State of Delaware Department of Correction

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

Technical and Pricing Proposal

Contract No. DOC-1202Mental

April 27, 2012

Respectfully Submitted to:
State of Delaware
Department of Correction
ATTN: BCHS
245 McKee Road
Dover, DE 19904

Submitted by:
Correct Care Solutions, LLC
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Nashville, TN 37217
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Due: April 27, 2012 – 4:00 PM EST

The package contains one (1) original plus ten (10) exact duplicate hard copies and eleven (11) CD copies of the proposal.

Cover Letter

April 26, 2012

Bureau of Correctional Healthcare Services
Delaware Department of Correction
245 McKee Rd.
Dover, DE 19904

Mr. Welch, Ms. Fabber, Ms. Blowey, Ms. Windle, Ms. Piccolo and members of the Evaluation Committee:

Correct Care Solutions (CCS) is pleased to submit this proposal to provide comprehensive mental health services, substance abuse treatment, DUI programming, and sex offender treatment for the State of Delaware Department of Correction (DDOC) in response to RFP #DOC-1202Mental.

CCS is the current medical services provider for the DDOC and we greatly value the partnership that CCS and the DDOC have built to provide medical services. Our goal is to develop the same long-term partnership for the delivery of mental health services.

CCS is extremely proud of its medical accomplishments in Delaware and of the business relationship CCS has developed with the DDOC. The CCS mental health team will work equally hard to meet and to exceed all DDOC expectations regarding this contract. Our goal will be to introduce changes that produce significant improvements in mental health care similar to the medical improvements we have made. The CCS medical accomplishments in Delaware have included:

- Achieving and maintaining NCCHC accreditation at all sites
- A significant decrease in inpatient length of stay from 4.7 days to 3.8 days per admission
- A 30% decrease in medical grievances at the Howard R. Young facility
- Implementation of an electronic medication administration record and physician order entry system

CCS has worked very hard to deliver a proposal that meets or exceeds the RFP requirements. We have thoroughly reviewed the RFP as well as the individual Q&A responses. We have researched the current level of services being provided to understand where changes need to be made and to maintain service levels where they have been adequate. We have had conversations with local service providers and with our on-site medical staff to ensure continuity of care is considered and included in each program being offered. We have interviewed several potential sub-contractors that specialize in substance abuse and/or sex offender treatment to enhance the overall level of service and expertise included in our proposal.

As a result of these efforts, CCS is proud to provide a proposal to the DDOC that includes a "Dream Team" of providers. We are convinced this team will deliver exceptional service and value to the DDOC.

CCS will manage all of the base mental health services as defined in the RFP. This includes providing regional and on-site clinical and administrative staff to coordinate all DDOC on-site mental health clinical operations.

Correct Care Solutions (CCS) has been providing mental health services for state inmates since 2003 when the company initiated its contract with the State of Kansas Department of Corrections (KDOC). CCS currently provides inmate mental health services in seventeen states to over 42,000 patients.

The KDOC contract continues today with CCS providing mental health services for 9,000 inmates across the state located in 10 institutions system-wide. Approximately 650 of these KDOC inmates are currently being actively treated by CCS for severe and persistent mental illness.

CCS is also responsible for the medical and mental health care of approximately 1,500 offenders within the Vermont DOC (VDOC). CCS treats approximately 784 mental health patients, including 117 severely functionally impaired patients, within the VDOC. This contract was transitioned from the current DDOC mental health services provider.

After interviewing several companies, CCS is proud to have selected two specialty subcontractors to manage their specific areas of expertise. These two companies have agreed to work exclusively with CCS on this project and CCS has agreed to the same because we firmly believe this is a "Dream Team" of providers for the DDOC.

CCS has selected Community Education Centers, Inc. (CEC) to manage the Substance Abuse Treatment and DUI Programming requirements of the RFP. CEC has been providing correctional treatment for over 17 years to criminal justice populations through collaborative partnerships with federal, state and local agencies. Since its founding in 1996, CEC has worked closely with contracting entities to meet the rehabilitative needs of drug-involved offenders.

Headquartered in West Caldwell, New Jersey, CEC operates in 18 states, employing more than 3,500 individuals and serving more than 210,000 offenders. CEC is the largest provider of reentry and in-prison treatment services in the United States.

CEC successfully manages substance abuse treatment and offender intervention programs within a wide range of state-operated institutions, including maximum, medium and minimum security, administrative segregation, community corrections, work release, day reporting and intake/assessment units. CEC presently operates in-prison and community-based reentry services for drug-involved offenders comparable to Delaware's in-prison programs in Texas, Illinois, Virginia, New Jersey, South Carolina, Florida, Oregon, Colorado, Wyoming, New Mexico, South Dakota, and California.

CCS has also selected The Counseling & Psychotherapy Center, Inc. (CPC) to manage the Sex Offender Treatment requirements of the RFP. CPC is an agency comprised of clinicians and criminal justice professionals who operate specialized sex offender management and treatment programs in many locations throughout the United States. The CPC headquarters is located in Needham, MA.

The CPC mission is to bring professional sex offender treatment and management to any community with a commitment to risk reduction from identified sex offenders through an outreach model of program development. CPC makes an effort to work with each offender to identify the triggers for their behavior and to guide them to develop a relapse prevention plan to prevent further victimization. The targeted CPC programs reduce the risk for any offender who is in or who will be re-entering the community. This includes offenders in denial whose risk can also be reduced even while they do not take full responsibility for their actions.

CCS will utilize its experience to design and implement a complete mental health services program designed to accomplish each of the specific objectives required by the DDOC. These objectives will include:

1. **An emphasis on proactive and consistent patient care across all DDOC facilities.** This includes having defined accountability for all CCS responsibilities along with improved CQI and risk management programming.

2. **An improved level of communication.** CCS is committed to having this occur across all facilities, between the CCS mental health and medical teams, between the CCS mental health team and the appropriate DDOC representatives, as well as managing appropriate communication with patients and with other concerned parties in the community to best prepare for community reintegration.

3. **Developing, implementing, and documenting specific mental health training programs.** Training programs will be developed by CCS and approved by the DDOC for custody staff members and for CCS mental health and medical services staff members as appropriate.

The CCS mental health services program for the DDOC will include policies, procedures, and protocols to provide consistency of care for each patient across all facilities. CCS will manage the DDOC patients as a shared pool of patients and will expect our facilities and our employees to communicate regularly to improve patient care. Our program will include structured conference calls to discuss and improve established policies. We will clearly define what is required to trigger a cross-team communication event and we will hold our team accountable for ensuring this happens whenever necessary.

The entire CCS team will be tasked with building a collegial sense of expertise for all patient cases, regardless where they occur within the system. Our team will regularly convene to discuss common issues and problems with the goal of developing joint solutions that can be utilized across the state. Our program will be designed to ensure that no CCS site will ever feel

unsupported or feel that it is operating in a vacuum. The entire CCS team will communicate and work cooperatively to provide the best possible proactive care for these patients.

CCS understands the importance of proactive treatment planning and has learned that the delivery of proactive patient care in the prison setting produces several long-term benefits, including:

- Fostering patient trust. CCS patients will feel important and heard. The entire CCS team will provide care with the respect and understanding that these patients deserve. This includes knowledge of each patient's specific situation and needs, including communication with previous care providers as necessary to ensure patient specific treatment programs continue to provide the best possible care while fostering patient trust.
- Reducing patient emergencies. Proactive patient treatment planning and care will reduce emergencies that typically result from the provision of reactive patient care. CCS will not wait for an emergency to occur. Instead, we will actively manage each patient to ensure their needs are understood and met.
- Identifying relevant trends. CCS will understand our patients and we will implement DDOC QAM audits to evaluate the program and help us anticipate issues before they occur.
- Improving the level of services being offered. CCS will work closely with the DDOC to develop site specific improvements where possible. For example, in Kansas, CCS has adapted several structured treatment programs from a group format to a cell-side format for those patients in the long-term segregation unit. This allows these patients to continue to receive the benefits of being involved in a treatment group even though they are in a long-term segregation unit.

Thank you for allowing CCS to present this proposal for comprehensive mental health services. I will personally assure you that CCS is committed to delivering all necessary resources to make this program a long-term success.

I look forward to expanding our partnership with the DDOC and I am confident the proposal we have developed will provide the excellent level of service the DDOC expects.

Sincerely,

Jerry Boyle

Gerard (Jerry) Boyle
President & CEO
615-324-5710 (direct)

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1 CCS Corporate Experience

In August 2003, Correct Care Solutions (CCS) was created in response to the industry need for a correctional healthcare provider with an innovative approach. Today, CCS is a privately owned, limited liability corporation in our ninth year of operation, and is specifically organized to provide comprehensive correctional healthcare services to systems such as the DDOC. With each of our successful contracts and satisfied clients, CCS has demonstrated the necessary capabilities and resources that make us a qualified and willing partner for the DDOC. We are proud of the fact that no CCS client has discontinued a contract for any reason. We remain dedicated to continuously improving our programs, and we will use this experience to design solutions-oriented programs for the DDOC Mental Health Services, Substance Abuse Treatment, DUI Programming, and Sex Offender Treatment Contract.

CCS at a Glance

- *Established in August 2003.*
- *Offices in Nashville, TN, Topeka, KS, Waterbury, VT, and Dover, DE.*
- *Privately owned. We answer to clients, not shareholders.*
- *Over 3,000 CCS employees provide healthcare services for over 64,000 patients in 20 states.*
- *Over 750,000 inmates pass through CCS facilities each year.*
- *Clients include state prison systems, county/regional jails, detention facilities and juvenile centers.*
- *Annual sales: $250 million.*
- *Annualized payroll and contractor's fees: $146,465,806*
- *Financially strong and stable.*
- *Impeccable litigation record.*
- *100% successful in our accreditation efforts.*

Correct Care Solutions (CCS) has been providing medical services to the DDOC since 2010 and mental health services for state inmates since 2003 when the company initiated its contract with the State of Kansas Department of Corrections (KDOC). CCS currently provides offender mental health services in seventeen states to over 42,000 patients.

The Kansas DOC contract continues today with CCS providing mental health services for 9,000 inmates across the state located in 10 institutions system-wide. Approximately 650 of these Kansas Department of Corrections offenders are currently being actively treated by CCS for severe and persistent mental illness.

CCS also provides medical and mental health care for the 1,600 offenders within the Vermont DOC. CCS treats approximately 784 mental health patients, including 117 severely functionally impaired patients, within the Vermont DOC. This contract was transitioned from the current Delaware Department of Correction (DDOC) mental health services provider.

Our 3,000 dedicated professional team members care for 64,000 patients in 20 states each day. Two of our clients are State Department of Corrections with mental health programs similar in scope and complexity to the one in Delaware. We also provide mental health services to many county and municipal jails, including large jails in Davidson County, TN, Shelby County, TN, Mecklenburg County, NC, and Norfolk, VA. Our programs in these facilities include the design and successful operation of comprehensive medical, dental, and mental health services for offenders.

The following map shows all of the States where CCS currently provides services. We're excited about the opportunity to expand the services we provide to the DDOC.

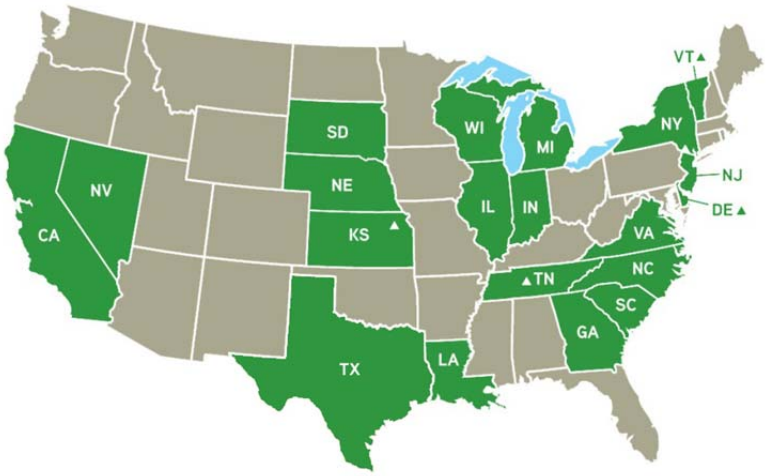


Figure 1: CCS Map. *This map illustrates all of the 20 States where CCS provides Correctional Health Care Services.*

Home Office
1283 Murfreesboro Road, Suite 500
Nashville, TN 37217

Northeast Regional Office
87 South Main Street
Waterbury, VT 05676

Mid-America Regional Office
534 S. Kansas Avenue, Suite 800
Topeka, KS 66603

Mid-Atlantic Regional Office*
1201 College Park Drive, Suite 101
Dover, DE 19904

*The CCS Mid-Atlantic Regional Office will support the DDOC Mental Health Services contract.

CCS operates humane, legally defensible mental health programs via written mental health plans with clear objectives and site-specific policies and procedures. The DDOC Mental Health Services, Substance Abuse Treatment, DUI Programming, and Sex Offender Treatment Contract, as operated by CCS, will be founded upon the standards established by the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), and in accordance with federal, state, and local laws, statutes and ordinances.

The DDOC can be confident that CCS will always strive to provide care consistent with an offender's rights under the U.S. Constitution and Delaware standards, related to mental health care of incarcerated individuals; specifically that:

- Offenders have a right to access healthcare services
- Offenders have a right to professional medical judgment
- An offender has the right to care that has been ordered

Corporate Philosophy

We are committed to being a true solutions provider in the correctional healthcare industry. Our concentration is on establishing partnerships with state, county, or federal agencies that are experiencing challenges meeting their healthcare delivery needs. With a constant focus on patient care, we will provide innovative solutions to our customers and efficiently execute our operational plans in coordination with our project objectives. Correct Care Solutions will continue to hire and retain only the best personnel in the industry and we will employ individuals that exhibit the "Five H's" we value in ourselves, and others.

★★★★★★★★★★

Our Values: The Five Hs

The Five H's are the attributes that we value most in ourselves, our employees, and in others.

Hunger: We have the fire to learn, teach, and grow. We encourage teamwork to help everyone reach their goals from the smallest unit to the company as a whole.

Honesty: We uphold the highest level of integrity in all our dealings with each other, with clients, and with our patients. We treat everyone with respect and dignity.

Hard Work: We are willing to out-work and out-think the competition to constantly place our customers first. We strive for quality in everything we do.

Humility: No matter how much success we achieve, it is important to remain humble and remember not to lose our roots, vision, values, and identity. We maintain our loyalty to our community by being good citizens in the areas where we live and work.

Humor: Given the amount of time we put towards our work, it is important to have a sense of humor. This allows us to remain passionate and to enjoy our work.

★★★★★★★★★★

Our Mission

From the beginning of our company, we have been determined to create an organization with three goals:

- To be the company quality healthcare staff want as their employer
- To be the company clients want as their partner
- To ensure every staff member treats patients with one thought in mind: "What if it was your family member?"

Organizational Chart

The current CCS Organizational Chart is provided on the following page.

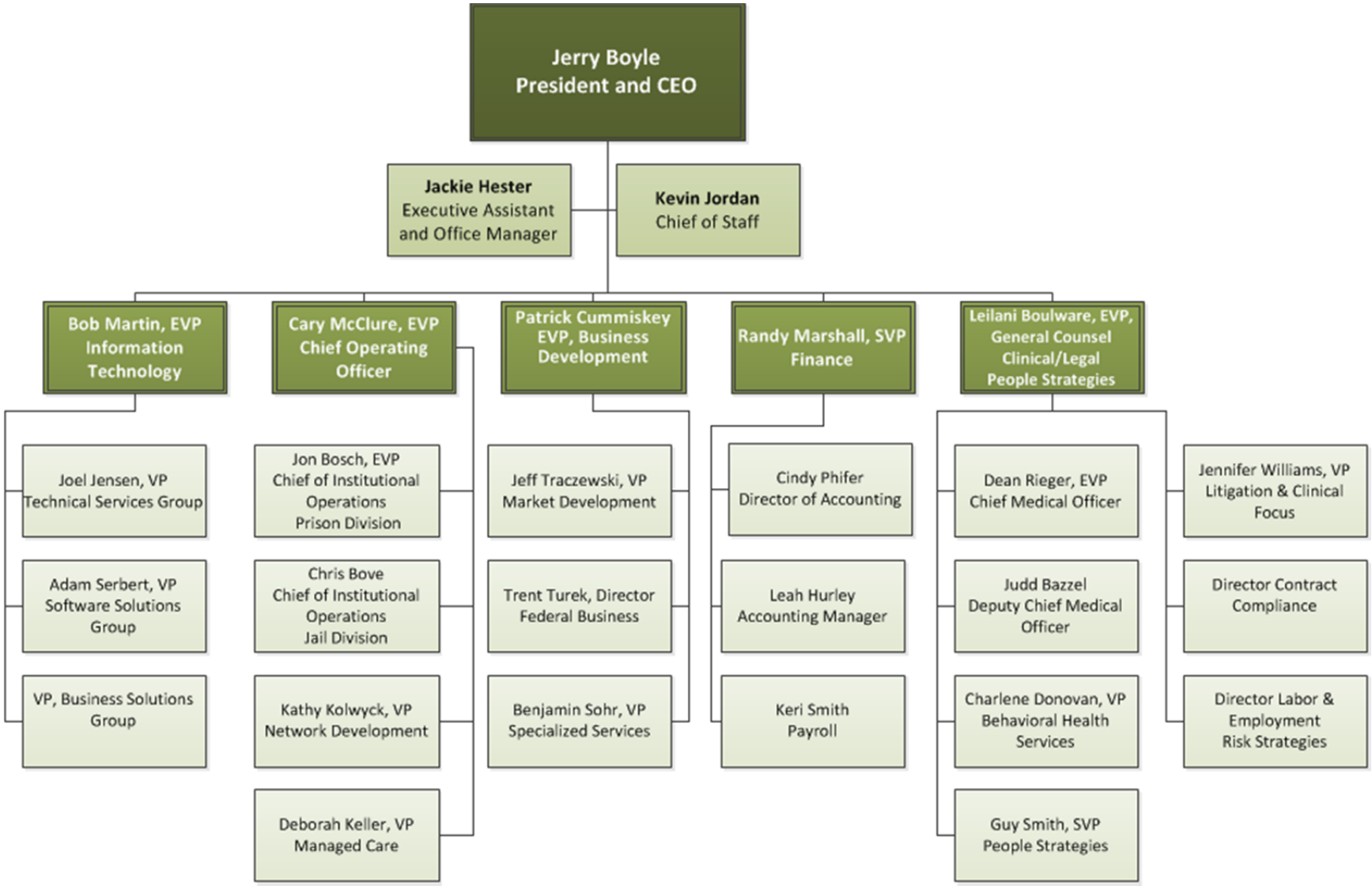


Figure 2: CCS Organizational Chart. *This chart shows the organizational structure of CCS as of January 2012.*

1.1 Minimum Requirements

1.1.1 Delaware Business License

CCS currently operates in the State of Delaware and has included a copy its Delaware Business Licenses in **tabbed attachment A** of this proposal.

1.1.2 Professional Liability Insurance

CCS meets the insurance requirements outlined by the DDOC, and a Certificate of Liabilty Insurance is included in **tabbed attachment B** of this proposal.

1.1.3 Demonstrated Experience

CCS exceeds the experience requirement of three (3) years experience in correctional healthcare and correctional mental health care. Our experience providing correctional mental health services is demonstrated in detail in **Section 1.3, Correctional Mental Health Contracts.** Our subcontractors' experience in Substance Abuse Treatment, DUI Programming, and Sex Offender Treatment is explained in their respective sections.

Mental Health Admissions Per 1,000 Offenders

Over the past two (2) years, CCS has had an average of 0.70 Mental Health admissions per 1,000 offenders, with an average length of stay of 23.5 days for the Vermont Department of Corrections.

1.2 Financial Stability

Correct Care Solutions is one of the industry's most financially stable companies, and is the second largest company in the industry. CCS has grown consistently and organically since its inception in 2003, and is projected to exceed a quarter billion dollars in revenue for 2012. Our basic financial metrics and resources are strong, as shown by the following examples (all amounts are as of December 31, 2011):

CCS has the financial ability to carry out the initial and ongoing needs for all operating, capital and maintenance requirements of the DDOC Mental Health Services, Substance Abuse Treatment, DUI Programming and Sex Offender Treatment Program. Since its inception, CCS has grown to an entity that now partners with 44 clients in 20 states, and during that time CCS has always held a strong liquidity position, as evidenced by the data above. To ensure that liquidity is never an issue, CCS maintains a $25 million revolving credit facility – and we would proudly note that this credit facility has ***never*** been drawn on; nonetheless it is there as an instrument to provide additional security to our partners. In addition, it's important to note that CCS has two extremely strong and financially capable equity partners who are investors in CCS: The Audax Group and Frazier Healthcare. These partners manage a combined $6.6 billion of investments through their private equity and other funds, and are fully committed to provide CCS access to additional capital if ever needed. In summary: Our strong market position and financial stability ensure that when CCS commits to a project, we absolutely have the ability and resources to fulfill all contractual obligations.

CCS has included balance sheets and income statements for the past three (3) years in the rear binder pocket of this proposal. Audited financials will be available after April 30, 2012.

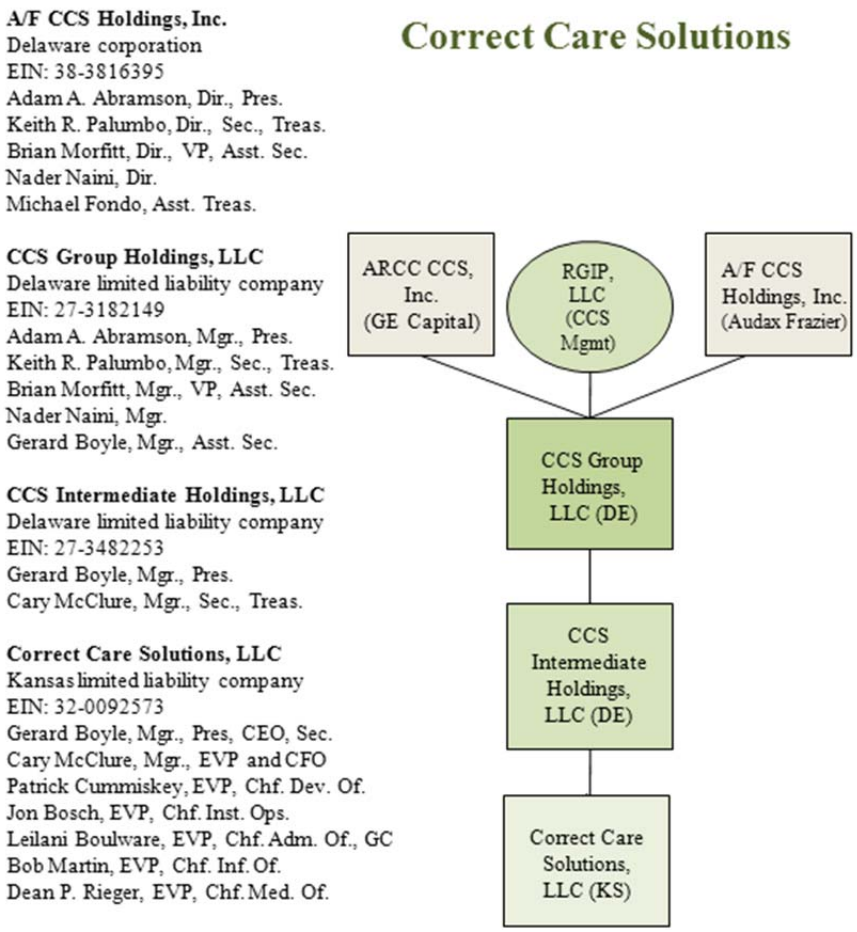
1.2.1 Corporate Reoganization

In 2010, CCS completed a re-capitalization of our company. This event resulted in no change in the CCS management team, but did result in the addition of two private equity strategic partners which further strengthen the ability of CCS to continue to expand its service offering to clients such as DDOC. This re-capitalization also resulted in the CCS management team expanding their ownership interest in the company.

Related Entities

Correct Care Solutions LLC, is the bidder on this project.

CCS Group Holdings and CCS Intermediate Holdings are holdings companies that have no independent assets therefore would not be in a position to absorb any debt. All assets reside in Correct Care Solutions, LLC.



