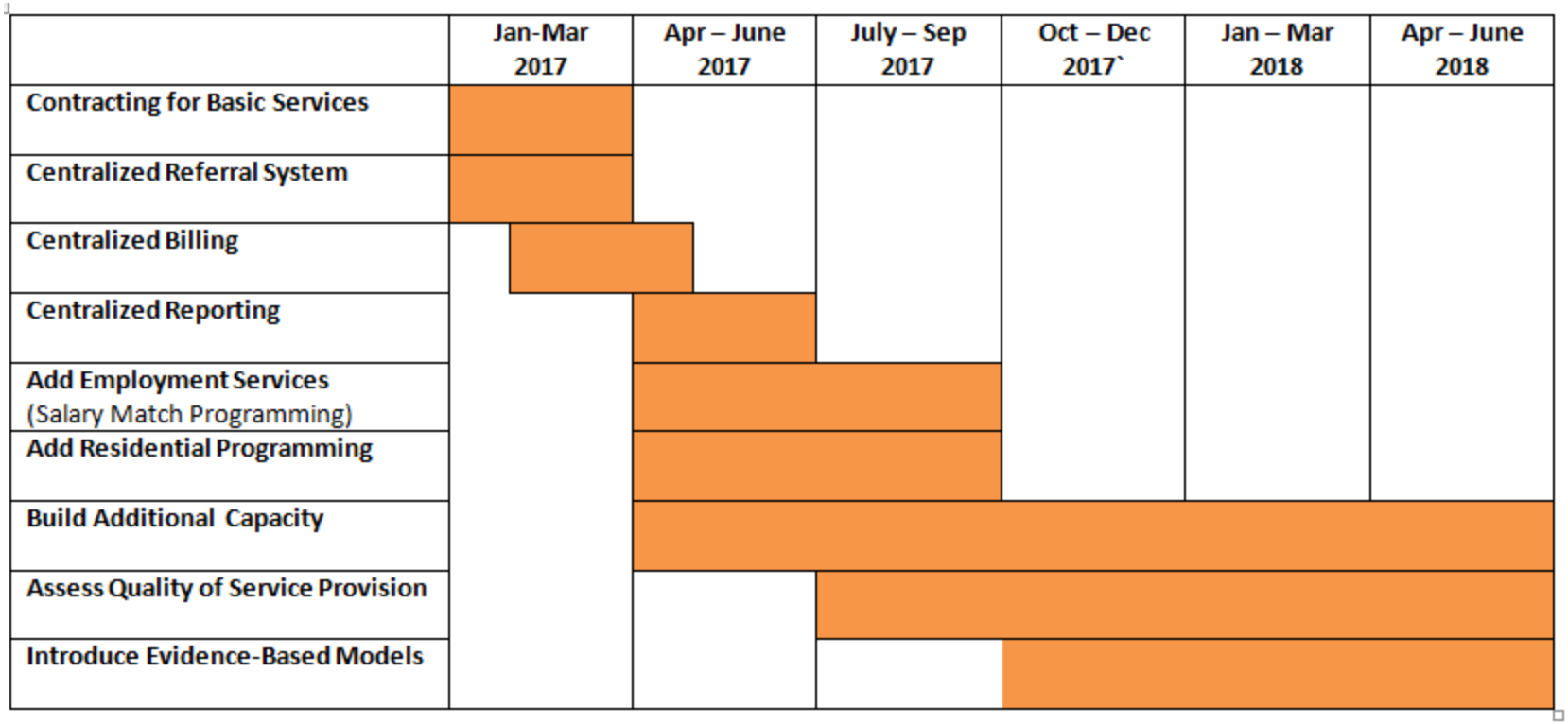
RSCs Role in Referral Process

- RSC acknowledges receipt of referral within 2 business days
- RSC reviews referral packet and follows up w/ CSU (as necessary); CSU responds to request for additional information
- RSC matches the case to the appropriate service(s), provider, and dosage (in consultation with CSU).
- RSC ensures funding availability.
- RSC makes referral to sub-contractor/DSP; DSP will acknowledge receipt of the referral with projected start date. (no eVA generated purchase orders).
- RSC notifies CSU within 5 business days of approved start date.

Centralized Billing Process

- CSUs now receive just one monthly bill (electronically) for services.
- DSPs invoice the RSCs by the 5th calendar day each month
- RSCs invoice the CSUs for all services provided by their sub-contractors (bundled invoices) by the 10th calendar day of the month
- CSUs review the invoices for accuracy and respond back to the RSCs within 3 business days of receipt of the bundled invoice (noting any potential discrepancies)
- RSCs submit verified monthly invoices to DJJ
- DJJ Accounts Payable Unit pays the RSC within 30 days of receipt of date correct invoice is received at CSU
- RSCs pay their subcontracted DSPs within 7 days of receipt of payment from DJJ.

Implementation Timeline



	Jan-Mar 2017	Apr – June 2017	July – Sep 2017	Oct – Dec 2017`	Jan – Mar 2018	Apr – June 2018
Contracting for Basic Services	■					
Centralized Referral System	■					
Centralized Billing	■					
Centralized Reporting		■				
Add Employment Services (Salary Match Programming)		■	■			
Add Residential Programming		■	■			
Build Additional Capacity		■	■	■	■	■
Assess Quality of Service Provision			■	■	■	■
Introduce Evidence-Based Models				■	■	■

Kids First | Integrity | Safety | Honesty | Diversity | Enthusiasm | Leadership

Excellence | Loyalty | Family | Dedication | Creativity | Goal Orientation | Respect

Service Coordinator for Eastern and Southern Regions