1.3 Correctional Mental Health Contracts

CCS provides mental health services for the following clients:

Augusta-Richmond County, GA
Mary Ann Gibbs
Sheriff's Office Richmond County
401 Walton Way
Augusta, GA 30901
Phone: (706) 821-1067
Fax: 706-821-1064
mgibbs@augustaga.gov
1,380 inmates
Contract Dates: January 1, 2011 - Present
Transitioned from Corizon (formerly CMS)

Dane County, WI
Sheriff Dave Mahoney
Dane County Sheriff's Office
115 W. Doty Street
Madison, WI 53703
Phone: 608-284-6170
Fax: Unavailable
mahoney@co.dane.wi.us
950 inmates
Contract Dates: January 1, 2008 - Present
Transitioned from Corizon (formerly PHS)

Davidson County Sheriff's Office, TN
John Ford, Chief
Davidson County Sheriff's Office
506 2nd Avenue North
Nashville, TN 37201
Phone: 615-862-8955
Fax: 615-862-8188
jford@dcso.nashville.org
2,800 inmates
Contract Dates: October 2005 - Present
Transitioned from Corizon (formerly PHS)

Douglas County, NE
Mark Foxall, Acting Director
Douglas County Department of Corrections
710 South 17th Street
Omaha, NE 68102
Phone: 402-599-2278
Fax: 402-599-2302
mfoxall@dccorr.com
1,250 inmates
Contract Dates: March 1, 2008 - Present
Transitioned from Corizon (formerly CMS)

Elkhart County, IN
Brad Rogers, Sheriff
Elkhart County Correctional Center
26861 CR 26
Elkhart, IN 46517
Phone: 574-891-2302
Fax: 574-293-0361
brogers@elkhartcountysheriff.com
750 inmates
Contract Dates: January 1, 2009 - Present
Transitioned from ACH

Forsyth County, NC
Donna B. Holmes, Captain
Forsyth County Detention Center
201 N. Church Street
Winston-Salem, NC 27120
Phone: 336-917-7653
Fax: 336-748-4227
holmesdb@fcso.us
1,016 adult inmates; 13 juveniles
Contract Dates: September 1, 2009 - Present
Transitioned from NaphCare

Kansas Department of Corrections (KDOC)
Viola Riggin, Director of Health Services
Kansas Department of Corrections
900 Jackson, Suite 900
Topeka, KS 66612
Phone: 785-296-0045
Fax: 785-296-0304
violar@kdoc.dc.state.ks.us
9,000 inmates — 12 prison facilities
Contract Dates: October 2003 - Present
Transitioned from Corizon (formerly PHS)

Kansas Juvenile Justice Authority (KJJA)
Psychiatry Only
Viola Riggin, Director of Health Services
900 Jackson, Suite 900
Landon State Office Building
Topeka, KS 66612
Phone: 785-296-0045
Fax: 785-296-0304
violar@kdoc.dc.state.ks.us
500 juveniles
Contract Dates: June 2008 - Present
Transitioned from Corizon (formerly PHS)

Lake County, IL
Scott Fitch, Contract Monitor
Lake County Sheriff's Office
25 S. Martin Luther King, Jr. Avenue
Waukegan, IL 60085
Phone: 847- 501-0960
Fax: 847-360-5763
sfitch@lakecountyil.gov
760 adult inmates; 30 juveniles — 2 buildings
Contract Dates: December 1, 2008 - Present
Transitioned from HPL/CHC

Lancaster County Jail, NE
Michael Thurber, Director
Lancaster County Corrections Department
605 S. 10th Street
Lincoln, NE 68508
Phone: 402-441-8922
Fax: Unavailable
mthurber@lancaster.ne.gov
467 inmates
Contract Dates: June 2, 2011 - Present
Transitioned from self-operation

Las Vegas, NV
Lt. Debra Baldwin, Contract Monitor
City of Las Vegas Detention Center & City Hall Jail
3200 E. Stewart Avenue
Las Vegas, NV 89101
Phone: 702-229-2402
Fax: 702-386-7070
dbaldwin@lasvegasnevada.gov
1,100 inmates
Contract Dates: February 1, 2009 - Present
Transitioned from Corizon (formerly PHS)

North Las Vegas, NV
Paul Gillenwater, Detention Services Manager
City of North Las Vegas Detention Center
2332 Las Vegas Blvd. North
North Las Vegas, NV 89030
Phone: 702-633-1400 x5754
Fax: 702-633-2488
GillenwaterP@cityofnorthlasvegas.com
600 inmates
Contract Dates: July 1, 2009 - Present
Transitioned from NaphCare

Louisiana Office of Juvenile Justice
Kelly Smith, Director of Health Services
P.O. Box 66458
Baton Rouge, LA 70896
Phone: 225-287-7995
Fax: 225-287-7986
kelly.d.smith@la.gov
350 juveniles
Contract Dates: September 1, 2010 - Present
Transitioned from local provider

Macomb County Jail, MI
Michelle Sanborn, Jail Administrator
Macomb County Jail & Juvenile Justice Center
43565 Elizabeth Road
Mt. Clemens, MI 48043
Phone: 586-469-5151
Fax: 586-469-6435
Michelle.sanborn@macombcountymi.gov
1,400 adult inmates; 100 juveniles
Contract Dates: September 12, 2001 - Present
Transitioned from Corizon (formerly CMS)

Marion County, IN
Tammy Wood, Captain
Marion County Jail
40 S. Alabama Street
Indianapolis, IN 46204-3635
Phone: 317-327-7724
tammy.wood@indy.gov
1,280 inmates
Contract Dates: January 1, 2010 - Present
Transitioned from Corizon (formerly CMS)

McHenry County, IL
Daniel Sedlock, Jr., Corrections Chief
McHenry County Jail
2200 North Seminary Avenue
Woodstock, IL 60098
Phone: 815-334-4000
Fax: 817-338-4713
djsedlock@co.mchenry.il.us
520 inmates
Contract Dates: September 1, 2005 - Present
Transitioned from local provider

Mecklenburg County, NC
Rachel Vanhoy, Business Manager
Mecklenburg County Sheriff's Office
801 East Fourth Street
Charlotte, NC 28202
Phone: 704-336-2543
Fax: 704-336-8585
Rachel.vanhoy@mecklenburgcountync.gov
2,800 adult inmates; 30 juveniles
Contract Dates: October 1, 2008 - Present
Transitioned from Corizon (formerly PHS)

Minnehaha County, SD
Mike Milstead, Sheriff
Minnehaha County Sheriff's Office
320 W. 4th Street
Sioux Falls, SD 57104
Phone: 605-367-4300
Fax: 605- 367-7319
mmilstead@minnehahacounty.org
300 inmates
Contract Dates: January 1, 2010 - Present
Transitioned from local provider

Monmouth County, NJ
Jeff Sauter, Business Administrator
Monmouth County Department of Corrections
One Waterworks Road
Freehold, NJ 07728
Phone: 732-294-5980
Fax: 732-294-5985
jsauter@co.monmouth.nj.us
1350 adult inmates
Contract Dates: January 1, 2007 - Present
Transitioned from CFG

Montgomery County, TN
Debra Sandifer, Detention Adm. Officer
Montgomery County Jail
120 Commerce Street, Suite 208
Clarksville, TN 37040
Phone: 931-648-0615 x1342
Fax: 931-542-5199
dksandifer@montgomerycountytn.org
650 inmates
Contract Dates: February 1, 2005 - Present
Transitioned from NaphCare

New Hanover County, NC
Psychiatry Only
Lise Ruefle, Major
New Hanover Sheriff's Office
3920 Juvenile Center Road
Castle Hayne, NC 28429
Phone: 910-798-4161
Fax: 910-798-4177
lruefle@nhcgov.com
650 inmates
Contract Dates: July, 2007 - Present
Transitioned from Corizon (formerly PHS

Norfolk, VA
Robert McCabe, Sheriff
Norfolk City Jail
811 E City Hall Avenue
Norfolk, VA 23510
Phone: 757-664-4951
Fax: 757-441-2531
Robert.mccabe@norfolk.gov
1,800 inmates
Contract Dates: July 1, 2004 - Present
Transitioned from Corizon (formerly PHS)

Portsmouth, VA
William Rucker, Lt. Colonel
City of Portsmouth Jail
701 Crawford Parkway
Portsmouth, VA 23704
Phone: 757-391-3217
Fax: 757-393-5042
ruckerw@portsmouthva.gov
500 inmates
Contract Dates: November 1, 2009 - Present
Transitioned from Corizon (formerly PHS)

Richland County Government, SC
Kathy Harrell, Assistant Director
Alvin S. Glenn Detention Center
201 John Mark Dial Drive
Columbia, SC 29209
Phone: 803-576-3210
Fax: 803-576-2135
harrellk@rcgov.us
1,100 inmates
Contract Dates: March 18, 2006 - Present
Transitioned from Corizon (formerly PHS)

Richmond, VA
C.T. Woody, Jr., Sheriff
Richmond City Jail
1701 Fairfield Way
Richmond, VA 23219
Phone: 804-646-0930
Fax: 804-646-5989
ctwoody@richmondgov.com
1,400 inmates
Contract Dates: July 1, 2011 - Present
Transitioned from self-operation

Shelby County Sheriff's Office, TN
Rod Bowers, Chief
201 Poplar Avenue
Memphis, TN 38103
Phone: 901-222-4735
Fax: 901-545-3310
rod.bowers@shelby-sheriff.org
3,000 inmates — 2 prisons & 3 jail facilities
Contract Dates: July 1, 2006 - Present
Transitioned from Corizon (formerly CMS)

Shelby County Division of Corrections, TN
Psychiatry Only
James Coleman, Director
1045 Mullins Station Road
Memphis, TN 38134
Phone: 901-222-8580
Fax: Unavailable
james.coleman@shelby-sheriff.org
3,000 inmates — 1 prison & 3 jail facilities
Contract Dates: July 1, 2006 - Present
Psychiatry Only
Transitioned from Corizon (formerly CMS)

Stanislaus County Sheriff's Department
Adam Christianson, Sheriff-Coroner
250 East Hackett Road
Modesto, CA 95358
Phone: 209-525-7216
Fax: 209-567-4417
chradam@stanislaussheriff.com
1,100 inmates
Contract Dates: July 1, 2009 - Present
Transitioned from CFMG

Tecumseh State Correctional Institution
Psychiatry Only
Robert Houston, Director
Folsom and W. Prospector Place, Bldg. 1
Lincoln, NE 68509-4661
Phone: 402-335-5142
Fax: 402-335-5123
rhouston@dcs.state.ne.us
950 inmates
Contract Dates: September 1, 2005 – Present
Psychiatry Only
Transitioned from Corizon (formerly CMS)

Vermont Department of Corrections
Trudee Ettlinger, Chief Nursing Officer
103 South Main Street
Waterbury, VT 05671
Phone: 802-241-2371
Fax: Unavailable
Trudee.ettlinger@ahs.state.vt.us
1,600 inmates — 8 DOC facilities
Contract Dates: February 1, 2010 - Present
Transitioned from Corizon (formerly PHS)/MHM

Waukesha County Sheriff's Office, WI
Margaret Schnabl, Captain
Waukesha County Jail
515 W. Moreland Blvd.
Waukesha, WI 53188
Phone: 262-548-7181
Fax: 262-548-7668
mschnabl@waukeshacounty.gov
460 inmates
Contract Dates: January 1, 2005 - Present
Transitioned from HPL/CHC

Westchester County, NY
Kevin Cheverko, Commissioner of Correction
Westchester County Department of Correction
10 Woods Road
Valhalla, NY 10595
Phone: 914-231-1000
Fax: 914-231-1262
KMC4@westchestergov.com
1,400 inmates
Contract Dates: July 26, 2010 - Present
Transitioned from local provider

Wyandotte County, KS
Linda Hendrix, Sheriff's Adm. Manager
Wyandotte County Sheriff's Office
710 N 7th Street
Kansas City, KS 66101
Phone: 913-573-2952
Fax: 913-573-8137
lhendrix@wycokck.org
400 adult inmates; 50 juveniles
Contract Dates: January 1, 2006 - Present
Transitioned from NaphCare

1.4 Accreditation History and Experience

CCS has a long history of upholding all local, state and federal standards, regulations and statutes. CCS has repeatedly demonstrated its ability to obtain and maintain accreditations for our clients. CCS also has experience managing turnaround successes for troubled ACA and NCCHC accreditation attempts at facilities after our transition. CCS has never lost or failed to obtain an accreditation status at any of our client facilities. Our on-going CQI programs guarantee standards are met and maintained.

CCS Client Facility	State	NCCHC	ACA	CALEA	Accred. Date	Re-Accred. Date	CMA-IMQ (CA Only)
Augusta-Richmond County Detention Center	GA	Yes			Prior to CCS	2013	
Dane County	WI	Yes	Yes		Prior to CCS	2010	
Davidson County Sheriff's Office – HDC	TN		Yes		Prior to CCS	2011	
Davidson County Sheriff's Office – CDCF	TN		Yes		Prior to CCS	2011	
Davidson County Sheriff's Office – CDCM	TN		Yes		Prior to CCS	2011	
Davidson County Sheriff's Office – CJC	TN		Yes		Prior to CCS	2011	
Davidson County Sheriff's Office – ORC	TN		Yes		Prior to CCS	2011	
Delaware DOC	DE	Yes			Prior to CCS	2011	
DeKalb County Sheriff's Office TRIPLE CROWN ACCREDITATION	GA	▲	▲	▲	Prior to CCS	08/2011	
Douglas County DOC	NE	Yes	Yes		Prior to CCS	NCCHC 2009 ACA 2011	
Durham County Detention Facility	NC	Yes			12/2005	2009	
Elkhart County Correctional Center	IN	Yes			Prior to CCS	2011	
Forsyth County – Adult Facility	NC	Yes			Prior to CCS	2009	
Forsyth County – Youth Center	NC	Accreditation Not Requested					
Johnson County	KS	Yes			2010		
State of Kansas – KDOC El Dorado CF	KS	Yes			Prior to CCS	2009	
State of Kansas – KDOC Ellsworth CF	KS	Yes			11/2004	2008	
State of Kansas – KDOC Hutchinson CF	KS	Yes			10/2004	2008	
State of Kansas – KDOC Lansing CF	KS	Yes			10/2004	2008	
State of Kansas – KDOC Larned CF	KS	Yes			11/2004	2008	
State of Kansas – KDOC Norton CF	KS	Yes			02/2005	2008	

CCS Client Facility	State	NCCHC	ACA	CALEA	Accred. Date	Re-Accred. Date	CMA-IMQ (CA Only)
State of Kansas – KDOC Topeka CF	KS	Yes			Prior to CCS	2008	
State of Kansas – KDOC Winfield CF (Last audit scored 100%)	KS	Yes			Prior to CCS	2009	
State of Kansas – KDOC Wichita Work Release	KS	Yes			Prior to CCS	2008	
State of Kansas – Juvenile Justice Authority	KS		Yes		Prior to CCS	2007	
Lake County ACC	IL	Yes	Yes		Prior to CCS	NCCHC 2009 ACA 2009	
Lancaster County Jail	NE	Accreditation Not Requested					
Lake County Juvenile Center	IL	Yes	Yes		Prior to CCS	2009	
City of Las Vegas	NV	Yes	Yes		Prior to CCS	2011	
Lexington County LCSD/DC	SC	Yes			Prior to CCS	2009	
Louisiana OJJ – Bridge City Center for Youth	LA		Yes		01/2012	N/A	
Louisiana OJJ – Jetson Center for Youth	LA		Yes		01/2012	N/A	
Louisiana OJJ – Swanson Center for Youth	LA		Yes		01/2012	N/A	
Macomb County Jail	MI	Yes			Prior to CCS	2012	
Marion County Jail **TRIPLE CROWN ACCREDITATION**	IN	▲	▲	▲	ACA 2010	NCCHC 2012 ACA 2013	
McHenry County Jail	IL		In Prog ress			2013	
Mecklenburg County	NC	Yes			Prior to CCS	NCCHC 2009 ACA 2008	
Midland County Jail	TX	Accreditation Not Requested					
Minnehaha County Jail	SD	In Progre ss				N/A	
Monmouth County Correctional Institution **TRIPLE CROWN ACCREDITATION**	NJ	▲	▲	▲	Prior to CCS	NCCHC 2009 ACA 2009	
Montgomery County Jail	TN	Accreditation Not Requested					
State of Nebraska – Tecumseh Correctional Institution	NE		Yes		Prior to CCS	2012	

CCS Client Facility	State	NCCHC	ACA	CALEA	Accred. Date	Re-Accred. Date	CMA-IMQ (CA Only)
New Hanover County Detention Center	NC	Accreditation Not Requested					
City of Norfolk Jail	VA	Yes			Prior to CCS	2010	
City of North Las Vegas	NV	Accreditation Not Requested					
City of Portsmouth	VA	Yes			Prior to CCS	2010	
Richland County Alvin S. Glenn DC	SC	Yes			Prior to CCS	2011	
Richland City Jail	VA	Accreditation Not Requested					
Shelby County – CJC **TRIPLE CROWN ACCREDITATION**	TN	▲	▲	▲	NCCHC Prior to CCS ACA 2006	NCCHC 2011 ACA 2012	
Shelby County – Jail East	TN		Yes		2007	2012	
Shelby County – Div. of Corrections and AOC	TN	Accreditation Not Requested					
Stanislaus County	CA				2010	2012	Yes
State of Vermont DOC	VT	Yes			Prior to CCS	2009	
Waukesha County Jail	WI	Yes			2005	2011	
Westchester County Dept of Corrections	NY	Yes	Yes		Prior to CCS	2009	
Will County ADF	IL	Yes	Yes		Prior to CCS	2009	
Will County RVJC	IL		Yes		Prior to CCS	2009	
Wyandotte County DC	KS	Yes			Prior to CCS	2009	
Wyandotte County DC Juvenile	KS	Yes			Prior to CCS	2009	

Figure 3: Accreditation statuses of CCS operated facilities. *CCS has a perfect record of attaining and/or maintain accreditation for clients throughout the United States! Please note that the State of Kansas discontinued NCCHC accreditation for budgetary reasons which is why after initial accreditation they were only re-accredited one time.*

1.5 Incurred Penalties

CCS has incurred no fines or penalties exceeding $1,000 nor any other amount, for non-performance since the company's inception.

1.6 Incurred Losses

CCS has incurred no losses of funds due to fines, delay damages, liquidated damages or forfeiture of performance or proposal bonds in whole or in part.

1.7 CCS Business References

CCS Business References	
Diamond Pharmacy Services Mark J. Zilner RPh Director of Operations Diamond Pharmacy Services 645 Kolter Drive Indiana, PA 15701-3570 Tel: 1-800-882-6337 x1003 Or 724-349-1111 x1003 Fax: 877-234-7050 or 800-523-0008	**BioReference Laboratories** Gary Reeves, Director of Correctional Care 481 Edward H. Ross Drive Elmwood Park, NJ 07407 Tel: 800-229-5227 ext. 8254 Fax: 201-791-1941 or 9753
Clinical Solutions, LLC Christi Thornberry Post Office Box 3309 Brentwood, TN 37024 Tel: 877-826-5488 Fax: 866-920-1597	**Bank of America** Karen Bell, Vice President 414 Union Street Nashville, TN 37239 Tel: 615-749-3031 Fax: 615-749-4762 or 3100
First Bank Douglas A. Remke Vice President 200 Fourth Avenue North, Suite 100 Nashville, TN 37219 Tel: 615-313-0080 Fax: 615-255-9817 or 615-687-1297	**Tennessee Real Estate Investments** Ron Sohr 4521 Trousdale Drive Nashville, TN 37204 Tel: 615-333-9500 Fax: 615-333-8507

Figure 4: CCS Business References. *Our business references will attest to the stability of CCS and to our ethical business practices.*

1.8 CCS Facilities and Probation

No facilities where CCS provides health care services are under probation.

1.9 Recent Accreditation Surveys

CCS has provided a sampling of the most recent accreditation surveys conducted in Davidson County,Tennessee, Dane County, Wisconsin, Lexington County, South Carolina, and Johnson County, Kansas. The accreditation surveys are included in **tabbed attachment C**.

2 Technical Approach

CCS offers a mental health program that is consistent with the NCCHC and ACA Standards for Mental Health Services in Correctional Facilities and emphasizes consistent quality of care across facilities. There are several key features necessary for a consistently high quality program, beginning with well-written and well-developed policy and procedure statements, offering meaningful and ongoing staff training, ensuring that each mental health team devotes a period of time each week to clinical team case reviews, encouraging use of formalized diagnostic decision trees and organized approaches to offering treatment, and engaging in release planning activities to help ensure that a client's transition to the free world is as successful as possible. As part of our program, we have developed a variety of tools that our mental health team members can utilize with clients to assist in the provision of efficient and effective mental health care. We will discuss some of these tools in more detail throughout this document.

2.1 Mental Health Services

The CCS Mental Health Services Program is fully NCCHC and ACA-compliant and designed to meet the needs of the incarcerated population. Our Program emphasizes identification, referral and treatment. The CCS program will be based on DDOC and documented policies and procedures addressing the provision of mental health services to include offender assessment and evaluation, suicide prevention, special needs treatment plans, referrals for care, on-going care and discharge planning. The CCS Mental Health Program falls under the direction of Charlene Donovan, Ph.D. and the Delaware based Regional Mental Health and Psychiatry Directors. Mental health referrals can occur at any time during the offender's incarceration.

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A CCS Turnaround Success – Mental Healthcare in Richland County Jail

*Under its previous healthcare provider, the **Alvin S. Glenn Detention Center was unaccredited**, had no Mental Health screening in place at intake, and had a troubling history of suicides and other sentinel events.*

Within two years of taking over as the healthcare provider at Richland County, CCS managed a significant turnaround for the Detention Center and with it a positive impact for its mentally ill incarcerated patients, and ultimately the community at large.

*With our oversight and commitment to standards and quality of care, the Center is now **NCCHC accredited**, Mental Health screenings have been implemented at intake, and the Mental Health program has received recognition for its improvement and quality.*

★★★★★★★★★★

Additionally, referrals may come from a variety of sources to include:

- The receiving screening process
- The health appraisal process
- Sick call encounters
- Individuals such as correctional personnel, legal representation, friends and family members

CCS Mental Health staff assigned to DDOC will be available to discuss our performance, contract details or any other issues pertaining to the Mental Health Program with the Bureau Chief.

Offenders identified as being prescribed psychotropic medications, those currently receiving mental health treatment and those identified as having a history of mental illness or chronic inebriation are referred for care. Referrals through the intake process will be evaluated by licensed Mental Health personnel within 24 hours. Urgent referrals will be managed by Mental Health staff immediately; health care staff will address urgent referrals received after hours and contact the on-call psychiatrist as necessary to manage these cases. Offenders requiring the services of the psychiatrist will be referred appropriately. If it is determined that on-going care and evaluation is required, a treatment plan will be established and the offender will be scheduled for his or her next evaluation.

When it is determined that the offender received mental health care prior to incarceration, efforts are made to obtain treatment information from community providers to facilitate continuity of care.

CCS has researched and evaluated the current level of mental health care being provided and our research results indicate improvements can be made. Our staffing plan includes:

- Local Psychiatrists
- Licensed Master's level Mental Health Professionals
- On-site mental health services seven days per week to improve continuity of mental health care

2.1.1 Mental Health Program Features

Psychiatric Services	CCS will provide psychiatrists authorized to order commitments to an inpatient mental health facility. Crisis intervention will be available for any offender who requires it.
Special Observation/Housing	Offenders with suicidal tendencies and other conditions are placed on special observation status. Mental Health personnel will perform scheduled rounds and evaluations when offenders are placed in observation or isolation.
Special Needs Program	CCS will identify those offenders who present with serious mental health issues likely to impact their ability to function independently while at DDOC. These offenders will receive an individualized treatment plan and the level of mental health service required to enable them to function adequately while at the facility.

Individual and Group Counseling	CCS will utilize a program of group and individual counseling services designed to address the mental health needs of the DDOC population. As part of the intake and health assessment process, those offenders identified with significant mental health needs will be evaluated by a member of the mental health staff for appropriateness in enrollment in group or individual counseling services.
Multidisciplinary Communications	CCS will implement a program to improve communication between nursing personnel, mental health workers and correctional personnel.
Psychotropic Medications	The psychiatrist will perform a health record review prior to prescribing psychotropic medications and will provide offenders with education on treatment and psychotropic medications and obtain informed consent Offenders are prescribed psychotropic therapy as clinically indicated. Offenders on psychotropic medications will be monitored for medication compliance and drug toxicity. CCS has an established Psychotropic Medications protocol for emergent and non-emergent use of psychotropic medications.
Reporting and Recordkeeping	CCS will keep current and accurate health records, service delivery logs and other reports related to mental health services.
Administrative and CQIP Meetings	CCS will participate in periodic, scheduled administrative and quality improvement program meetings regarding mental health services. Please see our CQI program details in **Section 2.6.8.**

2.1.2 Administrative Supervisor

CCS accepts the responsibility for the efficiency, quality and cost-effectiveness of mental health services in the DDOC system and will be accountable to the Bureau Chief for administrative and clinical performance under this contract. CCS will appoint a Regional Mental Health Director to provide clinical and administrative supervision, to manage mental health staff and to coordinate DDOC on-site operations. The position will liaise with the DDOC facilities administrators, staff and DDOC Mental Health Administrator. CCS has had discussions with Dr. Allyson Galloway and are including this current contractor employee as a potential candidate for this position. Dr. Galloway's resume can be found in **tabbed attachment D.**

2.1.3 Mental Health Assessments

Unless identified as emergent, health care personnel will complete a Mental Health assessment at the time of the comprehensive health assessment (within 7 days of intake). This assessment is in addition to the mental health screening completed at intake as a part of the initial assessment. Offenders will also be assessed to determine competency to make medical decisions. All

referrals generated from these assessments will be provided to mental health staff for necessary follow-up assessment.

A licensed psychiatrist will be on-call 24/7, and a Mental Health professional will provide on-site assessments of patients with clinical symptoms on a daily basis. Patients will be referred for care as determined appropriate. Mental Health Evaluations will include:

- History of psychiatric treatment and outpatient treatment
- Current psychotropic medication
- Suicidal ideation and history of suicide behavior/self-harm
- Drug and alcohol usage
- History of sex offenses
- History of expressively violent behavior
- History of victimization due to criminal violence
- History of cerebral trauma or seizures
- Emotional response to incarceration, adjustment issues, or decompensation
- Dementia
- Significant cognitive or emotional impairment
- Documentation of informed consent

2.1.4 Delaware Automated Correction System (DACS)

CCS is aware of the requirement to use the DACS medical module and all components as a part of any aspect of this RFP and its components. CCS will provide any initial and follow-up training for our personnel as we are already familiar with the DACS system.

2.1.5 Case Management

CCS will provide mental health case management for offenders presenting with psychiatric histories or symptoms, including:

- Serious mental illness
- Adjustment difficulties
- Decompensation
- Aggressive Behavior and/or victimization
- Suicidal/homicidal ideation
- Dementia
- Other significant cognitive/emotional impairment

CCS Mental Health Professionals are also trained to work with offenders entering the system who present as naïve to the correctional environment or particularly vulnerable based on stature, mental illness or developmental disability. These offenders are generally included in the Mental Health Special Needs program to ensure they have ongoing contact with mental health staff as they learn to negotiate the correctional setting. CCS has also utilized a peer mentoring program in certain facilities as an added component of proactive programming for this subgroup of clients. Additionally, we have found it useful to work directly with security team members regarding their interactions with offenders – not just those at risk for possible victimization in

corrections, but also those with past trauma issues involved in mental health services to address these issues – about most effective methods for interacting, directing and de-escalating these offenders.

CCS is experienced in providing gender specific services to female offenders, who present their own unique set of factors that require special attention. The extensive trauma experience of female offenders is well documented, and on-going losses while incarcerated, usually involving child custody issues, present events that at times seem overwhelming to female offenders. CCS recognizes the need for enhanced staffing levels at facilities managing female offenders, given the higher levels of serious mental illness noted among female offenders and this is reflected in our staffing plan. We find it essential that an underlying component of interactions with female offenders must include both a message of empowerment and encouragement toward a belief in self-sufficiency – messages of diminishment, abuse, demeaning work environments, substance abuse – all factors that often contribute to current behavior choices and internal self-assessments must be countered in order for female offenders to develop a sense of self-efficacy about their ability to face challenges and new tasks. CCS offers a variety of treatment opportunities for female offenders, and has found that group processes are a valuable modality as it makes use of group cohesion and social support factors that are particularly important for women. As resources allow, CCS attempts to make some group offerings “open-ended” so that new members may be incorporated into a group at any time.

Treatment referrals can originate as early as the Intake process, but are more often made as part of the mental health evaluation process, which allows for a more in-depth assessment of offender needs across the length of incarceration. CCS utilizes treatment plans for group, individual and special needs programming to ensure that treatment remains focused on goal attainment and that resources are effectively utilized to meet the needs of the offender population.

2.1.6 Mental Health Programming

CCS utilizes an identification, referral and treatment system to deliver mental health care to offenders in need. Any patient who requests mental health services will be referred.
The processof identifying those individuals in need of mental health services begins at intake and continues on through any point of referral throughout the duration of the individual’s incarceration. CCS provides information regarding services available to the offender during the intake and assessment process as well as upon referral or offender request for mental health services. Offenders presenting with mental health needs will be informed of the availability for assignment to a mental health professional for one-on-one treatment, case management and discharge planning, group treatment activities as deemed appropriate, additional services and therapies for those offenders in segregation. Of particular note is the need for mental health services in special needs units as well as segregation units. Special needs units, when designated for individuals with serious mental health issues, can serve as a safe and structured environment for clients to receive necessary and useful mental health programming. These units often lend themselves to mental health group programming, and CCS has significant experience in offering comprehensive treatment programs in special needs units, to include a full range of group treatment options. CCS will work directly with the BCHS and the MHTSD to ensure that the specific programming developed for the Special Needs Unit meets the needs of the DDOC and the offenders referred to this unit.

Segregation units can provide unique challenges not only to the individuals who are housed in such units, but also to the treatment staff tasked with providing services in such units. CCS has developed programming that targets individuals residing in segregation units; the programming can be offered in small group formats or in an individual, self-paced format. Offenders can choose not to participate in the programming but the option of participation is given to each person in the segregation unit.

Referrals are collected by health care staff at all facilities on at least a daily basis from all housing units. Health care staff triages all referrals for emergent needs and take any necessary action; any referrals requesting mental health services are forwarded on to mental health staff. Additionally, mental health staff responds to referrals from medical, security, jail administrative staff and family members. CCS utilizes a tracking system for referrals in order to ensure that no referral "falls through a crack" and to ensure that all referrals are addressed in a timely manner. The tracking system allows for quality improvement measures to be used to assess response timeliness.

The CCS psychiatrist will perform a health record review prior to prescribing psychotropic medications and will provide offenders with educational materials on all prescribed psychotropic medications. The CCS Mental Health Program at DDOC will include psychotropic therapy as clinically indicated. Offenders on psychotropic medications will sign an informed consent and will be monitored for medication compliance and drug toxicity.

CCS is aware of and will closely follow NCCHC guidelines and policies developed by law governing emergency use of forced psychotropic medications. Forced psychotropic medication should be utilized only in extreme cases in which all other attempts to de-escalate a client have been unsuccessful, and the client remains at imminently high risk for harm to self or others. CCS' policy and procedure covering forced psychotropic medications is detailed, providing all health and mental health care staff with clear guidance regarding the procedures to be followed at each point in the intervention. The policy and procedure is revised to incorporate any specific local legal requirements for utilization of forced psychotropic medications. CCS also considers use of emergency psychotropic medication to be a critical clinical event (CCE), and each occurrence is reviewed under the auspices of the CCS Quality Improvement program.

2.1.7 Receiving Screening

Per NCCHC P-E-02, J-E-02, ACA 4-4362, 4-4370 and DDOC Policy E-02, DDOC offenders will be screened at intake for mental health issues and illness by CCS Medical personnel and answers to questions are noted on the intake screening form. Offenders identified with suicide potential will be referred to mental health personnel for evaluation through DACS and noted in the offender health record. Offenders demonstrating self-injurious behaviors and those identified with suicide potential will be placed under constant observation until the mental health evaluation can be completed (within 24 hours) and an appropriate disposition determined. The CCS policy and procedure regarding suicide prevention and risk management identifies the steps to be taken when a client is placed in psychiatric observation, including notification of the psychiatric provider, PCO level and watch status, daily rounds by mental health staff, development of a treatment plan, the evaluation and consultation that must occur between mental

health and psychiatric staff prior to releasing a client from psychiatric observation, as well as the follow-up services that will be provided by mental health staff to ensure that the client is adjusting adequately to a general population setting.

CCS Mental Health staff will be available on-call 24 hours a day, seven (7) days per week for any urgent or emergent needs.

2.1.8 Treatment Plans

Per NCCHC P-G-02, ACA 1-HC-1A-07 and DDOC Policy G-02, CCS will offer development of individualized treatment plans to all offenders who are receiving mental health treatment and will be incarcerated in the DDOC system for more than 72 hours. This approach will be managed through the Interdisciplinary Treatment Team (ITT), composed of DDOC facilities treatment and security staff as well as CCS medical and mental health team members and ancillary vendors. Each offender who wishes to participate in the ITT treatment plans will be asked to sign a written agreement. Treatment plans are completed within 30 days and are revised as indicated every three to six months. CCS will also develop a basic mental health treatment plan for offenders who decline participation in the individualized program. When feasible, treatment plans will maintain connections between offenders and the community agencies that have been or will be serving them.

This individual treatment plan will minimally include information regarding medications, individual or group counseling sessions, any ordered diagnostic work-up, housing assignment disposition, impact on ability to function in general population, impact on programming and school, and frequency of follow-up indicated.

In cases in which an acute or emergent mental health issues arises, the client's existing treatment plan will be modified to address the level of care to be provided to re-establish stability of functioning. If the individual does not have an existing treatment plan at the time the acute or emergent condition arises, a treatment plan will be developed to manage through that episode as well as provide any additional care necessary to maintain stability of functioning once re-estasblished. Individual treatment plans (ITP's) are developed by the psychiatrist, or other qualified clinician. The treatment plan will specify the course of therapy and roles of health and mental health professionals in carrying out the plan. Treatment plans include at a minimum:

- Short and long-term goals
- Appropriate adjustment of goals and interventions based on progress toward achieving identified goals
- Complete five axis diagnosis
- Frequency of follow-up for medical/mental health evaluation and adjustment of the treatment modality
- The type and frequency of diagnostic testing and therapeutic regimens
- Referrals as clinically indicated
- Supportive and rehabilitative services (individual or group counseling, etc.)
- Documentation regarding adaptation to the environment
- Medication regimens
- Discharge planning information

Treatment plans for patients with mental health conditions incorporate ways to address problems, enhance strengths, involve patients in plan development and include relapse prevention and risk management strategies.

2.1.9 Psychiatric Nursing Services

CCS nursing staff provides support in the delivery of mental health medications to those offenders for which meds are ordered. CCS mental health staff will work collaboratively with the medical staff and provide orientation and training on mental health medication and issues.

CCS will establish a written individual treatment plan for all special needs prisoners/residents. When feasible, treatment plans will maintain connections between prisoners/residents and the community agencies that have been or will be serving them.

This individual treatment plan will minimally include information regarding medications, therapeutic diet, specialty appointments and consults, any ordered diagnostic work-up, housing assignment disposition, impact on ability to function in general population, impact on programming and school, and frequency of follow-up indicated. CCS will initiate or address these treatment plans in conjunction with the health assessment and initial physical examination.

Individual treatment plans (ITP's) are developed by the physician, psychiatrist, or other qualified clinician at the time that the acute need condition is identified. The treatment plan will specify the course of therapy and roles of qualified health professionals in carrying out the plan, it is updated when warranted and includes at a minimum:

- Short and long-term goals
- Frequency of follow-up for medical/mental health evaluation and adjustment of the treatment modality
- The type and frequency of diagnostic testing and therapeutic regimens
- Instructions regarding diet, exercise
- Supportive and rehabilitative services (physical therapy, individual or group counseling, etc.)
- Documentation regarding adaptation to the environment
- Medication regimens

Treatment plans for patients with mental health conditions incorporate ways to address problems, enhance strengths, involve patients in plan development and include relapse prevention and risk management strategies.

Withdrawal/Detoxification

Although patients suffering from withdrawal are far less common in a prison setting versus a jail setting, when medically indicated during intake, CCS will implement a complete detoxification program minimizing risk of adverse symptoms, and the need for off-site detoxification treatment. CCS routinely evaluates all prisoners/residents for substance abuse during intake screening. Many prisoners/residents arrive in the correctional setting under the influence of drugs or

alcohol. Significant histories of substance abuse increase the possibility that they will experience some degree of withdrawal. Under medical supervision, CCS will provide a detoxification and withdrawal program that complies with all applicable standards of treatment.

The CCS Withdrawal/Detoxification Program includes:

1. Medically supervised on-site detoxification services.

2. Assessment by medical personnel for inmates admitted to an infirmary cell.

3. CCS medical staff checks prisoners/residents in infirmary cells upon admission and at least every six (6) hours thereafter. Alcohol withdrawal patients are checked at least every two (2) hours when in active withdrawal, and at least every eight (8) hours once stabilized.

4. CCS evaluates prisoners/residents for the use of and/or dependence on alcohol or other drugs during the admission screening process. CCS obtains specific information regarding:
   - Type of substances used
   - Frequency and amount of usage
   - How long the inmate has been using
   - Time of last use
   - Side effects experienced when ceasing use in the past

5. CCS evaluates prisoners/residents for signs and symptoms of withdrawal. Prisoners/residents who report alcohol and/or drug dependence or who are identified as being at risk for withdrawal received a more in-depth evaluation. CCS uses information from the receiving screening process to classify prisoners/residents as being in mild, moderate, or severe withdrawal. The healthcare staff member completing the receiving screening evaluates the prisoner/resident for the following withdrawal symptoms:
   - Anxiety and agitation
   - Disorientation
   - Visual and auditory disturbances
   - Nausea and headache
   - Tremors
   - Paroxysmal sweats
   - Elevated pulse, respiratory rate, and blood pressure

6. When the healthcare staff member determines a prisoner/resident is at risk for moderate to severe withdrawal, or if an prisoner/resident indicates a history of complications from past periods of abstinence, CCS will advise housing them in an infirmary cell. These prisoners/residents receive a more in-depth evaluation. CCS completes the evaluation using the Addiction Research Foundation Clinical Institute Withdrawal Assessment – Alcohol (CIWA-Ar) tool. The CIWA-Ar is a validated tool designed to assess severity of alcohol withdrawal.

The CIWA-Ar has been extensively researched and shown to be a viable tool for nursing staff in both emergency departments and community settings. It describes symptoms of alcohol withdrawal that are graded based on the nurse's observation of inmate behavior or on the prisoner's/resident's response to questioning.

Based on the information documented on the CIWA-Ar tool, the nurse classifies the prisoner/resident as being in mild, moderate, or severe alcohol withdrawal syndrome. Then, in accordance with the CIWA-Ar recommendations and physician's assessment, CCS establishes an individualized treatment plan of actions to be taken when specific criteria are met. Nursing staff will contact the physician on duty or on call when monitoring results are outside established parameters of mild withdrawal.

The treatment plan may also include prescribed pharmaceutical therapy, as indicated.

7. CCS establishes a physician treatment plan as soon as we assess the potential for withdrawal from alcohol or sedative-hypnotics. The treatment plan includes a benzodiazepine during the acute withdrawal period and then tapered off if there are no other indications. Because of the important variability both in the severity of the withdrawal symptoms and in metabolism of the therapeutic agents, it is difficult to establish standard or routine dosage schedules. Lower dosages might be anticipated in prisoners/residents with significant liver disease.

   Mild Detoxification – When possible, CCS houses prisoners/residents undergoing mild detoxification in an observation cell until the completion of detoxification.

   Moderate Detoxification – CCS houses prisoners/residents experiencing more advanced cases of detoxification under close watch.

   Severe Detoxification – Prisoners/residents diagnosed with delirium tremens (characterized by profound confusion, hallucinations, and severe autonomic nervous system over-activity) who cannot be safely managed in the corrections environment may need to be transferred to an inpatient setting; any hospitalizations will be by the order of the CCS Physician/Medical Director.

2.1.10 Interdisciplinary Treatment Team Meetings

CCS Mental Health staff will participate in the ITT meetings with our Medical Staff and any other mental health care partners, security, and other DDOC staff. CCS will also participate in additional assigned activities related to DDOC institutions as requested by the facility warden or designee, and the BCHS.

2.1.11 Monitoring Offenders Undergoing Withdrawal

CCS medical personnel routinely provide an evaluation of all offenders for substance abuse during intake screening. When medically indicated, a complete detoxification program is implemented to minimize the risk of adverse symptoms and the need for off-site detoxification treatment.. CCS medical staff provide supervision that is in compliance with DDOC Policy G-08 (Substance Abuse Treatment Protocol), NCCHC P-G-08, ACA 1-HC-1A-34, clinicial protocols and all applicable standards of treatment. A physician, mental health staff member or Substance Abuse counselor makes the assessment of chemical dependency and CCS. Medical and Mental Health personnel will work in collaboration with the Substance Abuse Treatment Providers in the referral process.

2.1.12 Psychiatric Close Observation (PCO)

In accordance with DDOC Policy G-05 (Suicide Prevention, Policies and Procedures), NCCHC P-G-05, P-E-02, J-E-02, P-E-05, J-E-0f, P-A-10, J-A-10 and ACA 4-4C-32 CCS Mental Health staff will provide special housing, monitoring based on the PCO Level assigned and daily assessment on all offenders who have been placed on psychiatric watch. Licensed Mental Health Staff will evaluate any offender identified as potentially suicidal within twenty-four (24) hours. All offenders identified as potentially suicidal are assigned a level of risk and are further evaluated by a Psychiatrist or Psychiatric Nurse Practitioner within twenty-four (24) hours. CCS understands that all PCO offenders are downgraded from levels by a Psychiatrist, PhD Psychologist or Psychiatric Nurse Practitioner. CCS will work with DDOC to establish a training program for the staff members that incorporates not only relevant knowledge for serving as crisis watch monitors but also relevant security practices within DDOC.

2.1.13 Segregation

When CCS staff members receive notification by DDOC security staff that an offender is placed in segregation, the offender's health record will be reviewed within one (1) hour of the notification for any medical, dental or behavioral health conditions. Medical staff will provide special accommodations to any offender with conditions to which segregated confinement would be contraindicated and will address emergent behavioral health issues at this time.

In accordance NCCHC P-E-09, ACA 4-4400 and DDOC Policy E-09 (Segregated Offenders), any segregated offenders who have been receiving treatment for a serious mental illness will be referred to our Mental Health Services team. CCS will complete a Mental Health Review of Disciplinary Charges form and provide a copy to the institutional hearing officer by the next business day.

CCS staff will evaluate segregated mental health patients at least three (3) days per week. All evaluations will be conducted in accordance with DDOC Policy E-09, paragraph 7. The CCS Mental Health Services team will evaluate segregated offenders who do not have a mental health condition on weekly basis, in accordance with DDOC Policy E-09, paragraph 8.

CCS will develop programs for segregated offenders which includes group and individual therapy.

2.1.14 Confidentiality/Exchange of Information

Per DDOC Policy H-02, health records will be kept confidential by CCS, and the CCS Health Services Administrator or Nurse Manager will control access to the health records. Our entire system is encrypted, and HIPAA-compliant. As the current Medical Services provider, CCS will ensure that mental health records and medical records are integrated and all records will be made readily accessible for any other DDOC health care partners.

2.1.15 Technical Assistance and Training

CCS will provide a mental health and suicide prevention focused educational curricula for DDOC staff. The program on Suicide Prevention will be reflective of CCS policy and procedure and the DDOC Suicide Intervention and Prevention Training Manual. Additional training will include Trauma Informed Care, Mental Health Awareness, Co-occurring disorders and other subjects that CCS and/or DDOC feel would be beneficial. CCS will submit all curricula to the Bureau Chief for approval at least 30 days in advance of training.

2.1.16 Resolution of Disputes

In all roles awarded under this contract, CCS will facilitate a cooperative environment for the resolution of problems and disputes among DDOC health care services partners.

2.1.17 Medical Peer Review and Continuous Quality Improvement

In accordance with NCCHC P-C-02, ACA 4-4411, and DDOC Policy C-02, CCS requires annual peer review of its Psychiatrists, nurse practitioners and Psychologists. However, in accordance with the RFP, CCS will conduct peer reviews quarterly as directed by the Bureau Chief. In addition, a clinical review is conducted within the first three months of employment. When significant opportunities for improvement are identified, the CCS Peer Reviewer will work with the practitioner to develop a Performance Improvement Plan. The peer review will then be scheduled for follow-up at a date that is reflective of the magnitude of improvements to be made by the practitioner. The CCS Peer Review Program falls under the CQIP and is described in more detail in **Section 2.6.8.**

2.1.18 Performance Measurement

Correct Care Solutions takes a proactive approach in measuring performance in process and health outcomes. In addition to examining key processes such as intake, sick call, medication management, and discharge and release planning, CCS uses NCQA's Healthcare Effectiveness Data Information Set (HEDIS) measures in order to compare mental health outcomes to the community performance. We support the perspective that CCS is one stop in the mental health continuum of care for our clients, and this assures we are providing care that is congruent with generally accepted professional standards and with care provided in the community. The following is a list of our CQI studies, with notations regarding the nature of the study (Process or Outcome):

- Psychiatry Services (P)
- Mental Health Receiving Screening (P)
- Mental Health Screening and Evaluation (P)

- Mental Health Special Needs (P)
- Mental Health Return from Hospital – HEDIS (O)
- Segregation (P)
- Mental Health Treatment Plan (P)
- Suicide Prevention (P)
- Depression – HEDIS (O)
- Discharge Planning (P)
- Release Planning (P)
- Emergency Involuntary Psychotropic Medication Administration (P)
- Therapeutic Restraints (P)

CCS will provide examples of our Mental Health CQI screening forms at the request of the DDOC and will hold services to the DDOC QA Metrics.

Reports

CCS mental health staff will assist with the tracking of mental health prescriptions so that appropriate reporting on all pharmaceuticals ordered can be provided to the DDOC. The CCS transition to automated physician order entry should result in the ability to provide comprehensive reporting and an expedited review of all pharmaceutical management.

Collaboration

CCS is currently the Medical Services provider for the DDOC. Our Medical Services and Mental Health teams will work collaboratively to collect and report data and develop indicators and reports for management and administrative purposes. Having CCS provide both medical and mental health services ensures that all processes and data collection methods are standardized. This has the potential to result in more accurate and consistent data reporting than the DDOC would receive with multiple vendors.

2.1.19 NCCHC/ACA Accreditation

CCS has developed a mental health program for the DDOC that is in accordance with ACA and NCCHC standards. Please see **Section 2.5.28** for information regarding our NCCHC and ACA Accreditation experience.

2.1.20 Case Management of Delaware Psychiatric Center (DPC) Offenders

At the DPC, CCS will monitor the status of offenders daily. CCS will share daily reports for offenders in individual facilities with the primary care provider, facility manager responsible for on-site continuity of care, and DDOC staff designated by the DDOC Bureau Chief.

CCS will provide a daily physician-to-physician report on all hospitalized offenders to BCHS Medical Director as follows:

- Statewide system summary information will be sent to the Bureau Chief and DDOC Medical Director daily
- Connection will be made and kept with the hospital's utilization managers/discharge planners such that discharges can be arranged as soon as possible;
- Discharge summary information including offender instructions will be obtained at discharge and shared with the offender's facility health care staff such that appropriate care can be continued on-site
- Coordination and cooperation with the Utilization Review Services Vendor

2.2 Substance Abuse Programming

CCS has interviewed multiple substance abuse treatment providers in order to determine which company is best qualified to serve the DDOC as the CCS subcontractor. Through our interviews, CCS has selected Community Education Centers (CEC) as our subcontractor for Substance Abuse and DUI programming within the DDOC.

2.2.1 About Community Education Centers

Community Education Centers (CEC) has been providing correctional treatment for over 16 years to criminal justice populations through collaborative partnerships with federal, state and local agencies. Since its founding in 1996, CEC has worked closely with these contracting entities to meet the rehabilitative needs of drug-involved offenders.

Headquartered in West Caldwell, New Jersey, CEC operates in 18 states as well as the Commonwealth of Bermuda, employing more than 3,500 individuals and serving more than 210,000 offenders. CEC is the ***largest provider of reentry and in-prison treatment services in the United States.***

In this context and environment, CEC successfully manages substance abuse treatment and offender intervention programs with censuses ranging from 18 to 1,150 offenders. The programs operate within a wide range of state-operated institutions, including maximum, medium and minimum security, administrative segregation, community corrections, work release, day reporting and intake/assessment units. The in-prison and residential reentry programs that CEC operates on behalf of state, federal, and county agencies are recognized for both reducing recidivism and providing valuable alternatives to more expensive forms of incarceration. The broad range of services offered is grounded in our

The CEC Mission

To provide a healthy, drug-free, safe, and secure environment within which staff provides treatment services for offenders that focus on changing addictive and criminal behaviors. We provide the knowledge and skills necessary to lead a productive life-style prior to reintegration into society.

organizational mission and are well-aligned with the professional services request, and consistent with the mission of Delaware Department of Correction.

CEC presently operates in-prison TC and community-based reentry services for drug-involved offenders comparable to Delaware's in-prison programs in Texas, Illinois, Virginia, New Jersey, South Carolina, Florida, Oregon, Colorado, Wyoming, New Mexico, South Dakota, California and Bermuda – within both Company-owned and State-owned facilities. CEC's customers range from Federal Bureau of Prisons, National Governments (Bermuda), state agencies (Departments of Corrections and Health and Social Services) and county governments. At all levels, our relationship to our contracting agencies is anchored in our core values of loyalty to contracted stakeholders, dedication to meeting the needs of the population served, responsiveness to required facility level adaptations and commitment to integrity with respect to contractual obligations.

Comparable CEC Programs

CEC operates several programs that are comparable to the services requested by the Delaware Department of Correction the include:

Southwestern Illinois Correctional Center (SWICC) – East St. Louis, Illinois

CEC has been providing services to 671 adult males at SWICC since October 1, 2006 and has maintained DASA accreditation during the duration of its contract with the Illinois Department of Corrections. Within the context of the modified therapeutic community model, CEC has developed a dedicated methamphetamine recovery unit targeting the specific etiology of methamphetamine abuse using a groundbreaking clinical design to treat the unique needs of these residents. The success of the design was featured in a 2010 Corrections Today article entitled, Designing a National Meth Model authored by CEC's Director of Treatment Operations, Ed Roberts along with Dr. Richard Rawson developer of the "Matrix Model"; an advanced methamphetamine-specific curriculum adopted for use within the CEC's in-prison TC at SWICC.

Indian Creek Correctional Center (ICCC) – Chesapeake, Virginia

ICCC is a 984 bed, treatment dedicated facility. CEC was awarded the contract to provide a "cognitive" Therapeutic Community according to the Virginia DOC's preferred TC model in August, 2004. In August of 2011, CEC in partnership with the host facility was awarded ACA accreditation and achieved a score of 100% on all mandatory ACA TC Performance Based Standards.

In response to the high numbers of incarcerated military veterans in the Tidewater area of Virginia, in March of 2012 CEC adapted one of the 84 bed treatment units into one of the nation's first in-prison therapeutic communities responsive to the treatment needs of our nation's incarcerated veterans. Using tools, competencies and measures for participant progress at each phase of the treatment continuum, CEC is in process of pioneering another national model exemplary of its capacity for designing programs specific to the needs of the population served as well as the distinct characteristics and culture of a host facility. In addition to the veteran's unit, CEC also operates a 24 bed Intensive Training Unit within the TC aimed at addressing offenders scoring with "high hostility" and "low desire for change" using Texas Christian

University (TCU) assessment instruments and TCU treatment system curriculum providing state of the art evidenced based services to approximately 50 youthful offenders housed on the compound and integrated within the existing TC.

Leath Correctional Institution – Women's Recovery Academy, Greenwood, South Carolina
The Women's Recovery Academy (WRA) was established in July 2005 and provides residential therapeutic community services to 96 adult female offenders referred through the South Carolina Department of Corrections. CEC staff delivers 18 hours of direct service per week built upon specialized, trauma-informed curricula developed by CEC tailored to address the unique treatment issues of female offenders while integrating social learning principles of the classical TC model. WRA's program's design provides a "sanctuary" of safety and support for the women of Leath; providing them with the opportunity to acquire knowledge, rehearse skills and develop attitudes of resiliency and improved self-esteem necessary for them to successfully integrate back into the mainstream of society.

CEC References

References and contact information for institutions and government agencies are listed in the table below. These CEC contracts are for the provision of in-prison treatment programs comparable to those requested in the Delaware RFP.

Location Detail	Modality / Contract Reference	Capacity
The Right Living House 29 Ferry Road Ferry Reach St. Georges, GE, Bermuda	In-prison Therapeutic Community Reference information: Joanne Dean Director Bermuda Department for National Drug Control Suite 304 Melbourne House 11 Parliament Street Hamilton, Bermuda HM 12 (441) 292-3049	20 beds
SAT Program ("Modality 1") at Mayo Correctional Institution 8784 US Highway 27 W Mayo, FL	Modality 1: Intensive Outpatient services of four-to-six (4-6) months-duration, licensed through DCYF Reference information: Kim Riley Chief, Bureau of Substance Abuse and Treatment Services Florida Dept. of Corrections 501 Calhoun St Tallahassee, FL 32399-2500 (850)-717-3051 Fax (850) 922-0847 riley.kim@mail.dc.state.fl.us	110 beds
Everglades Correctional Institution 1601 SW 187th Avenue Miami, Florida		110 beds
Hernando Correctional Institution for Women 16415 Spring Hill Drive Brooksville, Florida		60 beds (prev. 70)
Okeechobee Correctional Institution 3420 NE 168th Street Okeechobee, Florida		110 beds

Location Detail	Modality / Contract Reference	Capacity
Taylor Correctional Institution 8501 Hampton Springs Road Perry, Florida		85 beds
Hollywood Transition Work Release Center 8501 W. Cypress Drive Pembroke Pines, Florida	Therapeutic Community/ Transition Re-entry Program Reference information: Kim Riley Chief, Bureau of Substance Abuse and Treatment Services Florida Dept. of Corrections 501 Calhoun St Tallahassee, FL 32399-2500 (850)-717-3051 Fax (850) 922-0847 riley.kim@mail.dc.state.fl.us	121 beds (female)
Sago Palm Re-Entry Center 500 Baybottom Road Pahokee, Florida	•Modality I: Reentry treatment services that include individual assessments, individual and group counseling, and substance abuse. Treatment services also include relapse prevention, interactive skill-based training, educational services, and alumni services Reference information: Kim Riley Chief, Bureau of Substance Abuse and Treatment Services Florida Dept. of Corrections 501 Calhoun St Tallahassee, FL 32399-2500 (850)-717-3051 Fax (850) 922-0847 riley.kim@mail.dc.state.fl.us	85 beds (male)
IYC Harrisburg Harrisburg, Illinois	In-prison Therapeutic Community (including specialized 200-bed Unit for Methamphetamine Addiction at SWICC) Reference information: John N Nunley Statewide Manager of Addiction Recovery Management NRC Stateville CC (815) 727-3607 john.nunley@doc.illinois.gov	64 beds
IYC Pere Marquette Grafton, Illinois		40 beds
Jacksonville Correctional Center Jacksonville , Illinois		80 beds
John A. Graham Correctional Center Hillsboro, Illinois		160 beds
Logan Correctional Center Lincoln, Illinois		64 beds
Taylorville Correctional Center Taylorvill, IL		120 beds

Location Detail	Modality / Contract Reference	Capacity
Southwestern Illinois Correctional Center (Fully Dedicated Drug Treatment Prison) East St. Louis, Illinois		671 beds
SCI Albion (Albion, Pennsylvania)	Pennsylvania Outpatient In Prison Programs Reference information: Terri Somers 2520 Lisburn Road, P.O. Box 598 Camp Hill, PA 17001-0598 (717) 728-2000	210 beds
SCI Greensburg (Greensburg, PA)		210 beds
SCI Laurel Highlands, (Somerset, PA)		420 beds
SCI Mercer (Mercer, PA)		210
SCI Retreat (Hunlock Creek, PA)		210
SCI Rockview (Bellefonte, PA)		210
SCI-Muncy (Muncy, PA)		150 beds
Chester County Prison West Chester, PA		99 beds
Northampton County Prison Easton, PA	In-Prison Therapeutic Community with startup of DUI, Delinquent Child Support intervention and 18 bed female TC anticipated June 2012 Reference information: Michael Bateman, Assistant Warden Northampton County Prison 666 Walnut Street Easton, PA 18042 610-923-4338	64 beds
Deer Ridge Correctional Inst. ("DRCI") 3920 Ashwood Road Madras, Oregon 97741	Reference information: Paul A. Billeci Addictions Treatment & Cognitive Services Manager Oregon Department of Corrections Transitional Services Division 1793 13th Street, SE Salem, Oregon 97302-2595 Paul.A.Billeci@doc.state.or.us	106
Indian Creek Correctional Center 801 Sanderson Road Chesapeake, VA	Reference information: Jean Mottley, Program Analyst Virginia Department of Corrections 6900 Atmore Drive Richmond VA 23225 PHONE: (804) 674-3296 x 1045 E-Mail: MottleyEL@vadoc.state.va.us	984 beds

Location Detail	Modality / Contract Reference	Capacity
Turbeville Correctional Institution Turbeville, SC	In-Prison Therapeutic Community Programming including a Correctional Recovery Program Reference information: N. Dayne Haile South Carolina Department of Corrections Office of General Counsel Post Office Box 21787 4444 Broad River Road Columbia, South Carolina 29210 (803)896-2380 (Office) (803)896-1766 (Fax)	272 beds
Leath Correctional Institution Greenwood, SC	In-Prison Therapeutic Community Treatment Program for Women	96 beds
Walker Sayle SAFPF Brekinridge, TX	In-Prison Therapeutic Community Reference information: Madeline Ortiz Director of Rehabilitative Programs Division Texas Department of Criminal Justice 936-437-2180 madeline.ortiz@DDOC.state.tx.us	632 beds
Halbert SAFPF Burnet, TX		612 beds
Glossbrenner SAFPF San Diego, TX		612 beds
Kyle IPTC Kyle, TX		520 beds
Correctional Training Facility, Hwy 101 North Soledad CA, 93960	Reference information: Steve Hedrick, Chief CDCR / Office of Offender Services 1515 S Street Suite 410 South Sacramento, CA 95814 steve.hedrick@cdcr.ca.gov	150 beds
Substance Abuse Treatment Program California Rehabilitation Center 5th Street & Western Norco, CA		225 beds
Substance Abuse Treatment (SAT) Program California Men's Colony (CMC) Highway 1 San Luis Obispo, CA		150 beds

2.2.2 Substance Abuse Treatment Services

CCS and CEC acknowledge and accept the Department's needs to provide substance abuse treatment services in the following programs in Delaware:

Program	Location
Key North	Howard R. Young Correctional Institution (HRYCI), Wilmington, DE
Key Village	Baylor Women Correctional Institution (BWCI), New Castle, DE
Key South	Sussex Correctional Institution (SCI), Georgetown, DE
Crest North	Webb Community Correctional Center (WCCC), Wilmington, DE
Crest North	Hazel D. Plant Women's Treatment Facility (HDPWTF), New Castle, DE
Crest Primary	Central Violation of Probation Center (CVOP), Smyrna, DE
Crest Central	Morris Community Correctional Center (MCCC), Dover, DE
Crest South	Sussex Community Correctional Center (SCCC), Georgetown, DE
6 for 1 for Men	Institution (HRYCI), Wilmington, DE
6 for 1 for Women	Baylor Women Correctional Institution (BWCI), New Castle, DE
YCOP	Howard R. Young Correctional Institution (HRYCI), Wilmington, DE
Boot Camp	Sussex Correctional Institution (SCI), Georgetown, DE
Aftercare (Including Boot Camp)	WCCC, HDPWTF, MCCC, SCCC
DUI Programming	Level TBD
	Baylor Women Correctional Institution (BWCI), New Castle, DE

The Key-Crest-Aftercare programs established and developed by the Delaware Department of Correction over the past twenty plus years has long been acknowledged as a national model, producing consistent results and serving as a resource for researchers, state and federal correctional administrators and service providers.

CCS and CEC propose to continue with best practices established by the Delaware Department of Correction, and to make ongoing contributions to the model's effectiveness and efficiency. The specific proposals for modifications and research-validated enhancements are detailed throughout this response and are aimed at integrating tradition with contemporary evidenced-informed innovations:

- Traditional practices with proven effectiveness (e.g., the social learning model and essential elements that defines the therapeutic community) with enhancements modeled on continuing research derived from "what works" innovations;
- Introduction of a framework to be used as a guide for the proposed development and implementation of an integrated treatment approach for co-occurring disorders in the DDOC Therapeutic Community programs.

The Delaware substance abuse programs represent a complex network of interrelated services characterized by several points of entry, multiple referral sources and a continuum of services spread across the state's correctional facilities. CCS and CEC acknowledge the complexity of the Delaware system, understand it, and are looking forward to the opportunity to not only comply with the RFP requirements for Substance Abuse and DUI programming, but also to work collaboratively with BCHS to further enhance and better manage DDOC substance abuse treatment services.

CEC's proposed State Director, Jim Elder MS, LCDP, CADC and the proposed Deputy State Director, Laura Sikora M.S.W., ICADC, ICCS, ICCDPD offer a combined 25 years of experience working within Delaware's Key-Crest-Aftercare, Six for One and Boot Camp substance abuse service delivery systems. This practical working knowledge of DDOC treatment programs along with the company's extensive experience as a provider of correctional substance abuse treatment, make CEC well positioned to meet the Department's substance abuse treatment requirements.

CCS and CEC understand, accept and acknowledge our obligation to the delivery of the services detailed in the RFP and proposed in this response. CCS and CEC further acknowledge that any request for a change in capacity or service type is to be specified in writing and approved in advance by the DDOC.

Treatment Bed Utilization

CCS and CEC understand that maintaining utilization of substance abuse treatment beds in a correctional setting is imperative and that failure to do so results in facility management challenges that extend beyond the substance abuse contract. CCS and CEC are committed to creating a treatment "culture" within programs that maximizes their therapeutic nature and decreases offenders' commonly held perception that "treatment" equates with punishment. In addition to creation of a therapeutic setting, it is equally important to accurately identify appropriate offenders for placement in substance abuse programs. CCS and CEC intend to accomplish this through proactive coordination with DDOC classification and the two-step recruitment and selection process described in **Section 2.2.5, Referral Process.**

Since maximizing treatment bed utilization is a priority, CCS and CEC will establish a statewide Case Flow Manager. Recruitment of potential program participants, implementation of waiting list management protocols and maximization of treatment bed utilization are proposed as the primary functions of this position. To facilitate the recruitment of potential candidates, this position will maintain a database to help roster wait-listed offenders and to inform placement decisions. This information will be backed up by DDOC's master list of offenders classified or court-ordered into treatment. The recruitment log data will be categorized by TC program and by referral source. System capacity as a whole will be analyzed and used for maximum efficiency.

CCS and CEC acknowledge responsibility for recruitment and for keeping treatment beds filled with appropriate offenders. Additionally, CCS and CEC understand and accept that monetary penalties may be imposed by the DDOC for failure to maintain a full census at each substance abuse program site.

2.2.3 Program Description

CEC's proposed "adapted" approach rests upon the foundation of the synthesis of three critical elements:

- Therapeutic Community
- Cognitive Behavioral Interventions
- Enhancing Intrinsic Motivation

Therapeutic Community

The widespread and sometimes indiscriminate use of the term "Therapeutic Community" underscores the importance to define the TC approach and to describe the basic components of the TC program model.

The term Therapeutic Community has come to represent a distinct approach applicable in almost any setting with almost any population. In recent years, TC models have been increasingly adapted for incarcerated substance abusers in prison settings. Overcrowded prisons, the influx of drug offenders, and the documented success of TC prison models in reducing recidivism and relapse have fostered this development.

CCS and CEC understand the modifications of the traditional TC model are increasingly shaped by the unique features of the individual correctional institution, the prison culture itself and the growing numbers of offenders with a wide range of special needs such as co-occurring disorders. However, to maintain TC program integrity, CCS and CEC believe that the core components of the model and the Essential Ingredients of using Community as *the* Method must be preserved and intentionally woven into the fabric of program design.

The following are the applied, basic elements of a TC program regardless of whether it is adapted to a prison setting, community corrections, female offenders, intensive outpatient programs or other special needs populations[1]:

Community Separateness	TC-oriented programs have their own names, often created by the clients. They are housed in a space or locale that is separate from other agency or institutional programs or units; and are generally as removed as possible from the drug-related environment.
Community Environment	The inner environment contains communal space to promote a sense of commonality and to facilitate collective activities such as group meetings. The walls display signs that state in simple terms the philosophy of the programs and the message of right living and recovery. Structure Boards identify all participants by name, seniority level and job function in the programs, and daily schedules are posted. These visuals display a "culturally compatible" organizational picture of the program that individual participants can relate to and understand, thus promoting affiliation.

[1] Adapted by CEC from Therapeutic Community: Theory and Research video featuring George De Leon, Ph.D., 1998 and ATTC Facilitator Guide, CSAT Item # M07 Version 10-99, 1999 p. 19-23

Community Activities	To be effectively utilized, treatment or educational services must be provided within a context of the peer community. With the exception of individual counseling, all activities are programmed in group formats. Ideally, these include at least one daily meal prepared, served and shared by all members; a daily schedule of group meetings and seminars; departmental job functions; organized recreational and leisure time, and ceremonies or rituals such as birthdays, phase graduations and events honoring cultural heritages.
Peers as Community Members	Members who demonstrate the expected behaviors and reflect the values and teachings of the community are viewed as role models. Indeed the strength of the community as a context for social learning is directly related to the number and quality of its peer role models. All members of the community are expected to be role models. TCs require these multiple role models to maintain the integrity of the community and assure the spread of pro-social learning effects.
Staff as Community Members	The staff is a mix of recovered professionals and other traditional professionals such as correctional, mental health, medical and educational professionals. It is essential for them to be integrated through cross training that is grounded in the basic concepts of TC perspective and community approach. While their professional skills will define their staff function as nurse, correctional officer, or mental health therapist, it is essential that they understand that their generic role as "staff" is now that of "community member". They are not providers or treatment specialists, but rather they are rational authorities, role models, facilitators and guides in the self-help community method.
A Structured Day	Regardless of its length, the day has a formal schedule of varied therapeutic and educational activities with prescribed formats, fixed times, and routine procedures. The structured routine helps to distract TC clients from negative thinking, boredom and other factors associated with drug use.
Phase Format	The treatment protocol or plan of therapeutic and educational activities is organized into phases that reflect a developmental view of the change process. Emphasis is placed on incremental learning at each phase, to prepare the individual for movement to the next stage of recovery and promote internalization of change.

Work as Therapy and Education	Consistent with the TCs self-help approach, all clients are responsible for the daily management of the facility which includes cleaning, activities, meal preparation, maintenance, coordinating schedules, meetings, and so on. In the TC, the various work roles help bring about essential educational and therapeutic effects – "work as therapy."
TC Concepts	There is an organized curricula focused on teaching the TC perspective, particularly its self-help recovery concepts and view of right living. The concepts, messages and lessons of the curriculum are repeated in the various groups, meetings, seminars, and peer conversations as well as in readings, signs, and personal writings. CEC's curricula target those dynamic criminogenic risk factors known to be predictive of future criminality.
Peer Encounter Groups	The encounter group is the main therapeutic group, although other forms of therapeutic, educational and support groups are used as needed. The basic objective of the encounter group in any TC is to heighten individual awareness of specific attitudes or behavioral patterns they need to work on changing. However, depending on the type of TC, the Encounter Group process' level of staff direction and intensity may vary. The Encounter process involves the balanced use of both "evocative" and "provocative" tools. Provocative tools are designed to challenge and highlight discrepancy between individual behaviors and attitudes against the backdrop of the communities' shared values of recovery and right living; while evocative tools are aimed at support, encouragement, and reinforcement of observed pro-social changes. Residents in CEC TCs are provided ample opportunity to learn and rehearse these skills with direction, instruction and guidance from staff to help them avoid "drift" from the purpose of this important element of the program.
Awareness Training	All therapeutic and educational interventions involve raising the individual's consciousness (awareness) of the impact of his or her conduct and attitudes on the social environment. And, conversely, it involves increasing their awareness of the impact of the behaviors and attitudes of others on themselves in the social environment. That is, the community becomes a "mirror" in which residents see themselves as "members" of a change-dedicated community.
Emotional Growth Training	Achieving the goals of personal growth and socialization involves teaching individuals how to constructively and appropriately identify, express and manage feelings to assist them in meeting the interpersonal and social demands of life in the community.

Planned Duration of Treatment	An individual's length of stay depends on their stage of internalized change and recovery engagement. However, a minimum period of intensive involvement is required to assure internalization of the TC teachings. The optimal lengths of time for full program involvement must be consistent with TC goals of recovery and the associated developmental view of the change process.
Continuance of Recovery	Completion of primary treatment is a stage in the recovery process. Regardless of whether aftercare is implemented within the boundaries of the main program or separately, the perspective and approach guiding aftercare must be continuous and consistent with that of primary treatment in the TC. For this reason, CEC extends TC – oriented treatment approaches to program completers as they participate in aftercare.

Cognitive Behavioral Interventions

While adhering to "…an explicit theoretical framework…which defines, conceptualizes and illustrates the basics of the TC" (DeLeon, 2000), CCS and CEC propose modifications that maintain essential TC elements while better supporting the Department in managing the diverse needs of Delaware's correctional offender population.

Founded on the principles of evidence-based best practices and the social learning context, the CEC adapted TC incorporates cognitive-behavioral principles designed to promote a recovery lifestyle, individual accountability, social responsibility, and self-reliance. The complementary blending of evidence-based methods targets specific dynamic criminogenic risk factors in accordance with Risk, Need and Responsivity principles. The CEC adapted TC is "engineered" within a "culture of community" to prepare offenders for a successful reintegration into the broader "free world" community. CEC's treatment model is built upon a stage-wise, core curriculum targeting specific phases of treatment. It is governed by standards of practice and regulated by quality assurance protocols.

Each curriculum session has a standardized format. It begins with a rationale section in which the scope, breadth, and reason for teaching the lesson are provided. After the key points of the lesson are outlined, an introductory summary of concepts and definitions are offered along with an explanation of the lesson objectives. Once these preparatory steps have been completed, the major activities of the session begin and role plays are facilitated by staff. Each session concludes with a summary of the material covered and homework is assigned to reinforce learning.

CEC's cognitive behavioral curricula focus upon two discreet targets:

- Skills acquisition - *practical life skills acquired through training and rehearsal*
- Cognitive restructuring – *methods used to identify and correct criminal thinking patterns*

Cognitive Behavior methods have evolved over the last 30 years, impacted by a variety of theoreticians and practitioners. Much of the seminal work in cognitive interventions began with the efforts of Aron Beck (1970's), Ross and Fabiano (1980's), Albert Ellis (1970's), and Bush (1990's). Almost at the same time, and parallel to the development of the Cognitive Restructuring modalities, a number of social scientists were also exploring Cognitive Skills training, as a form of psycho-social-emotional interventions. Such individuals as Bandura (1970's), Meichenbaum (1980's) Goldstein and Glick (1980's), and Taymans (1990's) developed strategies and curricula to teach skills to skill deficit individuals. These early pioneers set the foundation and established benchmarks for the development of CEC's cognitive behavioral curricula proposed for implementation in Delaware.

Within the context of the broader therapeutic culture, the CEC treatment approach deploys various interventions based on a cognitive-behavioral modality. In addition to the focus on attitudes, beliefs, and other cognitive processes, these interventions include a behavioral component. Residents are taught the skills needed to identify and correct the attitudes and thoughts that have proven disadvantageous to them and society.

Once learned, residents are encouraged to apply these skills to everyday situations in the TC's "microcosm" (mini-society). In time and through a sufficient treatment "dose", that which is ***learned***, becomes ***lived*** (internalized); thereby better preparing residents for meeting the challenges of reentering society following a period of incarceration. As a result of ongoing independent research regarding "what works" with the offender population it is becoming increasingly apparent that criminal behavior is more susceptible to pro-social change when offenders learn to intermingle and use tools from both cognitive restructuring and cognitive skills acquisition oriented programs. CEC proposes to synthesize the concepts and tools from these two programmatic approaches into one completely integrated, seamless service delivery system. More specifically, the use of the following curriculum sessions is proposed for use in the Delaware programs as a research-informed, comprehensive and integrated cognitive behavioral curriculum:

Core Skills: *Cognitive behavioral sessions aimed at acquiring basic skills sets (building blocks) for behavior change, encouraging Compliance and Conformity to the norms and values of the TC.*

Many participants entering the program will lack the communication skills necessary to fulfill even the most basic TC roles. CEC's TC model enhances these critical skills by requiring attendance at communication skill-building groups (Core Skills groups) from the first week and while in the Orientation phase of program. Core Skills prepare the new participant for the authentic communication and peer interactions expected of TC members, and include techniques for Affirming, Asserting, Self-Listening, Tension –Sensing and Focusing. Core Skills groups provide a forum for communication skills specific to successful TC participation to be internalized and ritualized quickly, increasing participants' initial familiarity with TC argot. Core Skills enhance the integrity of the community as a whole by encouraging initial conformity and preparation for problem solving, decision making and higher level skills expected in subsequent program phases. Following is a sampling of some of the Core Skills sessions offered:

AFFIRMING	Simple positive statements – such as, "I can learn to succeed" – that you teach your habit self in order to re-shape it and build inner strength.
ASSERTING	Stating your point respectfully and constructively so that it is most likely to be heard and dealt with fairly.
BRAIN-STORMING	Coming up with lots of possibilities and choices, instead of just one or two, for any problem or course of action.
CALMING	Simple techniques you can use on the spot to calm you down when you need quick relief and time to think; for example, mindful breathing or the serenity prayer.
FOCUSING	Pulling your attention and energies back onto a task when they seem to wander, being able to keep up your efforts when things get tough.
FORECASTING	Thinking through what is likely to happen as a consequence of some action in order to choose the best action to take.

Principles of Recovery (PORs): *PORs Are simple precepts for daily living, each forming the topical basis for a cognitive restructuring group session.*
The "Principles" help to define pro-social norms which have universal applicability. They are introduced early in Phase II, then applied and elaborated throughout the full program in numerous ways. Each POR session is delivered into two sections; Cognitive and Behavioral. 50% of the group's time is spent on the cognitive section, and the 50% on behavioral skill practice. POR sessions include:

- Step Slow and Steady
- Your Dangerous Situations
- Stick to Your Structure
- Truthful Living
- Learn by Practice
- Avoid Your Triggers
- Be A Member
- Make the Moment Count
- Remember the Past
- Nourish Your Inner Self
- Peer Support
- Put Recovery First
- Trust the Truth
- Respect Life

Correctional Recovery Training (CRTs): *Aimed at training offenders to better cope with the important life challenges they are likely to face by replacing impulsive and criminal reactions with pro-deliberate, pro-social, and pro-sober responses driven by skills sets previously acquired and practiced in earlier phases of the TC.*

Once we have provided the building blocks for cognitive behavioral change to the residents in our programs, we expect them to move into an "action mode" demonstrating a commitment to the developmental change process. This is the cognitive behavioral movement they make from Phase 2 to Phase 3: they are moving from learning and adjusting their behaviors to the ***rules*** to identifying and accepting a ***role*** within the community.

TC residents now need to demonstrate what they have learned by putting it into action within the community. And, while it is possible in the early stages of our programs to practice Core Skills, Principles of Recovery, and begin to recognize and acknowledge Negative Habit Self Behaviors, preparation for "right living" demands that there be a greater level of coordination of these

concepts to put into practice. The CRT sessions are the venue in which residents can develop a more complex integration of the various skillsets that they have acquired. Where the focus of previous skill development sessions was concept driven, the CRT's are scenario based, emphasizing the move from an idea to an action.

CRT's presuppose a knowledge of other program concepts; Thinking Errors & Negative Habit Self Behaviors, Core Skills, and Principles of Recovery covered in early phases of treatment, therefore appear in latter parts of Phase 2 and in Phase 3 after these other components have been delivered and residents tested as to measure their understanding.

CRTs are grouped into the following categories with multiple topics within each:

- General Life Skills
- Anger Management
- Specific Life Skills ((Work & Family)
- Relapse Prevention
- Spirituality
- Responsible Living

Enhancing Intrinsic Motivation

An essential premise of CEC's treatment philosophy is that the motivation to change must eventually come from within, if it is to be sustained. That is, the treatment process must induce a commitment to ongoing identity and lifestyle change on the part of the individual.

The majority of residents served by our programs are motivated to participate in treatment primarily by external factors—namely to receive early release from prison, or to avoid re-incarceration. Although there is a therapeutic benefit to 'acting as if' one has adopted a pro-recovery value system, this benefit will be short-lived without the development of a deeper understanding of the dynamics and benefits of making a commitment to such a value system. Attempts to simply coerce residents to comply with the staff's agenda are likely to elicit counterarguments, either overtly or covertly.

Principles of Motivational Enhancement

The CEC treatment philosophy incorporates an understanding of motivational enhancement strategies such as motivational interviewing and the use of peers as role models to enhance engagement in programming. Recognition and rewards are also used to foster greater intrinsic motivation for recovery and change. These interventions are more than just a set of techniques or strategies. They are key components of the treatment philosophy and framework that guides CEC's treatment approach.

While not the "end all, be all" of the CEC approach, the motivational interviewing framework of – express empathy, develop discrepancy, roll with resistance, and support self-efficacy – guide counselor involvement in individual, group and community interactions, and is consistent with the spirit of CEC's treatment approach.

The expression of empathy plays a crucial role in facilitating positive change. When a resident feels understood and genuinely listened to, he/she is more open and honest during individual and group counseling sessions and more willing to explore ambivalence about change. Therefore, it

is imperative that all staff demonstrate a basic capacity to understand a resident's feelings and point-of-view without expressing criticism or passing judgment. For example, when interacting with a resident who expects immediate gratification, a counselor can validate the resident's perception of urgency while also providing a clear directive of the expected behavior. This response serves to both deescalate an agitated resident and to communicate concern for the resident's needs without conceding that these needs supersede the orderly operation of the program.

More focused efforts to promote the expression of empathy take place during clinical activities. To encourage open and honest discourse in individual and group counseling sessions, CEC counselors are trained to avoid passing judgment and instead focus on validating the resident's needs and thereby encourage them to validate and respect the needs of the peer community. For example, if a resident expresses a desire to use drugs in moderation despite a long history of serious substance abuse problems, the clinical focus should be on the resident's ambivalence regarding the preferred need to be abstinent. Specifically, a counselor might say to the resident, "I understand that you wish you could use drugs and still be okay." This statement encourages open and honest dialog, which helps the counselor gain a better understanding of the resident's specific treatment needs. Moreover, this approach avoids the risk that residents will share only what they think their counselor wants to hear.

"Therapeutic" or constructive confrontation is; however, a key component of CEC's treatment model and should be viewed as a goal, rather than as a technique. That is, the counselor's goal is to develop discrepancy between what the resident says juxtaposed against what their attitudes and behaviors display. As a follow-up to the earlier example, the resident who expresses a desire to use drugs in moderation is questioned about his/her past attempts at using in moderation. This gives the resident the opportunity to face the discrepancy between a 'desire to use moderately' (considering a long history of problem use) and a desire to hold a job, be a positive family member, or stay out of jail.

Developing discrepancy is frequently met with habituated resistance from residents. When this happens, it is important for the counselor to be mindful of this process and to avoid the temptation to argue or debate with the resident or attempt to 'bust-through' the resident's denial or 'break the resident down.' Confrontation as an 'in-your-face' technique is not supported by the treatment literature as an effective method to bring about attitude or behavior change (Miller, Benefield, & Tonigan, 1993; Moos, 2005). In contrast, the tempered and deliberate use of advanced confrontation techniques that highlight discrepancy have been shown to be effective. An impassioned appeal motivated by "responsible concern" from a peer and/or well-respected staff person, can have a profound impact on the resistant resident's ambivalence about considering a need to make a change in their life.

The third principle, 'roll with resistance,' admittedly represents a constant challenge for the CEC counselor but, when embraced, provides clarity and a sense of peace. The process of arguing with a client is not only counterproductive to the goal of behavior change but also results in staff frustration. Ultimately, the resident must commit to a new way of thinking and interacting with the world and a counselor arguing with the resident will only serve to reinforce negative behaviors. Acceptance by the treatment staff that there could be resistance frees up energy to

focus on the real issue at hand. Ultimately, the goal is for the counselor to assist the resident in finding his/her motivation to change and to nurture this motivation by collaborating with the resident on a specific, measurable, and realistic plan of action.

The fourth principle of motivational interviewing is the need to support self-efficacy. Self-efficacy is a person's belief that they can successfully complete a task and is a key factor in promoting and maintaining motivation to change. This is particularly true since motivation, like hope, is a dynamic variable that fluctuates over the course of treatment.

A cornerstone of the CEC treatment model is the belief that every resident must change if they are to successfully re-enter the broader community and each has the inherent capacity to become a positive and productive citizen. Although CEC counselors believe in a resident's capacity to change, the resident may not. Therefore, built within the context of individual, group, and peer support sessions are opportunities to reaffirm the individual's ability for self-improvement.

Stages of Change

The integration of the transtheoretical stages of change model within the context of motivational interviewing has been documented as an effective way to address criminal and addictive behaviors (Prochaska, DiClemente, & Norcross, 1992). The CEC treatment model draws on the five stages of change: ***Precontemplation, Contemplation, Preparation, Action,*** and ***Maintenance***, as described by Prochaska and colleagues in the transtheoretical model. CEC counselors share what is known about the change process with residents in the context of involving them in this process. Residents are encouraged to share when they feel they do not need to change. The affirmation of the resident's viewpoint is not a sign of agreement, but rather a validation of the resident's opinion. Once the counselor has identified where the resident is within the stages of change model, he/she can determine the optimal therapeutic/educative interventions for moving the resident forward towards change.

Residents in the ***Precontemplation*** stage do not recognize that they have a problem. During this stage, it is critical to assess whether the resident agrees that the behavior that brought him/her to treatment requires changing. This is particularly true for residents in involuntary treatment programs. As might be expected, residents are often firmly entrenched in the precontemplation stage and may be viewed by the untrained counselor as treatment resistant or oppositional. Once the counselor recognizes that the resident is ambivalent and residing in the precontemplation stage of change, he/she can utilize motivational enhancement to meet the resident at their frame of reference, thus improving the likelihood of treatment gains.

In the ***Contemplation*** stage, a resident is aware that he/she has a problem and is considering the need for a change. Given the salience of the disadvantages of their pattern of behavior (e.g., the current incarceration), some residents may be able to recognize that they have a problem and acknowledge a desire to change, but lack the ability to take action. Staff may view a resident as highly motivated because he/she will admit to a problem and express a desire to change. However, the transition from contemplation to action is challenging, so the treatment focus for residents at this stage is to nurture this motivation towards taking concrete steps towards change.

In the ***Preparation*** stage, a resident has an intention to change but may lack the necessary knowledge and/or skills. It is at this stage that a real strength of the CCS and CEC treatment model is evident. CEC's programs provide therapeutic interventions that help prepare residents for growth and change. Structured curricula serve to educate residents about addiction, interpersonal skills, problem solving, anger management, and domestic violence, to name a few. Most important, CEC's programs provide opportunities for residents to implement and practice the new skills that they acquire.

Residents in the ***Action*** stage are taking clear steps to change what they value, the way they think, and how they behave. The most obvious indicators of change occur during this stage and demonstrate that the resident has prepared for greater challenges. Within the context of the CCS and CEC continuum-of-care treatment model for Delaware, residents at this stage are provided with increased opportunities to exercise internal control. Therefore, it is imperative that residents at this stage be provided the opportunity to face the challenges of community integration while being provided with sufficient support to reduce the likelihood of relapse.

By establishing support systems in their home communities, faith-based services, and 12-step programs and through active involvement in aftercare follow-up, the proposed adaptation of Delaware's substance abuse continuum will support residents in the final stage of Maintaining the changes they made.

Below is a summary outline of the characteristics and targets of the CCS and CEC proposed program:

Program Characteristics

- Programs are designed and implemented around Social Learning Theory and use of effective treatments (e.g., cognitive-behavioral) and appropriate service dosage (e.g., competency based phase progression/regression).
- Programs providing gender-specific female services create a therapeutic milieu that reflects a theoretical orientation and structure born out of Relational Theory, Pathways Theory, Trauma Theory, and Addiction Theory (Covington & Bloom, 2004).
- Programs providing co-occurring services take an integrate approach combining substance abuse treatment and mental health services due to the prevalence and complexity of co-occurring disorders in prison and community correction programs.
- Program directors, clinical directors, operation directors, and assessment staff ensure that residents are appropriate for their respective programs based on standardized and objective assessments (e.g., ASI, CEST, LSI-R, LS/CMI) that incorporate risk, need, and responsivity factors.
- Programs target anti-social behaviors and use effective behavioral treatment strategies such as the use of open communication and feedback, the use of recognition, the use of rewards and graduated sanctions, urinalysis testing, and furlough restrictions (as allowed by DDOC), that are based on providing reinforcers for pro-social thinking and behavior, as well as extinguishers for anti-social thinking and behavior.

- From the moment of admission, CCS and CEC programs prepare offenders to return to the community by providing reentry planning and service brokerage, (e.g., family programming, GED, work release, participation in faith-based groups, aftercare follow-up and 12-step support groups).
- Program directors maintain a commitment to quality that includes peer reviews, process, and outcome evaluations, (e.g., ACA accreditation, BCHS Quality Assurance Matrix, Correction Program Assessment Inventory).
- Program directors actively generate support both internally and in the community for evidence-based principles of offender rehabilitation. This support is generated by meeting regularly with, and involving, external stakeholders such as Department of Correction, Probation and Parole, State of Delaware's Individual Assessment Discharge and Planning Team (IADAPT) and TASC in program accomplishments and strategic planning.

Program Targets

- Change values, beliefs, attitudes, and feelings favorable to criminal and antisocial behavior through social learning experiences and cognitive-behavioral strategies and conspicuously posted motivational signage.
- Reinforce pro-social affiliations by reducing antisocial peer associations by encouraging participation in twelve-step programs, faith-based organizations, peer led support groups (e.g. Alumni Associations) and aftercare treatment activities with other TC program graduates.
- Reduce psychiatric symptoms and increase levels of functioning for offenders with co-occurring disorders.
- Address the biopsychosocial problems associated with substance abuse through urinalysis testing, substance abuse treatment, relapse prevention, and wellness programs.
- Teach pro-social alternatives to dishonesty, stealing, and aggression through self-control, self-management, problem solving, and conflict resolution skills.
- Promote positive attitudes regarding education, vocation and employment through community transition programming and work-release programs.
- Promote and improve family socialization and role models through family programming and supervision.
- Provide opportunities for residents to empathize with the harm done to victims through moral reconation and restorative justice strategies.
- Provide gender-specific female services that support self-reliance, have integrated mental health, substance abuse, and other wrap-around services, are based on a trauma-informed, strength-based (asset) model, use women only groups, and administer female-normed screening and assessment instruments when possible, (Covington & Bloom, 2004).

In summary, the CCS and CEC proposed "adapted" approach integrates TC elements, Cognitive Behavioral strategies and methods designed to Enhance Intrinsic Motivation. CEC has extensive experience delivering high fidelity, evidence-based services and a proven track record of reducing recidivism for drug involved offenders. The CCS and CEC model brings quality staff,

evidence-based treatment, and a therapeutic environment together to inspire and promote self-responsibility and recovery.

CCS and CEC believe that implementation of this adaptive approach is the best way to meet the diverse treatment needs of Delaware's correctional populations; and we look forward to a successful collaboration with DDOC.

2.2.4 Target Population

The CCS and CEC proposed substance abuse programming for the state of Delaware is designed for individuals (the target population) that likely:

- Present histories of poly-substance abuse and periods of extended incarceration that may be or may not be related to substance abuse and/or dual diagnosis.
- Have limited informal support systems, fractured family relationships, intermittent or limited work experience, low levels of education and/or illiteracy, health difficulties and significant behavioral challenges.
- Have conviction histories for a wide variety of serious crimes, are likely to report an extensive history of alcohol abuse and/or illicit drug use, and are also likely to report illicit drug use during the past 30-days prior to their incarceration.
- Most are likely to have both alcohol and drug problems; a significant number also have co-occurring disorders.
- Are socially and economically disenfranchised, with a record of failure in educational, vocational, cognitive, emotional and social areas of functioning.
- Most lack general life skills abilities and exhibit poor impulse control have problems with authority figures, exhibit criminal thinking errors and lack effective decision-making skills.

Based on years of experience in the field, and in Delaware, CEC has identified the following constellation of characteristics typically found amongst the offender population that contribute to continued drug/alcohol use, associated criminal activity and recidivism.

- Poor recognition of past patterns of relapse
- Reliance upon criminal associates are primary source of social network
- Low frustration tolerance
- Thrill seeking/high risk taking behavioral patterns
- Lack of consequential thinking
- Bored/disinterested with conventional leisure activities
- Lack of emotional maturity

Through the treatment methods described in this proposal, CEC looks forward re-partner with the DDOC in order help advance the State's internationally-acclaimed, 3-step substance abuse treatment program (KEY, Crest, Aftercare) as a proven model for the successful rehabilitation of

drug offenders. CEC will work with the DDOC as described in our proposal to promote an optimal flow through the treatment continuum as described below. As the former substance abuse treatment provider between 2002 (as CiviGenics) to 2010, CEC is uniquely positioned to understand inner-working of Delaware's correctional system in order to make this work for the Department.

Prison Programs

As the first component of Delaware's substance abuse treatment program, the primary goal, consistent with the Department's mission, is to provide a therapeutic community treatment for the State's incarcerated Men and Women blended with evidence based, cognitive behavioral treatment methods that are "tailored" to the needs of the diverse Key populations. The following overarching objectives will guide CEC in their goal:

- Change offenders' negative patterns of behavior, thinking and feelings that predispose them toward substance abuse and associated criminality.
- Apply methods consistent with the treatment perspective that drug abuse is a disorder of the whole person; addiction is the symptom, not the essence of the disorder
- Provide substance abuse treatment for offenders during the last 12-18 months of incarceration and prepare them for the next stage of treatment – Crest (or in some case community base aftercare).
- Maintain a structured day of educational and therapeutic activities reflective of a disciplined, regimented routine for residents aimed both at offender rehabilitation and safe and secure management of facility operations.
- Provide intensive programming seven days a week with well-trained, qualified staff.
- Integrate co-occurring disorders treatment in conjunction with CCS and the BCHS.
- Work collaboratively with facility Warden and Deputy Warden to enhance the program to the proposed addition of a CBT certified instructor and Educational Supervisor (preferably bi-lingual) at HRYCI.
- Apply gender-responsive, trauma-informed and family reintegration treatment methods for the women participating in Key at Baylor Women's Correctional Institution.

Community Corrections Programs

As the second component of Delaware's correctional substance abuse treatment program, CEC's the primary goal for Crest programs is to apply evidence based and best practices principles for offender reentry in order to assist Delaware's male and female offenders sentenced (or referred) to a Level IV facility an opportunity for successful reentry. Successful completion will be performance driven, and not exclusively time driven based on measurable "standard achievements" accomplished within each phase of treatment.

To be considered for successful completion of the CREST Program, a participant must demonstrate the application of treatment tools to real world situations, while satisfactorily completing all three phases of treatment. The approval of program staff during clinical case review, phase testing and recommendation for completion by the Program Director to the facility Warden (or their designee) is required.

CEC understands that presently phase one and phase two are all conducted at the Central Violation of Probation Center (male offenders only). We are willing to work with the DDOC in adjusting time frames and phase alignment if necessary. Once completed, offenders are then transferred to one of the three work release centers to participate in Phase III, the work release phase of the Crest program (Webb Community Correctional Center, Morris Community Correctional Center, or the Sussex Community Correctional Center). Female offenders participate in all phases of treatment in the CREST Program at the Hazel D. Plant Women's Treatment Facility, or can be transferred to SCCC for Phase III. The primary objective for Crest programs is to prepare offenders for reentry and for referral to aftercare and/or other community based services.

Aftercare including Boot Camp

Aftercare is the third and final component of the substance abuse treatment continuum. Aftercare begins once an offender has completed Crest (or in some cases Key or Boot Camp) and is released to probation. Offenders taking part in Aftercare are living full-time in the community at an approved "host residency" and return weekly to an assigned center for outpatient group sessions and individual counseling. CEC proposes to work collaboratively with Probation and Parole to initiate random urine drug screening as to improve treatment compliance and adherence to the conditions of supervision.

CEC's proposed four phase continuum is described detailed in **Section 2.2.13 Program Requirements.**

Special Populations Programs

6 for 1 Programs

CEC's proposed 6-for-1 Program will operate as a "modified" TC for the detention (unsentenced) population, in that it is characterized by structured community activities, peer bonding and mutual accountability. It differs from the State's Key and Crest Therapeutic Communities in the widely varying length of stay experienced by participants – up to 45 days.

To enhance the client's "community experience" in the limited time provided, CEC proposes to supplement the (typically) long-term process of self-discovery and maturation using more directive, brief intervention cognitive-behavioral skill building curriculum (Motivational Enhancement, Core Skills, Principles of Recovery etc.). This provides the basic communication, self-management and life skills many participants will need to successfully negotiate the next phase of their recovery, in prison or in the community. The condensed curriculum complements TC methods, but is not in any way, intended to replace or compromise the Program's core methodology – social learning through "community as method".

Our proposed mission at 6-for-1 is building a solid foundation for behavioral change by getting clients motivated, interested and confident in their ability to continue the recovery process. The approach ensures the program design integrates the most effective elements of the Therapeutic Community's social learning approach with an advanced cognitive behavioral curriculum supported by Twelve Step and other Self-Help approaches. CEC proposes to provide

comprehensive assessment (ASI), brief treatment, referral and preparation – all designed to meet the Program's mission most effectively within the detentioner's relatively abbreviated time in treatment.

CEC staff at 6-for-1, as within other proposed programs, will be responsible for managing the community process rather than for directing it. With staff acting as Rational Authorities, the community itself remains the primary agent of change – even under limited duration of the treatment "dose". Staff focus on holding all members of the community responsible for doing the work of helping one another change – encouraging, supporting and holding one another accountable - rather than taking on that primary responsibility themselves. This approach makes extensive use of peer meetings.

The 6-for-1 Program's philosophy, mission and goals are consistent with the needs of the target population. Our goals will include maximizing the potential for success by:

- Motivating participants for further treatment, whether formal programming or self-help, inside the prison or in the community;
- Providing a brief but intensive treatment experience in the TC culture; and,
- Building participant's basic communication and coping skills to negotiate challenges in the immediate future.

A key goal for clients who will be transferring into further treatment is to build motivation, confidence and skills for future successful participation in substance abuse treatment.

Young Criminal Offender Program (YCOP)

The Young Criminal Offenders Program is a long-term modified therapeutic community for adolescent males being prosecuted through Superior Court as adults. The program holds a maximum of 40 clients. To be admitted to YCOP, a client must be at least 16 years old but not yet 18. He must be ordered to YCOP by a judge. Clients are eligible regardless of the nature of their charges or the length of their sentences. Both detainees and convicted juveniles are admitted. It takes at least one year to successfully complete the program, but clients may stay in the program for two years depending on their age at admission. A system of progressive discipline is employed to correct negative behavior, including 30 day restrictions known as "phases" for clients who break cardinal rules. Clients who are not 18 years old can very rarely be unsuccessfully discharged from YCOP, since they cannot be housed with the adult population.

The proposed program is designed to treat criminal thinking and behavior, substance abuse, educational needs, anger management, social skills development, family conflicts much as the adult programs do, however YCOP was created by the state legislature to accommodate juveniles who are not considered appropriate for juvenile detention facilities. All YCOP clients are housed together and do not have contact with adult inmates. They are required to attend educational classes in addition to participating in program functions.

Boot Camp

Community Education Centers proposes "correctional recovery" programming for habitual criminal offenders (male and female) who also possibly have drug abuse or drug related issues as well. As the former provider of services at Boot Camp, CEC served approximately 100 inmate cadets on a monthly basis with substance abuse, addiction and recovery education between 2003 (as CiviGenics) to 2010.

CEC's proposed Boot Camp model is a six-month program divided into three highly structured phases. The first focuses on military-style discipline and life skills. The second phase focuses on drug treatment and community service projects. The third phase centers on job-seeking and acquiring the personal skills that will make for a successful re-entry into their home community.

Eligibility for Boot Camp

Consistent with the provisions of Title 11, Part IV, Chapter 67: Boot Camp Intensive Incarceration, § 6705. Sentencing; boot camp designation, and § 6706. Criteria for selection and classification by the Bureau, eligibility criteria are as follows:

- Must be 18 years of age
- Have been sentenced to a period of incarceration of 5 years or less
- In accordance with the Bureau of Prison's assessment and determination, be physically and mentally capable of successfully completing the rigorous boot camp program
- Have a term of not less than 9 months, nor have more than 18 months remaining in Level V incarceration

In addition, § 6707: Contract; admission into the program states that,
"No offender may participate in the boot camp program unless such individual voluntarily enrolls by agreeing to be bound by a written contract with the Bureau, which contract shall clearly set forth the obligations, duties, responsibilities and expectations with which such offender must comply".

2.2.5 Referral Process

SAMHSA's Treatment Improvement Protocol (TIP) 44 states; "Effective corrections-based substance abuse treatment requires offender screening and selection coordination between the criminal justice and substance abuse treatment systems and an understanding of the goals of both systems."

CCS and CEC will work cooperatively with DDOC classification staff, medical and mental health service providers to develop an efficient process for placing appropriate offenders in substance abuse programs. A Screening Selection Committee and two-step screening process will be implemented to maximize treatment bed utilization and provide the most appropriate treatment service to meet the needs of each offender.

A recent UCLA review concluded that without a well-defined screening and selection protocol, between 3% and 11% of female TC participants in California correctional institution, and between 3% and 17% of male TC participants, were determined (based on DSM-IV criteria) to be neither alcohol nor drug dependent. The focus of the proposed screening and selection process

is to target the most intensive programming to the highest risk/highest need offenders. Those offenders evidencing relatively minimal risk to recidivate, who are less severely addicted and who are highly self-motivated to change are not viewed as appropriate candidates for long-term, intensive programming from a cost benefit perspective.

Specifically, CCS and CEC propose:

- Implementation of a centralized Screening and Selection Committee comprised of BCHS Substance Abuse Treatment Administrator, CEC's Case Flow Manager, CEC Deputy State Director, CCS Medical/Mental Health provider staff and DDOC classification personnel.
- Introduction of an objective Two-Step process for pre-screening and selection of offenders, and an electronic pre-screening eligibility database.

Screening and Selection Committee

Basic information available through DDOC records will be used by the Committee to gain an understanding of the offender's substance abuse history and associated criminality. Information to be reviewed includes:

- Booking records
- Prior inmate self-report/interview information
- Results of previously administered screening/assessment instruments
- Past correctional records
- Past treatment records
- Police reports
- Correctional staff reports
- Emergency medical reports
- Prior drug/alcohol offense records
- Drug test results

The proposed Screening and Selection Committee's "decision to treat" will be based on five overarching principles:

1. Substance abuse treatment need
2. Risk to recidivate
3. Motivation (readiness to change)
4. Justice system considerations including sentence structure, parole eligibility, institutional security considerations and criminal history
5. Corroborative information related to inmates' substance abuse/criminal history

Eligibility – will be determined through the use of quick screen instruments administered by the Case Flow Manager while the inmate is housed in general population. Screening is aimed at determining if the potential program participant meets the correctional and treatment system criteria for receiving TC services. The proposed screening instruments are the TCU-Drug Screen II (TCU-DS II) and the Circumstances, Motivation and Readiness (CMR) Scales, Prison Program Intake Version.

Suitability **–** is assessed after eligibility has been determined. A more comprehensive clinical assessment is administered to determine if an offender is capable of benefiting from treatment. The proposed suitability assessment instrument is the Addiction Severity Index (ASI), 5th Edition.

Characteristics of the "decision to treat" process for placement in the TC include:

- Accurate pre-screening accomplished through integrating the dual roles of the Department of Corrections and the TC program staff and the establishment of a TC Selection Committee made of members from each system.
- Initial diagnostic impressions, as confirmed by a TCU-DS II, the CMR (or other quick screen instruments as agreed upon with the Department of Correction and treatment provider).
- Participants are sentenced (or classified by DDOC) to the residential substance abuse treatment program. The parameters of an offender's sentencing order (or conditions established by classification) require sufficient time to complete the multi-phase treatment continuum.
- Sufficient time remaining on sentence to benefit from placement in the TC.
    - For the full TC Key-Crest-Aftercare continuum, offenders must be within 18-24 months of Short Term Release Date (STRD) at the time of admission to the level V program and have sufficient time (6-9 months) remaining on post-release conditions of probation in order to benefit from the community-based, outpatient (Aftercare) component of the treatment continuum.
- Medical or mental health conditions are determined "stable" by the DDOC medical and participation in intensive TC treatment must not negatively impact the health of the inmate.
- Residents with a history of psychiatric disorders are admitted upon determination by the DDOC medical/psychological vendor staff that the resident is stable and compliant with medication protocol.
- Offenders with minor open charges may be approved for participation, after consideration of the potential for interruption in treatment and/or significant prison time likely to result from the open charge.
- Offenders with sex offenses are considered on a case-by-case basis and under the authority of the Department of Correction.
- Offenders with a positive urine drug screen during the current period of incarceration may be approved for admission, but only after 60-days has passed since the date of the last positive drug screen.
- Pending DOC disciplinary action referrals to be reviewed on a case-by-case basis.

Offenders will be directed toward or wait-listed for specific treatment program levels based on their acuity of substance abuse, their assessed risk for relapse, and evidence of needed services by type and parameters of sentencing orders. With the prior approval of the Department of Correction, offenders who do *not* meet established criteria may be considered on a case by case basis, but only with the approval of BCHS and the consensus of the proposed TC Selection Committee.

Exclusionary Criteria – The primary criteria that would preclude participation in treatment are legal, medical, sentencing and security considerations as determined by the TC Selection Committee under the authority of the BCHS.

Although there are no hard-and-fast rules, reasons for exclusion include fire-setting, active self-mutilation or active suicidal ideation, history of recent suicide attempts, serious violent behavior during current period of incarceration, sexual predatory behavior, severe psychotic symptoms, active homicidal ideation, severe impulse control problems, untreated tuberculosis or other infectious disease, being gravely disabled, or having an IQ below 70 (moderately mentally challenged).

The presence or absence of any of these criteria does *not* definitively preclude admission to the program. Rather, the recency of such behaviors viewed as an important contributing factor as along with their substance abuse, remorse, behavior during the screening interview, and placement history.

Inmates who have a history of leaving other programs without permission (AWOLs) and those with minimal drug use may be accepted, although they are not ideal candidates.

The exclusionary criteria may be more accurately viewed as *eligibility* considerations during the admissions process. In some cases, additional information (e.g., mental health records, booking reports, institutional disciplinary reports etc.) will be required before the TC Selection Committee can reach an informed decision.

Exclusionary criteria for individual offenders are sometimes *dynamic* and need to be re-visited periodically by staff responsible for managing waiting lists. For example, an offender may be excluded for consideration for a medical condition, an unstable mental health condition; excessive time left prior to the earliest parole hearing or planned work release classification. Each of these exclusionary criteria has the potential to change over time, and offenders may *eventually* become eligible for admission.

Offenders that are initially excluded from participation, who evidence a high need for substance abuse treatment (as determined by pre-screen procedures) will be provisionally wait-listed as potential candidates, once the stipulated eligibility conditions have been met. These conditions may include stabilization of medical or mental health conditions, resolution of DOC disciplinary charges or open charges, or updated calculations of earned time. Certain exclusionary criteria – those based on *static* conditions such as past offense history, (e.g., certain sex offense and arson categories) will be excluded from the provisional waiting list unless directed otherwise by the Department and/or agreed upon by the TC Selection Committee.

Two-Step Pre-Screening and Selection

Step 1. Screen out candidates who are ineligible for reasons of sentence structure and classification considerations.

It is anticipated role of the Department to perform this level of justice system screening. General screening criteria (to be determined by the Department) may include:

- Security or safety risk
- Felony holds that would result in an increase in sentence length
- Immigration or naturalization holds that would interfere with probation
- Criminal history exclusionary criteria (as determined by DOC)
- Classification score and administrative determinants inappropriate to the proposed placement

Step 2. Clinical screening and integration of justice system data.

CCS and CEC propose that our role will involve: (a) clinical pre-screening, and (b) establishing a system-wide screening and selection approach to assess the treatment needs of the correctional population as a whole, with review and approval of the Department.

Clinical pre-screening will include initial diagnostic impressions (as confirmed by a TCU-DS II (Texas Christian University Drug Screen-2nd Version), CMR (Circumstances, Motivation and Readiness Scale) or other quick screen instrument as agreed upon with the Department of Correction and treatment provider.

CCS and CEC propose developing an electronic system that:

1. Identifies and “tags” offenders court ordered to treatment with priority for offenders who have been provided the opportunity for suspension of remaining sentence on condition of successfully completing treatment (an "addiction" sentence)
2. Match treatment opportunities to targeted cohorts of offenders using objective criteria;
3. Monitor bed and treatment slot vacancies daily;
4. Use data reports to generate offender placement recommendations to the classification board(s) weekly

The proposed pre-screening process will be overseen and coordinated by the centrally-located Case Flow Manager, under the authority of the BCHS. CEC has successfully implemented a similar, two-step model in other state contracts over the past two (2) years. Effective and cost efficient management of treatment resources has been achieved through the use of the type of rigorous screening and data management protocols outlined above.

2.2.6 Recruitment

Recruitment of potential program participants and waiting list management protocols are also proposed as primary functions of the statewide Case Flow Manager. Recruitment and wait list management activities are aimed at maximizing treatment bed utilization through coordinated efforts with DDOC Classification staff. To facilitate the recruitment of potential candidates, the Case Flow Manager will maintain a database containing, at minimum, the elements listed in the table below. This information will be backed up by DDOC’s master list of offenders classified or court-ordered into treatment. The recruitment log data will be categorized by TC program and by referral source. System capacity as a whole will be analyzed and used for maximum efficiency. Lists of eligible candidates will be reviewed by CEC and DDOC (Screening and Selection Committee) collaboratively to ensure that offenders who are determined to be eligible are promptly placed in the appropriate program.

Waiting List data elements will include the following:

- Name of prospective client
- Gender of prospective client
- Special needs to be accommodated while in treatment
- Delaware DOC identification number,
- Date of Birth
- Court-Ordered or Classified Substance Abuse Program (Key/Crest/CVOP/Boot Camp/DUI)
- Referral Source (Department contact person) and Referral Date
- Open Charges (if applicable),
- STRD
- Interview status

Additional responsibilities of the proposed Case Flow Manager position include:

- Coordinate with DDOC to determine final eligibility requirements for each host facility
- Confer with host institutions to obtain approval for informational seminars and other acceptable recruitment activities (e.g. video presentations)
- Coordinate schedule for inmate recruitment activities within each applicable facility
- Secure approval for all visual materials, presentations, etc. to be used for recruitment
- Obtain institutional approval for all materials to be posted/distributed
- Deliver scheduled motivational presentations to prospective inmate program participants
- Include presentations by senior program participants (from TCs) if permitted by institution
- Schedule regular meetings with institutional classification personnel and other referral sources (e.g. sentencing judges) to coordinate and assess recruitment strategies

2.2.7 Physical Locations and Number of Beds of the TC Programs

CCS and CEC acknowledge and accept the Department's needs for substance abuse service delivery provisions at the following locations and for the offender capacities as outlined within the RFP:

Program	Location	Capacity	Serving
Key North	Howard R. Young Correctional Institution (HRYCI), Wilmington, DE	200	Males
Key Village	Baylor Women Correctional Institution (BWCI), New Castle, DE	58	Females
Key South	Sussex Correctional Institution (SCI), Georgetown, DE	120	Males
Crest North	Webb Community Correctional Center (WCCC), Wilmington, DE	76	Males
Crest North	Hazel D. Plant Women's Treatment Facility (HDPWTF), New Castle, DE	68	Females
Crest Primary	Central Violation of Probation Center (CVOP), Smyrna, DE	200	Males
Crest Central	Morris Community Correctional Center (MCCC), Dover, DE	56	Males
Crest South	Sussex Community Correctional Center (SCCC), Georgetown, DE	90	Males & Females
6 for 1 for Men	Institution (HRYCI), Wilmington, DE	80	Males

6 for 1 for Women	Baylor Women Correctional Institution (BWCI), New Castle, DE	30	Females
YCOP	Howard R. Young Correctional Institution (HRYCI), Wilmington, DE	40	Males
Boot Camp	Sussex Correctional Institution (SCI), Georgetown, DE	100	Males & Females
Aftercare (Including Boot Camp)	WCCC, HDPWTF, MCCC, SCCC	300	Males & Females
DUI Programming	Level TBD	50	Males
DUI Programming	Baylor Women Correctional Institution (BWCI), New Castle, DE	20	Females

2.2.8 Collaboration Between CCS, CEC, and Security Staff

As an owner and operator of 17 jail and detention facilities with a combined capacity of approximately 9,000 male and female offenders; each with its own embedded treatment component, CEC understands that safety and security is primary for any facility administrator. CEC also notes that the Structured Day element of an effective therapeutic community complements and even enhances the security objective resulting in safer and more secure facilities. Dietch, Koutsenok, Burgener, Cartier (2001) attest to the favorable impact on custody staff working within a healthy TC program in the areas of:

- Less stressful job environments
- Higher levels of job satisfaction
- Fewer occupational injuries and risk
- Lower rates of staff sick leave
- Less inmate-on-inmate and inmate-on-staff assaults
- Less disruptive inmate behavior overall

As a result of this understanding, CEC has earned a reputation for building effective partnerships with custody and probation and parole counterparts. CEC views correctional staff as a member of the treatment community team. The day-to-day operations of inmate recruitment, offender movement, program schedule planning and even correctional staffs' observation of a resident's "walking around behavior" become a critical part of the totality of the treatment milieu.

Our staff is specifically accountable for respecting the established lines of communication and lines of authority within each facility. CEC staff is expected to work cooperatively with CCS and host facility staff at all levels to support the fundamental mission of Department of Correction and Bureau of Community Corrections for safe and humane rehabilitation services, public safety and secure facility operations.

Upon receipt of the award, CCS and CEC will implement measures designed to encourage a cooperative professional relationship with DDOC staff. A standard element of the company's service implementation includes program staff training that addresses:

- The role of the treatment program as "guest" within the host institution
- The correctional mission (i.e. public safety)

- Lines of communication, authority and responsibility (chain of command)
- The legal limitation (per federal law) on inmate confidentiality within the institution
- Procedures for reporting unusual incidents and Departmental violations to institutional staff
- Maintaining professional boundaries
- General guidelines and parameters for day to day interaction with correctional officers, probation officers and other facility personnel

More specifically, in order to achieve the desired goal of integrating the change dedicated culture of the TC within the operational aspects of the host facility, the following strategies are proposed as a plan for interaction, collaboration and partnership with DDOC and other vendor staff:

- Maintenance of a daily log shared between treatment and custody staff documenting routine and significant occurrences during each shift
- Weekly multi-disciplinary team meetings inclusive of CCS, CEC, custody, classification and medical and mental health vendor staff
- Weekly meetings between CCS, CEC site program directors, and facility Wardens and/or their designees
- Cross training between DOC and treatment provider agencies with the goal of developing a common understanding of treatment approaches and the role of each provider within a comprehensive system of custody and care

2.2.9 Treatment Staff Description and Qualification

Inexperienced staff that lack an understanding of the offender population and are unfamiliar with criminal personalities are vulnerable to the type of exploitation and manipulation that may expose the correctional system to security risks that adversely affect the safety of correctional personnel and offenders. Such risks may compromise not only the integrity of therapeutic programming, but also may potentially contaminate other parts of the custodial setting and the correctional behavioral healthcare system.

As employers of more than 7,000 professionals across the country, CCS and CEC understand these risks. We remain committed to recruiting, training and retaining qualified addictions professionals experienced in navigating the constellation of characteristics of the correctional offender “client” and the multiple nuances of the correctional system.

Staff Characteristics: CEC’s Philosophy

CEC’s philosophy regarding clinical staff is informed by the work of key researchers in this area.

Andrews and Bonta (1994) identified four essential characteristics of an effective correctional treatment relationship; they contend that effective employees:

1. Establish high quality relationships with the client by being fair, firm, and consistent.
2. Demonstrate anti-criminal expressions (i.e., prosocial modeling).

3. Approve of the client's anti-criminal expressions (i.e., pro-social reinforcement).
4. Disapprove of the client's pro-criminal expressions (i.e., punishment), while at the same time demonstrating alternatives, (i.e., modeling/skills training).

The Therapeutic Community approach identifies the role of staff as that of being a "rational authority" (De Leon, 2000). A rational authority is one that is "authoritative", based on the ability to guide through greater understanding and knowledge, rather than "authoritarian", which is simply based on having the power to order people around. Thus, CEC staff are expected to continuously strive to be "students of life" and to become role models for right living themselves, as it is through such an ongoing personal commitment that one becomes a credible "rational authority" in the eyes of those we treat.

Also, Covington and Bloom (2004) suggest there are seven employee qualities necessary to provide effective services to women. They include:

1. Show consistency in caring and availability
2. Serve as a role model for women
3. Maintain a treatment relationship that is mutual, collaborative, individualized, and continually negotiated
4. Maintain confidentiality
5. Engage in visible and systemic advocacy for substance abusing females for stigma reduction systems development
6. Ensure self-care and request and participate in clinical supervision
7. Stay abreast of current developments in the field of gender-specific programming

Complementing CEC's staffing philosophy is our commitment to quality staff training. All CEC staff are trained in evidence-based principles (EBP), motivational enhancement, social learning and cognitive-behavioral strategies. They receive ongoing supervision and feedback with leadership skill-building opportunities from those whose behavior and attitude are in alignment with EBP. It is important to CEC as a company that program directors create opportunities to solicit staff input into the program and support the development of qualified leadership through a mission-driven, facilitative, team-based, management philosophy.

CEC has a strong track record of meeting conditions and terms for staffing similar to those outlined in the Delaware RFP. We fully expect to meet the DDOC staffing requirements in the event of a contract award. CEC will accomplish this as outlined in the following sections.

Staffing the Treatment Programs

CCS and CEC intend to work in partnership with the DDOC to retain only CADC Program Directors and Clinical Supervisors. Furthermore, it is the intent of CCS and CEC to interview and retain staff meeting CADC or CAAC requirements from the current vendor, only after input from BCHS and facility Wardens. Staff not certified as an addiction professional will be reviewed on a case-by-case basis. Once consensus to retain the non-certified staff between the Department, CCS and CEC has been determined, a comprehensive learning and development

plan for the employee will be submitted to the BHCS Substance Abuse Treatment Administrator for consideration. If approved, the written plan to obtain certification within one year will be submitted to the Substance Abuse Treatment Administrator and placed in the employee's personnel file.

As routine steps in the hiring process for all employees, CEC will:

- Conduct all employee interviews at a time and location convenient to each facility.

- Require all potential employees fulfill minimum job qualifications and credentials and be accountable "to comply with all provisions of the DOC's Code of Ethics and the CEC Code of Ethics. A copy of the Code of Ethics for both DOC and CEC will be provided to each employee and this will be acknowledged in the employee's records with a signed, witnessed, and verified copy prior to employment. Employees will not be hired until such verification is provided.

- Perform reference and employment checks and complete the security clearance application process. CEC notifies potential employees that they may be subject to complete background investigations at the discretion of the DOC, and that an NCIC criminal records check will be processed by the Department of Corrections to verify information on employment applications. CEC will replicate the previously established process for submitting all clearances through the State Office Manager, directly to the DDOC Centralized Clearance Office. The State Office Manager will maintain an employee clearance log to monitor expiration dates, and promptly inform the Centralized Clearances Office regarding any staff changes.

CCS and CEC acknowledge that individual security clearances are only valid for a period of time defined by the DDOC, and that they may be issued for shorter periods, at the discretion of the Department. CCS and CEC agree to be responsible for renewing the clearance requests for any employee retained from the current vendor whose clearance is scheduled to expire and at the appropriate time for each employee under this contract. (In addition, CCS and CEC acknowledge that the DOC reserves the right to deny any employee access to DOC facilities, information, or clients, as the result of confidential information obtained during the course of the security clearance policy, or for violation of DOC policy).

CCS and CEC will:

- Ensure that CEC staff receives institutional management, operations, procedures and security training provided by the DOC.
- Schedule all treatment staff for required training, including Understanding the Therapeutic Community (TC 101), Motivational Interviewing, Cognitive Behavioral Approaches for the Criminal Justice Client, and Clinical Documentation Guidelines.
- CCS and CEC understand that its counselors may provide specialized dual diagnosis, gender-adaptive and young offender programming. In response, CEC will offer a qualified trainer at each respective location to prepare staff for adapted treatment methods tailored specifically to these special populations.

- Require and ensure that all employees:
  - Adhere to the DOC's Code of Ethics.
  - Participate in and support the DOC's program audit process.
  - Comply with all DOC policies and procedures, including policies and procedures regarding staff training.
- Assign sufficient staff for each treatment program location.

CCS and CEC acknowledge that the following requirements apply to all DDOC Substance Abuse treatment Services employees:

- No employee shall enter into any business relationship with inmates or their families (e.g., selling, buying, or trading personal property), or employ them in any capacity.
- No employee shall have any outside contact (other than incidental contact) with an inmate, ex-inmate, his family or close associates, except for those activities which are an approved, integral part of the treatment program and part of the employee's job description.
- Employees may not engage in any conduct which is criminal in nature or which would bring discredit upon CCS, CEC or the DOC. CCS and CEC shall ensure that the conduct of all its employees is above reproach. Not only must employees avoid misconduct, but the appearance of misconduct as well.
- Any violation or attempted violation of the restrictions referred to in this section on employee conduct shall be reported telephonically and in writing to the facility Warden, including proposed action to be taken by CCS or CEC. CCS and CEC understand the Warden will consult with his supervisors and a determination will be made if the employee may continue to work with DOC inmates. CCS and CEC understand and accept that any failure to report a violation or to take appropriate disciplinary action against employees may subject CCS and CEC to appropriate action on the part of the DOC up to and including termination of the contract.

Furthermore, CCS and CEC will identify and maintain minimum employment qualifications for all staff performing services under this contract. Job descriptions which accurately describe duties for all positions will be discussed with all employees who are required to sign in acknowledgement of their understanding. The signed job descriptions will be maintained on-site and made available to department personnel for review along with proof of certification for each employee. Each job description will define the tasks to be accomplished and outline the minimum qualifications for each position, including educational and certification requirements.

Additional Staffing Detail: Recruitment of Certified Addictions Professionals

Finding licensed and/or certified staff can be challenging. In preparation for the anticipated award, CEC has initiated collaboration with the Delaware Certification Board, Inc. (DCB), Delaware's addictions professional credentialing authority. We've learned there are only **315** Certified Alcohol and Drug Counselors (CADCs) and 20 Certified Associate Alcohol and Drug Counselors (CAACs) in the state of Delaware. Given this reality and the associated challenges of hiring approximately 90 certified addiction professionals required to staff the Key-Crest-

Aftercare, Boot Camp and DUI programs, CEC has launched an aggressive, proactive recruitment drive through the DCB in advance of the anticipated award. A recruitment mailer has been sent to the addresses of each of Delaware's certified addiction professionals inviting them to consider a career with CEC in Delaware. In addition, CEC has posted an advertisement for Key-Crest-Aftercare positions on the DCB website with additional focus on the recruitment of Cognitive Behavioral certified professionals in preparation for the proposed program changes at HRYCI – Key North.

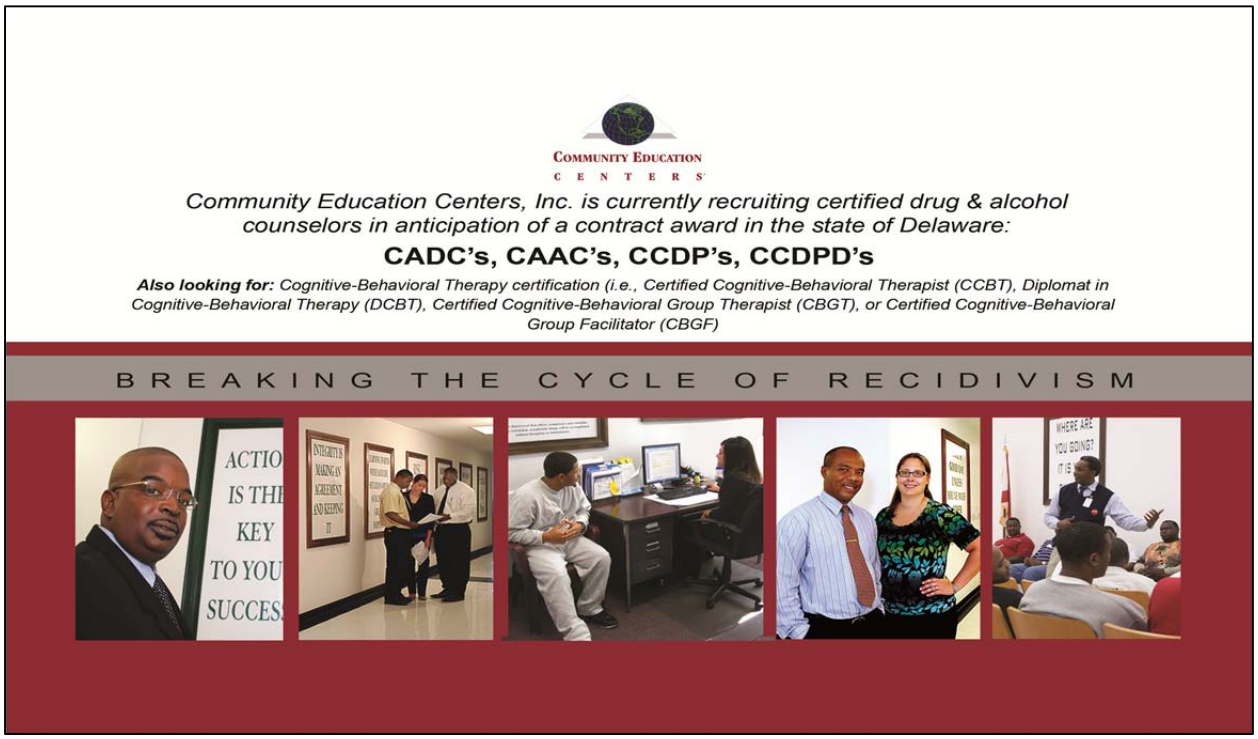

Figure 5: Delaware Certification Board Recruitment Mailer. *CEC has sent this recruitment mailer has been sent to the addresses of each of Delaware's certified addiction professionals inviting them to consider a career with CEC in Delaware.*

CEC recognizes with the limited pool of certified staff in the state, a contingency plan is required. If a prospective candidate is not yet certified, CEC proposes to submit a written request justifying the need to hire the non-certified individual to the BHCS Substance Abuse Treatment Administrator. Each written request will include a comprehensive learning and development plan for the applicant to obtain their CAAC within one year of employment.

In order to support the success of this "contingency plan" approach, CEC is prepared to offer a satellite extension of their existing CADC training academy to all non-certified staff approved by the Substance Abuse Treatment Administrator. CEC is prepared to support all costs associated with assisting these staff to obtain their first tier CAAC credentials including transportation, application fees and costs of providing approved trainers.

Based upon the success of our CADC academy established in 2006, CEC is confident in our capacity to provide non-certified Delaware staff a convenient way to develop industry specific skill sets, and attain state certification in the field of addiction services. Furthermore, the academy will afford existing CAAC's and CADC's presently a part of the contract, the

opportunity to obtain continuing education hours required to either maintain or advance their current certification/licensing credentials. CEC's training academy is one of New Jersey's State certified training providers for the Certified Alcohol Dependency Certification program for addiction professionals. The academy is an International Credentialing and Reciprocity Consortium (IC&RC) provider; thereby meeting criteria as an approved Delaware Certification Board provider.

CEC has been a training vendor for the state of New Jersey in good standing for the past 6 years, has state approved curriculum and 7 approved instructors, with four holding Licensed Certified Alcohol Dependency Certification. The CADC training academy offers a 270 hour training program that consists of 45 courses relevant to the field of addiction services inclusive of study sessions required for test preparation and oral board examinations. These courses are categorized in five domains; each consisting of 9 relevant topics in the field of addiction. The training takes place on a weekly basis following a rotating annual schedule. At present, training takes place at two sites providing access to North Jersey staff and Southern Staff encompassing Pennsylvania and Delaware territories.

In the event of a contract award CEC is eager to offer their CADC academy format to not only Key-Crest-Aftercare, Boot Camp and DUI staff, but also to DDOC staff who may be interested in pursuing an addictions professional credential.

CEC understands that there is a direct and obvious link between staff recruitment and staff retention in any program implementation: a deficient recruitment campaign will result in a smaller applicant pool and a less than optimal match between a candidate's qualifications and the demands of the position. This, in short order, will increase turnover. On the other hand, a robust recruitment effort that may require an initial investment of energy and planning will, if candidates are well screened for experience, competency and motivation, result in a stable high-caliber workforce of advancing expertise.

Interaction, Collaboration and Partnership with DDOC and Host Facility

CCS and CEC have earned reputations for building effective partnerships with custody and probation and parole counterparts and understand the role of "guest in the host facility".

At each level, CCS and CEC assure frequent, timely and accurate communications. CCS and CEC will share information concerning our treatment philosophies and operations with institutional, probation and community providers in Delaware to better coordinate an integration of services along the entire treatment continuum. CCS and CEC understand from our past experience in Delaware, as well as in other states, the operational *and* therapeutic relevance of maintaining clear and consistent lines of credible communication among stakeholders.

In support of this plan for open communication, CCS and CEC propose to establish a daily communication protocol at the site level. The Program Director and/or Clinical Supervisor will serve as the single point of contact at each facility and will remain on call during weekend hours as well.

The above site level contact persons will also be responsible for:

- Coordination of referrals with other institutional providers, including medical, mental health and classifications departments as needed
- Coordination with the appropriate DDOC contact regarding referrals to community based providers; including HIV, Housing, Vocational Education and other re-entry support service providers
- Communication with TASC and Probation and Parole

The State Director and Deputy Director will be primarily responsible for communicating and coordinating with facility Wardens and the BHCS Substance Abuse Treatment Administrator. The Regional Vice President, State Director and Deputy State Director, each remain on call 24-7 and are to be issued mobile devices to support easy access to DDOC staff at all levels.

In addition, in coordination with CCS, the both the Regional Vice President and State Director propose quarterly meeting with members of the BHCS to review program reports and to respond to any concerns or questions. If appropriate, the State Director will arrange for selected Program Directors and/or other CEC staff to attend these quarterly meetings. The DDOC will also have access to CEC senior management whenever requested for discussion or planning purposes.

Active and ongoing communication between CCS, CEC, the Department, and institutional/ facility staff will not be limited to formal meetings and procedures, but will also be conducted informally at each facility. These day-to-day communications will principally occur between the CEC Program Director and Clinical Supervisor and the designated DDOC program contact person on site at each facility.

Open lines of communication are a part of how CCS and CEC do business. Our management philosophy emphasizes open communication and promotes effective partnerships. CEC is committed to re-establishing a strong and mutually rewarding relationship with the Delaware Department of Correction.

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2.2.10 Treatment Vendor Staffing and Work Shift

CEC has provided our proposed staffing and work shift schedule by facility in **tabbed attachment F**. As noted in the RFP, the proposed treatment staff provides program coverage seven days a week from 7:00 AM to 8:00 PM Monday through Friday and 8:00 AM to 8:00 PM

on Saturdays and Sundays. YCOP, 6 for 1 DUI and Boot Camp work shifts vary per Addendum #3. Based on the attached work shift schedules, CEC proposed staggered shifts to allow for weekend and evening coverage as noted in the RFP. This proposed staffing plan allows for an optimal scheme for ample coverage of programs as outlined within RFP Addendum #3.

In addition, each site Director will be responsible for developing an on-call procedure for staff coverage in instances where unforeseen circumstances result in gaps in staff coverage. Program Directors and Clinical Supervisors are responsible for uninterrupted TC service delivery when scheduled staff is unable to report to work due to illness or other qualifying events. Directors will also be expected to maintain a recruitment strategy of maintaining a "clinical reserve" of qualified counselors who have been interviewed and cleared to work on a preliminary basis by the DDOC. This "reserve" will serve as insurance against vacancies that may occur as a result of personnel management or other reasons for employee termination and allow for vacancies to be filled in a timely manner.

Program hours will be modified as appropriate and approved in writing by the BCHS. CEC will work with the DDOC to determine counselors' hours following notification of contract award and prior to commencement of services.

2.2.11Transition Resources

CCS and CEC propose to develop a Transition Plan for each offender completing substance abuse treatment. As noted, CEC's approach to transitioning offenders from a correctional setting to the community is based on the idea that ***successful reentry begins at intake***. Every treatment service offered within the program is aimed at preparing residents for Aftercare. Additionally, we look to embrace partnerships with community based providers and Probation and Parole in the interest of successful offender transition to the community.

CEC has historically worked closely with a variety of Delaware government and community-based service agencies. CEC has experience providing referrals to safe housing, medical assistance, mental health services, education, vocational training, DUI evaluation and other services supportive of continued recovery and successful offender reentry. In an effort to support their transition from prison to community, each resident will receive a copy of CEC's Resident Resourcing Brochure in phase three/reentry. This brochure will be developed specifically for the DDOC to provide important contact information that residents are likely to need following release from treatment. The brochure is intended to be used by each offender while they are in residential treatment as a resource for the development of their personal transition plan. Sample contact information is provided in the table below. A more comprehensive draft of the Residents Resourcing Brochure is available in **tabbed attachment F**.

Recovery Support Systems	Women's Health
Alcoholics Anonymous (Sussex)----------945-1411	Center for Women/Infants (Dover) ----------744-7249
Alcoholics Anonymous (Kent) ----------736-1567	Center for Women/Infants (Milford) ---------- 430-5739
Alcoholics Anonymous (24 hrs) ----------655-5113	Maternity Services (Kent) ----------674-4700
Narcotics Anonymous (NA) ----------800-317-3222	Women's Wellness Resource Center ---------- 430-5540
Narcotics Anonymous (NA) ----------429-8175	Christiana Care Breast Center (Newark) ---------623-4200
Chemical Dependence Anonymous-----1-888-CDA-HOPE	Christiana Care Women's Health System--------733-2326
Addiction Coalition of Delaware ----------84-2322	Planned Parenthood of DE ----------655-7296
Children of Alcoholics ----------656-5554	
Employment & Education	**HIV Services**
Del. Tech. (Workforce Training Programs) ------856-5400	Wellness Clinic (Sussex) ---------- 856-5135
Vocational Rehabilitation (Sussex) ----------856-5135	Wellness Clinic (Smyrna) ----------739-5610
Vocational Rehabilitation (Kent) ----------739-5478	Wellness Clinic (Wilmington) ---------- 428-2538
Vocational Rehabilitation (New Castle) --------- 326-8930	Sussex AIDS Committee ----------644-1090
Department of Labor (Sussex) ---------- 856-5230	People Living with AIDS (Sussex) ----------628-2011
Department of Labor (Kent) ----------739-5473	People Living with AIDS (Kent) ----------697-4494
Delaware Job Hotline ----------800-414-5748	AIDS Delaware ----------226-5350
James Groves Adult Education (GED) ---------- 856-9035	

Figure 6: Sample List of Contact Information. *A more comprehensive draft of the Residents Resourcing Brochure is available in tabbed attachment F.*

Release Preparation Activity Checklist (RePAC)

While reentry planning begins with the development of the initial treatment plan and guides goal setting and performance criteria throughout participation in the program, formal discharge planning occurs during phase three. As with the treatment planning process, residents take an active role in co-developing a concrete, practical discharge plan covering all areas of assessed need. The counselor's role in transition planning is that of facilitator, to provide resources and guidance to residents as they create their own release plans

CEC's client-centered discharge planning instrument – the Release Preparation Activity Checklist (RePAC) is a systematic tool for ensuring comprehensive preparation for all major areas of sustainable recovery after release. The RePAC covers fourteen areas including, planning for housing, work, social support, recovery services and financial management.

Coordination with Probation and Parole – Probation and Parole Case Management

CEC will further support clients' re-entry through coordination with Probation and Parole. The majority of Aftercare participants' sentencing structures include a level of probation upon successful completion of residential treatment; and it is through this stipulation that special case management arrangements will be implemented through a multidisciplinary process.

CEC proposes to become an active participant in the multi-agency aftercare team by:

- Establishing cooperative and effective professional working relationships with representatives of the Probation and Parole Offices in Wilmington, New Castle, Dover and the Georgetown Probation and Parole – Day Reporting Office.
- Initiating (when appropriate) and attending bimonthly community-based case management meetings with the following participants: (1) aftercare client; (2) Probation Officer(s); (3) TASC representatives; and others involved in the client's aftercare case

management. These may include representatives of mental health, family support or other specialized service agencies determined by the team to add value to the process.

CEC's Program Directors, Clinical Supervisors, and/or Aftercare Counselors will be responsible for maintaining all pertinent data, and incorporating information from external providers to form a comprehensive analysis of the client's goal achievements.

As a team, this group directly addresses the challenges a client may be facing and collectively designs a treatment plan of action. A team composed of the client, and criminal justice, judicial and treatment representatives will review concerns over urinalysis results, missed individual appointments, missed groups, as well as broader re-entry concerns. Non-compliance with sentence conditions, lack of progress or evidence of the potential for relapse will be addressed by the multidisciplinary team. Sanctions or a relapse intervention may be imposed. These strategies are intended to reduce the rate of probation/parole violations through preventative coordination and planning.

2.2.12 Urinalysis Testing

CEC understands the success of any program for drug offenders depends, ultimately, on the reliability of monitoring participants' behavior. If treatment and correctional staff does not have accurate information about whether a participant is being compliant or not compliant in the program, there is no way to apply incentives or graduated sanctions, or to appropriately adjust treatment and supervision of the offender. The general consensus in the research literature (e.g. Goldkamp et al 2002; Harrel and Roman, 2001; Linquist, Krebs and Lattimore, 2006) is that sanctions and incentives are strong motivators of behavioral change in substance abuse treatment programs. With this in mind, CEC agrees to work collaboratiively with the DDOC and Probation and Parole (Aftercare) to implement regularly scheduled, random urinalysis testing at each stage of the Key-Crest-Aftercare programs. If an offender has a positive UA, sanctions will be imposed in accordance with guidelines established by the DDOC, with the possibility for the offender to work their way back into the program.

CEC envisions a process involving a thorough case-by-case multidisciplinary team review targeted towards balancing the safety and security of the facility with the "clinical" approach of increasing sanctions and referral to treatment for offenders with positive tests. The multidisciplinary team case management review will incorporate input from both the participant's probation officer and CEC aftercare staff.

If this review process identifies a case where an increase in treatment intensity is appropriate as an alternative to violation of probation, then an intervention similar to the sample "weekend intervention" schedule outlined below would be implemented.

Aftercare Weekend Intervention	Saturday
9:00 am-9:15 am	Arrival of clients and check in with counselor on duty for signatures of attendance.
9:15 am – 10:00 am	Coming Back From a Relapse Workbook: The History of Relapse pages 3 – 4 Exercise 1: Analyzing Relapse
10:00 am – 10:30 am	Clients join residential TC for the Morning Meeting where they do Growth Reports and get feedback from the community.
10:30 am – 12:00 pm	Identifying Relapse Factors pages 6 – 8 Exercise 2: Factors that can Lead you to Relapse Exercise 3: Finding the most Significant Relapse Factors for you.
12:00 am -12:45 pm	Lunch
12:45 pm – 1:45 pm	Relapse and Identifying Relapse Factors Assignments.
1:45 pm – 3:00 pm	12-Step or SOS Self-Help Meeting
3:00 pm – 3:30 pm	Discussion of 12-Step Meeting and completion of the Self Help/ Support Group Report Form.
3:00 pm-3:30 pm	Handout Homework Assignment: How Did I Get Here from the Relapse Prevention Workbook for Chemically Dependent Criminal Offenders Exercise 1: Why Do I Want to Change
3:30 pm – 4:00 pm	Client Wrap Up followed by cleanup of Aftercare Area. Group dismissed.

2.2.13 Program Requirements

Program Phases

Phases of treatment are defined by CEC as a habilitative, developmental process of attitudinal, thinking and behavioral change facilitated by, and measured within three discreet phases of treatment. Each phase is characterized by its own set of benchmarks ("standard achievements") that residents are required to meet in order to be eligible for advancement to the next phase. Standard achievements are measurable indicators of a resident's readiness for phase progression consistent with CEC's view that Recovery (a developmental process) parallels the incremental trajectory of the phase system. Standard achievements inventories are completed by staff, residents (on themselves) and the by a formalized peer review process. Results are collected and reviewed during a clinical team meeting in order to objectively determine participants phase movement eligibility.

The proposed phase system can also be understood of in terms of the following levels of engagement in and affiliation with the TC:

- ***Compliance*** (Induction: adherence to rules)
- ***Conformity*** (Engagement: participating as a member)
- ***Commitment*** to ***Community*** (Affiliation: participating as a role model)
- ***Commitment to Recovery*** (Transformation: internalizing change)

Conceptually, CEC's phase system also parallels *Stages of Change* (Prochaska and DiClemente, 1982) whereby a resident's *individual and internal* motivation to change can be conceptualized in terms of the developmental trajectory as one moves from ***Pre-contemplation*** (ambivalence) to ***Contemplation*** (thinking about change), ***Planning*** (for change) and eventually toward ***Action*** (toward behavior change) in order to eventually arrive at a more normalized and stable level of consistency (Maintenance) with regard to the desired behavioral change. The table below is meant to provide a visual depiction of the interplay between each of the above concepts as applied to CEC's proposed phase system:

Phase One: Induction		
Level of Internalization Induction	**Level of Engagement** Compliance Conformity	**Stage of Change** Pre-Contemplation Contemplation
Phase Two: Primary Treatment		
Levels of Internalization Engagement Affliliation	**Levels of Engagement** Conformity Commitment to Community	**Stage of Change** Contemplation Planning
Phase Three: Reentry		
Level of Internalization Transformation	**Level of Engagement** Commitment to Community Commitment to Recovery	**Stages of Change** Planning Action

CEC believes that providing treatment services within the proposed phase design allows each participant to maximize their eventual internalization of a new set of learned attitudes, behaviors and emotional/social skills. Through rehearsal and repetition in the TC's "mini-society" these skills and behaviors become second nature, a reflex, or a new way of thinking.

The incremental learning at each stage facilitates change at the next, and each change represents increased competence, personal growth, maturation and the capacity to apply the lessons and

skills learned in the TC's milieu to real world circumstances as an alternative to previously learned maladaptive patterns of anti-social behavior.

CEC's psycho-educational and skills-building curricula, program staff roles, TC social structure, community rituals, program vernacular, peer interactions, standardized privileges and sanctions are all synthesized as external treatment strategies to motivate, support, catalyze and incentivize incremental internal progress toward Learning and Living new thinking, behavior and attitudes of positive pro-social change and habilitation.

Orientation and Phase One: Induction
Clinical Objective: Compliance and Conformity
Stage of Change: Precontemplation → Contemplation
Duration: Key: 90-Days
Crest: 60-Days

CCS and CEC propose to place special emphasis on the Orientation Phase within each of the identified Delaware programs. There is consensus among correctional researchers that underscores the importance of a deliberate, early stage treatment focus on enhancing motivation and client engagement strategies.

"Because of the frequency of early dropouts and associated costs, greater vigilance for 'front end' stages of treatment is crucial." Simpson, Dwayne. 2008. Revisiting the basics of treatment, *Research Reports From IBR*, 17(2), 1-4.

Lasting approximately 30-Days, and encapsulated within Phase One, CEC's Orientation phase is designed to assist clients in negotiating the "compliance stage" and to counter early drop outs. This approach would be especially relevant to Delaware's Crest Primary at CVOPU.

New residents in the TC are often overtly resistant or at the very least, ambivalent about accepting the rigid TC structure. Therefore, orientation is designed to educate new participants about the TC and to provide them with basic recovery concepts, substance abuse education and most importantly a reason to engage as a member of the peer "community". To that end, balancing a safe environment with the emotional security and predictability of a structured routine and daily schedule is the emphasis. Central to the success of this effort is creating a psychologically safe environment free from the drugs, violence, and sexual misconduct that are generally assumed to compromise successful treatment efforts, and that very often reinforce the inmate sub-culture of the general prison population.

The client's *relationship to the peer community* is the agent of change in the TC. During Orientation clients have the opportunity to develop a trusting alliance with the other residents in the community and achieve a sense of belonging, thus initiating the change process. Client perspectives about treatment are shaped to large degree by the role models of the TC and by the deportment and attitude of staff. By design, orientees are assigned low-ranking jobs within the community social order, or "structure". Mentoring relationships are employed to provide newer residents with a coach/big brother who has more experience in the community. Mentoring is viewed as a valuable intervention for guiding new "family members" and helping them to

understand that they are not alone in their journey. This is also the phase of treatment where intake and assessment occurs and when referrals are made in order to address psychological and physical health issues; further contributing to the supportive qualities of the TC treatment environment.

Overall, the orientation phase represents an opportunity for a client to "buy into" the need for treatment, if not internally and authentically, at least superficially and behaviorally as they are encouraged to "act as if" during drill training, motivational exercises and pure discipline didactics. The global objective of Orientation is for participants to learn how to be a member of the TC, follow the rules and to *experience a sense of affiliation and engagement with the TC "family"*.

For early stage success to occur it is imperative program expectations are stated clearly and early on so new residents become acquainted with the language, philosophy and structure of the TC. Before a resident can adapt to community norms (conform) he or she must first be educated as to what those norms are and how they are demonstrated behaviorally. Similarly, before a client can be held accountable to the rules of the community (comply) he or she must first be given the opportunity to learn, understand and rehearse them. To this end, CEC has developed 10 curriculum sessions entitled *Orientation to the CEC TC Model.*

A brief overview of these modules follow:

Session Title	Description
1. Program Overview & Levels of Engagement/Motivation	Interactive overview of the program, rules and expectations for participants.
2. The Role of Community & Culture	Focus a culture of community and on Four Barriers to Lifestyle Changes.
3. The History & Evolution of the Therapeutic Community	History and evolution of the TC and common features found to be effective in helping people to change.
4. The TC View of Treatment & Recovery	"More Common Features" are covered, which include an overview of "TC Values", "Rational Authority", and the Four TC Views of the Person, of the Disorder, of Recovery and of Right Living.
5. Community As Method, Part 1	10 Essential Ingredients of the TC: Part One
6. Community As Method, Part 2	10 Essential Ingredients of the TC: Part Two
7. The Morning Meeting	Morning Meeting rationale and common elements.
8. Structure, The Work Ethic, & The Standard of Excellence	Work ethic, structure, "work as therapy" and standard of excellence concepts are explored through interactive exercises.

Session Title	Description
9. Rules, Tools, & Expectations	Cardinal, Major and House Rules are explained as are the tools of “reinforcers” and “extinguishers”.
10. Human Development, Right Living, & The Phases of the Therapeutic Community	Overview of the phase system and how one successfully navigates movement through accomplishing “standard achievements”.

During Orientation, participants learn the purpose and process of treatment planning. They also learn the role of the counselor, and the incremental steps to assuming full participation in the TC process. As more senior community members within the TC encourage new residents to "plug in to the process” the TC program counselor works to establish therapeutic “rapport” with new clients guiding them client toward a stronger affiliation as a member of the change-dedicated, peer governed “community”. New residents are supported by both peers and staff in their potential to eventually mature into a contributing member and toward recognizing their “inner self” potential to ***“build a future that is better than your past”*** as described in the CEC program philosophy.

The remainder of Phase One serves as an opportunity for counselors to introduce clients to the various addiction models, HIV awareness, early recovery concepts, 12-Step and other self-help philosophies and to educate residents about patterns of criminal thinking. Additional curriculum sessions are offered from CEC’s treatment session “library”

Finally, residents in Phase One are introduced to the cognitive behavioral building blocks - Core Skills. CEC’s Orientation methods provide an “immersion” experience for the resident in the TC culture, and are designed to:

- Initiate the new resident into the social organization, groups and meetings of the Therapeutic Community
- Begin to engage him/her in the preparation for the change process
- Teach a basic skill set (Core Skills) to enhance initial participation and engagement
- Introduce basic recovery concepts, self-help approaches and substance abuse education on the “whole person”

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First, Let Us Know These Things…

That our lives matter, because we are born with potential;
That we are not victims of circumstance;
That to be free, we must master our own habits;
That we can be part of something greater than
Ourselves and
Thereby find the greatest part of ourselves.

Then, Let Us Do These Things…

Humble ourselves to learning
Learn to be learners,
Out of respect for our own potential and out of
Respect for those who teach us
Take courage against our fears and be steady in our efforts;
Help each other and draw strength from each other,
For the one who falls low can bring us all down
Unless we help him (her) rise, and the one who rises
High can take us all higher if we strive together.

Build A Future That Is
Better Than Your Past!!

★★★★★★★★★★

Following are the proposed standard achievements residents would be accountable for prior to eligibility for advancement from phase one to phase two:

- Is cooperative with security staff's expectations
- Responsibly completes treatment plan assignments
- Compliant with Facility & Program Rules
- Effective use of Big Brother / Big Sister mentor
- Demonstrates responsible work ethic through timely completion of committee tasks; cleaning duties and maintenance of living space
- Interacts with peers appropriately; fosters positive regard for self and others
- Accepts responsibilities rather than avoiding them through making excuses, blaming others or playing the victim
- Demonstrates sense of community membership / and community affiliation
- Attends all community functions on time without prompts
- Shows courteous respect for authority figures
- Demonstrates insight and skills acquisition during Self Discovery Process Group
- Contributes to the TC environment
- Participation in role play exercises
- Can recite program philosophy
- Participation in Morning and Evening Meetings
- Can accurately explain Habit-Self –vs- Inner Self
- Participation in Encounter Groups
- Can accurately explain each of the Core Skills
- Demonstrates a practical grasp of concepts specific to addiction education
- Can accurately explain the Principles of Recovery
- Is beginning to role model in the community
- Can accurately explain the purpose of DEAL process
- Has accepted the need for treatment
- Is contemplating the need to make behavioral changes
- No learning experiences (LE) within past 2 weeks
- Passing score on written or oral Phase One exam

Phase Two: Primary Treatment
Clinical Objective: Conformity → Commitment to Community
Stage of Change: Contemplation → Planning
Duration: Key: 210-Days
Crest: 60-Days

During Phase Two (primary treatment), resident and counselor planning efforts shift gradually from the community member's behaviors to their personal goals for achievement during the remainder of treatment and in preparation for a new life after graduation. Treatment goals in this second phase of the program begin to reflect major steps toward recovery including an improved understanding of the client's personal pattern of relapse, learning to apply (live) Principles of

Recovery, TC concepts and 12-step philosophy to daily living in the TC. Life-skills training, increased understanding of criminal thinking patterns, family relationships and communication are offered; all driven by clinical objectives and curriculum design targeting the replacement of antisocial attitudes and criminal sentiment with pro-social and pro-sober values of right living aiming at increased durability of the client's recovery process and potential for a successful return to society. During primary treatment, participants begin to demonstrate commitment to themselves, which slowly compliments the initial objective of Conformity to the Community and is expressed and measured within the context of their increased affiliation, stake and engagement as a credible member of the peer social organization.

Commitment is the personal resolve to remain in the treatment process and complete the treatment program for one's self. In the primary phase participants focus is guided toward earning status and corresponding privileges within the peer community and residents are assigned increasing levels of responsibility and corresponding “jobs” within the community hierarchical structure. Staff focuses on measuring treatment goals against the backdrop of the community structure and begins to look for residents for Role Modeling and mentorship responsibilities to younger TC members – early indicators of a Commitment to Recovery (i.e. mutual self-help).

To this end the program staff, along with the Top of the House (residents in job positions with the most responsibility) engineer “community responsibilities” (experiences within the structure of the community) revealing the maladaptive thought process and illicit destructive patterns of behaviors of residents in order to facilitate increased levels of emotional and behavioral self-awareness. This type of “structural engineering” is community-wide, and challenges to individual members helps to solidify the integrity of positive peer pressure and pro-social peer alliances further increasing an individual resident's personal resolve, resiliency and commitment to change. When this type of collective “special project” (challenge) is offered up to the community and its members; residents are guided to dig-in, work together and find out what about the given experience is challenging them. They come face to face with their individual tendencies to revert to a "convict code" of antisocial posturing and to respond automatically in situations over-which they have very little control except the extent to which they are able to control how they choose to respond. In the face of this type of “learning experience” clients are challenged to ask themselves, "How did I respond emotionally, cognitively and behaviorally and how well will these responses serve me toward the goal of prosocial change in the broader “free world” community outside the TC?" Through their own reflection in the mirror of their peers, they begin to see not only the constellation of characteristics that lead to them to a life of crime and drugs; but more importantly, learn to access their “inner-self” potential to make lasting changes and to improve the quality of their lives. Residents in primary treatment are taught, *“That which is Right with you, is more powerful than anything that is wrong”*.

The conceptual assumption derived from this type of special challenge to the community and the associated learning is that a certain level of mental and emotional discomfort (cognitive dissonance) is required as a catalyst for initiating change. Every interaction and treatment activity in the TC is now realized by the resident as either an educational or therapeutic experience; each resulting from both support and challenge from the peer community.

Below are proposed standard achievements residents would be accountable for prior to eligibility for phase three advancement:

- Attended all required Phase II Group session and submitted attendance verification
- Holds peers accountable in an appropriate manner
- Fully compliant with facility & program rules
- Responsibly completed treatment plan assignments
- Demonstrates responsible work ethic through taking on additional responsibilities within program's structure board
- Productive use of time management sufficiently to meet all relevant institutional and program schedules
- Demonstrates treatment maturity and appropriate control of emotions required for the challenges of off-grounds, Phase III participation
- Has a strong sense of community membership / and program affiliation
- Attends all community functions on time
- Consistently shows respect for authority figures
- Role models active participation during group sessions
- Uses program tools to manage anger effectively
- Models appropriate participation during Morning and Evening Meetings
- Can recite (and explain in peer seminar) program philosophy
- Models appropriate participation during Peer Awareness Groups
- Can teach Habit-Self –vs- Inner Self to new residents
- Demonstrates concern for others acting as a helper to other community members in Phase I
- Can teach the Core Skills to new residents
- Is beginning to apply the Core Skills in a more practical manner to assist with daily personal challenges
- Can accurately explain each of the Principles of Recovery and teach them to others
- Has an understanding of the 12-Step Fellowship
- Has presented effective communication skills with accurate understanding of curriculum content during peer seminars
- Improved avoidance of negative peer influence
- Is taking action toward making behavioral change
- No learning experiences (LE) within past 2-weeks
- Passing score on written or oral Phase Two exam

Phase Three: Reentry
Clinical Objective: Commitment to Community → Commitment to Recovery
Stage of Change: Planning → Action
Duration: Key: 60-Days
Crest: 60-Days

The re-entry phase generally encompasses the last two to three months of TC treatment. For Key residents going to Crest; reentry planning constitutes preparing for the next phase of the continuum (Crest). For Crest residents going to Aftercare, phase three treatment is comprised of traditional pillars of reentry support such as; housing, employment, continuing education, social services, mentorship arrangements, vocational rehabilitation etc.

Application of all previous learning in the TC is manifest in this phase either through stable employment in the community and/or as demonstrated in holding a position in the top of the community structure and consistency of role model conduct.

During this period, integration of recovery principles and internalization of TC concepts are evidenced as residents begin to translate what they have Learned into how they will Live following release from the DDOC. Successful reentry participants now recognize that recovery, the change process and continued self-reflection are a life-long endeavors rather than the singular event of their current treatment episode. In Community Corrections (Crest) programs residents are afforded work and weekend furloughs as a “real time” graduated exposure to what life after treatment will be like. In Key programs, visiting counselors from Crest help residents to plan for their next phase of treatment and participation in other classes and institutional work assignments afford opportunities for application of newly acquired treatment tools.

Evidence of problem-solving skills, effective communication, and healthy decision-making manifest in the re-entry phase and should reflect a change of values as evidenced by the choices a client makes, the initiative he/she takes, and how they respond to disappointment and uncomfortable emotions when circumstances do not unfold as they envisioned.

Participants in the re-entry phase are expected to assume additional responsibilities in the therapeutic community and in the institution. One of these additional functions is assignment as a “Tutor” (mentor) for other participants new to the program.

One major criterion for graduation is an assessment of how well participants have performed in their work assignments. Another consideration is how well participants have adjusted to their dual commitments: treatment and work. Giving back to the community becomes a treatment goal, and preparation for a healthy separation from the TC is the primary focus.

Phase three standard achievements include:

- Has shown responsibility in managing off-grounds privileges without problems (Crest)
- Has completed a comprehensive Re-Pac (Release Preparation Activity Checklist)
- Established a social support foundation in the community: Bank Account, Stable Employment, Housing (Crest)
- Has an working understanding of personal risk factors and can describes strategies for reducing those factors
- Demonstrates ability to balance work and treatment obligations
- Has understanding of personal pattern of relapse and knowledge of craving reduction practices
- Consistently accepts responsibilities rather than avoiding them
- "Gives back" to community and contributes to the TC environment
- Attends all community functions on time
- Has good understanding of and is acclimated to 12-step fellowship and approaches
- Demonstrates and improved pro-social identity and improved positive self-image in Self Discovery Process Group
- Describes how they have successfully used solving skills in a real world setting
- Is capable of describing use of program tools in real world circumstances
- Is ready to continue recovery in a community-based setting
- Models appropriate participation in Evening Meetings
- Describes application of Principles of Recovery in real world setting
- Models appropriate participation in Encounter Groups
- Has demonstrated application of program's tools in real world circumstances
- Is focused on personal recovery
- Is using leisure time in a constructive manner
- Is a pro-social role model to peers
- Has reached out to community based resources to assist post discharge success: Social Services, Labor Department, Continuing Education
- Completed treatment plan assignments in a timely manner
- Is working toward building a sober support system in the community
- No learning experiences (LE) within past 2-weeks
- Passing score on written or oral Phase Three exam

Phase Four: Aftercare
Clinical Objective: Commitment to Recovery
Stage of Change: Action → Maintenance
Duration: Six (6) months

Research indicates that the longer an offender is engaged in treatment, the better the expected outcome.

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A study by McClelland et al. (2000) found that approximately 50 percent of clients who complete 12 months or more of drug abuse treatment remained abstinent for an additional year after completing treatment" (A Report to the Joint Finance Committee of the Delaware General Assembly: Correctional Treatment Strategies in Delaware: Strategies for Success, 2004)

"Faye Taxman identifies a variety of barriers that have been identified in the literature (Taxman, 2000). They include: Insufficient duration of treatment for offenders to effect behavioral change" (A Report to the Joint Finance Committee of the Delaware General Assembly: Correctional Treatment Strategies in Delaware: Strategies for Success, 2004)

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After completing treatment, many individuals have trouble transferring previous learning from one setting to another, so the gains made in residential treatment may diminish or be lost unless a sustained continuity of the TC learning experience is provided. In light of this, CEC places special emphasis on Aftercare and understands the relevance of a structured and comprehensive aftercare treatment component. The purpose of Aftercare treatment is to prevent future criminal behavior by providing a continuum of structured mutual support and continued treatment services essential for successful outcomes.

Phase four - Aftercare is where continued practice of the recently acquired skills, cognitive restructuring and all other markers of the TC's rehabilitative efforts are put to the test.

In Aftercare, as in the residential TC there are incremental phases and performance benchmarks within each phase designed to cumulatively support a drug and crime free lifestyle. The table below offers an example of the proposed aftercare phases and standard achievements within each:

Aftercare: Phase One	Aftercare: Phase Two	Aftercare: Phase Three
Attend group x 2 weekly for 30-days	Attend group x 1 weekly *(unless otherwise specified by counselor or probation)*	Attend group x 1 weekly *(unless otherwise specified by counselor probation)*
Obtain and maintain gainful employment / bank account	Maintain gainful employment / bank account	Maintain gainful employment / bank account
Obtain housing supportive of a recovery environment	Maintain stable housing supportive of recovery	Maintain stable housing supportive of recovery

Aftercare: Phase One	Aftercare: Phase Two	Aftercare: Phase Three
Compliance with all conditions of probation & parole / TASC / DOC / Aftercare	Compliance with all conditions of probation & parole / TASC / DOC / Aftercare	Compliance with all conditions of probation & parole / TASC / DOC / Aftercare
Complete all phase 1 treatment plan objectives and action steps	Complete all phase 2 treatment plan objectives and action steps	Complete all phase 3 treatment plan objectives and action steps
Selection of and weekly contact with an aftercare big brother / sister	Obtain a sober mentor (or sponsor) in the community	Be a Big Brother or Big Sister to a newer member of aftercare (weekly contact)
Establishing attendance to a community based sober support groups *(x1 weekly)*	Regular attendance to community based sober support group *(x1 weekly)*	Ongoing attendance and commitment to sober support group involvement
Negative urine drug tests	Negative urine drug tests	Negative urine drug tests

In summary:

- By the end of induction/orientation, residents are aware of the rules and procedures of the TC, are feeling comfortable as a member of the TC, and have committed themselves to the "community spirit";
- By the end of the primary treatment stage, residents have gained some understanding of the issues underlying their drug use, are able to emotionally support other residents, and are not behaving in an anti-social deviant manner;
- The re-entry stage provides increased contact with the wider community, gives residents increased independence, and focuses on preparing residents to cope with the outside world, including developing supportive friendship and self-help networks and, where appropriate, re-establishing communication with their immediate families;
- Aftercare provides a peer and staff supported "safety net" where TC graduates apply learned tenants of right living to free world circumstances while balancing obligations to family, treatment and conditions of probation and parole.

2.2.14 Treatment Content

Consistent with the RFP requirement for programs to provide evidence-based, best practices interventions and treatment components, CEC fully endorses the convergence of the Therapeutic Community model with cognitive behavioral principles enhanced by motivational interventions. CEC has significant experience with this approach which represents the basis for one of the core doctrines of our treatment programs- that "all change is self-change", meaning that change in a person takes place through profound alteration in beliefs, attitudes and self-identity along with the offender taking personal responsibility for planning for and taking action toward behavior change.

The proposed CEC adaptive model relies on the individual's relationship to the peer community as the primary motivator for personal change. Cognitive behavioral methods place a greater emphasis on the thought processes that affect feelings and behaviors, and the management of those thought processes, (for example, using "Thinking Reports"). Motivational interventions

move external influences for change to internalized motivation for self-change. The three methods are entirely complementary when integrated thoughtfully and in balance, as detailed in **Sections 2.2.3, Program Description** and **Section 2.2.19, General Requirements: Treatment Methodology**, each having demonstrated effectiveness in meeting the needs of the most chronically treatment-resistant populations.

Proposed Treatment Components

Assessment

The proposed substance abuse assessment is the electronic version of the Addiction Severity Index (ASI 5th Edition) to be completed by a Program Counselor within 72 hours of a residents admission. The ASI provides multidimensional ratings on the following six life areas:

- Medical Status
- Employment/Social Support Status
- Alcohol/Drugs
- Legal Status
- Family/Social Support
- Status
- Psychiatric Status

The completed ASI will be reviewed by the Clinical Supervisor who will guide the counselor in the development of the client's Individualized Treatment Plan (ITP).

CEC is also proposing to use the Client Assessment Inventory (CAI) and the Staff Assessment Summary (SAS). These instruments are derived from a comprehensive theory of TC treatment and recovery, and are proposed for use as part of the client's self-assessment of their own change process.

The Orientation phase of treatment includes a number of activities that support the ongoing assessment process and development of subsequent treatment plans. Offenders learn the concept of recovery as a recovery of the "whole person". This concept is made more understandable by using DeLeon and Kressel's Fourteen Therapeutic Domains, broken down into four dimensions:

1. Developmental - a) Maturity, b) Responsibility, c) Values;
2. Socialization - a) Drug/Criminal Lifestyle b) Maintaining Images c) Work Attitude d) Social Skills;
3. Psychological - a) Cognitive Skills, b) Emotional Skills c) Self Esteem/Self Efficacy
4. Community Member - a) Understands Program Rules, Philosophy and Structure b) Community Engagement and Participation c) Attachment, Investment and Stake d) Role Model.

Each of the concepts in the four dimension areas are operationally defined and the offender rates their level of agreement in terms of how much a statement describes or does not describe his/her behavior.

The client completes the Client Assessment Inventory (CAI) ; and the assigned primary counselor completes a rating of the client on the Staff Assessment Summary (SAS). The client and counselor then compare ratings. Typically when clients start in treatment their ratings on the CAI are much more favorable than that assessed by the counselor's SAS. As the client progresses in treatment the client and counselor ratings become more similar, indicating the client has learned to see himself as others see him (i.e., increase accuracy of self-perception).

The domains in which the client has very low ratings may become the focus of the first treatment plan update. The ratings in these individual domains can then be used to help the client understand problematic areas of the ASI ratings. For example if the client rated low in the Family/Social Status areas of the ASI there are likely to be low ratings in the Developmental, Socialization, and/or Psychological Domains. This process is repeated every 30-days to assess progress and to inform the ongoing treatment planning process between client and counselor.

The ASI data is analyzed in combination with the subsequent, sequential administrations of the CAI and SAS to support and direct the ongoing, collaborative treatment planning process between client and counselor throughout the entire continuum of treatment.

Summary of Proposed Assessment Instruments – Purpose, Validity and Application

Addiction Severity Index (5th edition) (ASI)
The ASI is a multidimensional clinical interview developed to address the premise that adequate evaluation of addictive behaviors must incorporate the context of the problem, with respect to both causal and consequent variables (Inciardi, 1994, McLellan et al., 1980). It is structured to break down into separate "problem areas" issues that either contribute to, or result from addiction: these include medical conditions, employment, alcohol use, drug use, legal involvement, family and social relations, and psychiatric status.

The ASI produces a problem severity profile for patients, with "Severity" defined as "need for additional treatment." based on objective data (questions about number, intensity and duration of problem symptoms over a lifetime, and within the past 30 days and client judgment, as measured on a 5-point Likert Scale.

McLennan, A.T. et al The Fifth Edition of the Addiction Severity, J. Substance Abuse Treatment 9:199-213, 1992

According to the National Institute on Alcohol Abuse and Alcoholism, the ASI instrument has been used extensively for both treatment planning and outcome evaluation, and has been normed with multiple treatment population groups. Its developers (McLennan, A.T. et al) recommend its use to match clients with appropriate treatments.

Client Assessment Inventory (CAI) and Staff Assessment Summary (SAS)
Measuring changes in the individual during treatment is a first step in the effort to understand the change process and what can be done to improve treatment effectiveness. The therapeutic

community (TC) Client Assessment Inventory (CAI) and Staff Assessment Summary (SAS) were developed specifically for that purpose.

"These instruments, derived from a comprehensive theory of TC treatment and recovery, measure client self-report and staff evaluation of client progress along fourteen domains of behavior, attitude, and cognitive change. Analyses of scale properties indicate that both client and staff instruments reliably differentiate clinical changes during treatment. Client self-ratings are initially consistently higher than staff ratings".

Kressel, D., De Leon, G., Palij, M., Rubin, G. J Substance Abuse Treatment, Measuring Client Clinical Progress in Therapeutic Community Treatment: The Therapeutic Community Client Assessment Inventory, Client Assessment Summary, and Staff Assessment Summary 19(3), pp. 267-272, 2000.

Upon contract award, CEC State Director, Jim Elder will provide training to Clinical Supervisors and Program Directors on the administration of the ASI and the CAI/SAS protocols as applied to reliable and adapted assessment procedures tailored to the correctional population.

Individualized Treatment Planning

Master Treatment plans will be completed within 7-days of admission to a CEC substance abuse program and will be based on the results of the ASI, collateral information gathered from DDOC (e.g. sentencing order, criminal history) and diagnostic impressions determined from the clinical interview. The client and his or her primary counselor co-develop and Individual Treatment Plan, completing information in each of the following categories:

- Problem number and description of problem
- Short term Goal
- Long Term Goal
- Method of Accomplishment
- Type/frequency (of intervention)
- Target date
- Date resolved

Problem areas include drugs and alcohol use, education, employment, legal, medical, family, sexual problems, religious/spiritual, behavioral or emotional and recreational. The client is responsible for self-identifying problems based on his or self-assessment and subsequent discussion with the counselor.

Treatment plan updates are developed between client and counselor through the CAI/SAS process. The client rates themselves using the CAI, and the Counselor rates the client using the SAS assessment instrument. The client and counselor compare and discuss their ratings; and this information is incorporated into the treatment plan updates. Treatment plans are updated a minimum of every 90-days to reflect progress made in areas specific to the fourteen treatment domains.

Individual Counseling, Minimum One Session Per Month

Individual counseling represents a face-to-face 50 minute session between a client and their identified counselor and are provided a minimum of once per month. Individual counseling sessions are goal-oriented, face-to-face meetings focused on the treatment plan. Sessions may be scheduled by the participant and/or counselor at any time. Individual counseling sessions center on treatment plan development, including the review, re-assessment, evaluation and revision of treatment plan elements. For example sessions may include review of the individual's progress toward recovery, steps to achieving the next level within the community, individual steps needed to be promoted to a higher position in the community, family relationship issues, sexual abuse issues, and other issues that are unique to the participant. During the Re-entry phase, individual counseling helps the participant plan for transition into the next phase of treatment, aftercare and/or to community-based services.

Caseload Therapeutic Groups, Weekly

Chemical dependency, like criminality, is a complex set of learned maladaptive behaviors that are often used to avoid, distort, deny, or overindulge an individual's feelings. Group process requires the offender to examine the role addiction plays in disguising or abetting these feelings, focusing on the importance of trusting and supportive relationships within the counseling group.

CEC offender treatment programs adhere to Walsh's assertion that "group counseling is not group therapy." [Walsh, A., Correctional Assessment, Casework & Counseling, American Corrections Association, 2001, 231.] Group therapy is more likely to deal with unconscious motivations and is a process that may last months or years. Group counseling, in comparison, is relatively short and focuses on specific life-adjustment problems. Per Walsh, the goals of the CEC's Self-Discovery Process group are directed toward the rejection of unrealistic and irresponsible values and behavior and the substitution of realistic and responsible values and behavior. The general goals of group are improved self-awareness, genuine problem sharing, an awareness of the self-defeating nature of a criminal lifestyle, improved coping skills, and an understanding of the benefits and possibilities of the straight life.

Self-disclosure, a central part of the Self-Discovery Process goup, is counter to the general "inmate code". Often inmates in a group session go to great lengths to lead the group away from themselves and toward others or to general topics. It is often necessary to counter these tendencies by providing more structure than would be the norm in similar groups for non-offenders. For example, role-play is an excellent method for focusing on interpersonal interactions, opening up reactions and creating awareness of entrenched responses to personal situations.

While these process counseling groups may be more structured than the classic psychotherapy group, therapeutic factors remain the foundation. Some of these factors, such as instillation of hope, universality/social comparison, development of socializing techniques, for instance, are mechanisms for change. Other factors such as altruism, imitative behavior and group cohesiveness represent characteristics of effective process groups.

Self-Discovery Process Group counseling occurs in "static" groups (i.e., a cadre of offenders that may include clients from each phase assigned to a particular counselor caseload) and is provided in weekly 90-minute sessions.

Psychoeducational Classes

While these process counseling groups may be more structured than the classic psychotherapy group, therapeutic factors remain the foundation. Some of these factors, such as instillation of hope, universality/social comparison, development of socializing techniques, for instance, are mechanisms for change. Other factors such as altruism, imitative behavior and group cohesiveness represent characteristics of effective process groups.

Psychoeducational topics will be drawn from the CEC comprehensive Group Education and Group Skills curricula library. Each type of group (education and skills) will be matched to the offender's phase of treatment and tailored to any specialized needs they may have (e.g. gender-specific, trauma informed, pre-adjudicated detainees, veteran offenders, young offenders, offenders with co-occurring disorders etc.). Group Education and Skills Groups are:

- Co-presented between staff and participants, or
- Partly presented by a participant or group of participants.

All sessions are highly interactive, using a facilitation method developed by CEC for the correctional clients known as Interactive Skills Training (IST). Research indicates that the target population is characterized by low literacy levels, limited ability for abstract or conceptual thinking, and shorter attention spans; and that interactive learning is most effective with this population.

These sessions are informative, but not "didactic" in the traditional sense. Each session is structured to include role play, (between two or more participants), "sole play", and/or role modeling for the group. Questions to the group, focused discussion, visual materials and homework assignments add to the learning experience and help participants to better internalize and retain information, ideas and behavioral skills more readily.

Supporting materials include facilitator guides, workbooks and other handouts and may include assignments for self-study ("homework assignments"). Some topics are introduced in one phase and expanded and reinforced in subsequent phases.

CEC's written group education and skills curriculum (and supporting materials) have been developed and refined over the past four years. All modules have been developed in cooperation with field researchers, or are based upon, and supported by published research sources. Upon contract award staff will be trained on the IST approach. An electronic disc of the curriculum library will be provided with material specifically tailored for use at each site. See **Section 2.2.15, Psycho-Education Treatment Topics,** for examples of curricula proposed for use with the DDOC contract.

Encounter Groups

CEC views the Encounter group as "the hallmark feature of the therapeutic community" and as "profoundly illustrating by example some of the TC's basic teachings: compassion and responsible concern, the necessity for confronting reality, absolute honesty, and self-awareness as the essential first step in personal change" (DeLeon, 2000). Staff facilitate the highly interactive process, making use of several traditional and non-traditional confrontational methods, enacted by senior members of the community. Staff presence and close monitoring is essential and is required by CEC without exception.

Upon award of the contract, CEC staff will be trained by the State Director and CEC's Director of Treatment Operations on the competencies required for becoming an effective facilitator of this important TC group process. A detailed description of the rationale and procedures of the Encounter Group are detailed in **Section 2.2.19, General Requirements: Treatment Methodology.** CEC proposes to offer encounter groups in DDOC programs 1-2 times weekly, and to modify the encounter process according to each program's population. For example, using "tempered" confrontation with co-occurring populations.

Urinalysis Testing

For a detailed description of role in applying urine surveillance as part of our approach to substance abuse treatment please refer to **Section 2.2.12, Urinalysis Testing**, of the proposal.

Addiction Education

CEC's proprietary curriculum *Addiction and Recovery* is offered to participants in the Orientation. Offered in six (6) sessions, these staff facilitated seminars provide a basic overview of the dynamics of addictive disorders and the basic principles of recovery. Developed as a "pre-treatment" curriculum, the sessions sequentially build upon one another as to allow residents to make an evaluation of whether or not they think addiction is a problem for them. The sessions offered are:

- Disease Model
- The Substitute Solution Model and Self-Medication
- Euphoric Recall and Self-Reinforcing Model of Addiction
- Denial and Defense Mechanisms
- Self-Assessment
- The Need for Support and Available Resources

Life Management Skills

CEC views the TC as a "training ground" for the application of practical life skills required for successful reentry. Our approach to substance abuse treatment views the "whole person" as the sum parts of cognitive, social, psychological and emotional dimensions. The integration of cognitive behavioral curriculum with the social learning model allows for residents to learn and rehearse life management skills necessary for living in the broader "free world" community.

Trauma Informed Care

As experienced providers of gender-specific, trauma-informed services, CEC and CCS are aware that experiences of trauma quite often precedes problems resulting in the incarceration of women (e.g. substance abuse and vulnerability to violence).

"*The prevalence of physical and sexual abuse among women in substance abuse treatment programs is estimated to range from 30 percent to more than 90 percent, depending on the definition of abuse and the specific target population. In addition, alcohol and drug problems have been shown to increase women's vulnerability to violence through exposure to unsafe situations* (Parks & Miller, 1997)".

Similar to substance abuse and increased risk of exposure to violence, the threat of and actual loss of children resulting from incarceration increases women's vulnerability to further trauma:

A survey of female inmates in the Massachusetts prison system revealed experiences of loss that contributed to feelings of disconnection and increased potential for traumatization:

"*Many women in prison have lost family members and/or experienced abuse in family or other relationships. Of women surveyed in a Massachusetts prison, 38 percent had lost parents in childhood, 69 percent had been abused as children, and 70 percent had left home before the age of 17. Seventy percent of women had been repeatedly abused verbally, physically, and/or sexually as adults. Further compounding the sense of loss and disconnection, the majority of women in the criminal justice system are mothers who may be at risk of losing their children during their incarceration*" (Garcia Cull and Duff 1996).

Within the criminal justice system "resistance" and "acting out" behaviors are quite often characteristic of the female population. These behaviors can mirror or mask underlying symptoms of PTSD. It is possible that many incarcerated women have undiagnosed PTSD, which may also contribute to the high prevalence of depression (the second most common disorder). Other research in trauma-informed treatment reveals that, "*Female abuse survivors typically demonstrate extreme difficulties with anger, depression, self-image and trust*". [2]

Both providers' integrated approach to trauma-informed treatment focuses on establishing three critical elements within the scope of services adapted to women impacted by trauma:

- physical and psychological safety;
- helping the client feel understood and safe within the therapeutic environment;
- enhancing resiliency, protective factors/"*self- righting tendencies*" that exist in everyone.

The targets of trauma-specific work for women reentering their communities following incarceration for both CEC and CCS is stabilization, safety, and understanding. Risk reduction

[2] New Directions for Mental Health Services: Using Trauma Theory to Design Service Systems, No. 89 Spring 2001. Maxine Harris (Editor), Roger D. Fallot (Eds.) April 2001

for relapse (a return to associated criminality) in a gender-responsive context necessarily includes addressing habituated patterns of criminality by communicating a therapeutic setting that fosters a "resiliency attitude" and adopts a culture built upon a "strengths perspective".

A 2004 study specific to the efficacy of relapse prevention strategies for females (*Qualitative Interviews on Substance Abuse Relapse and Prevention Among Female Trauma Survivors*)[3] demonstrates that individual relapse prevention skills by themselves were found to be insufficient for maintaining abstinence from substance abuse and associated criminal conduct. In the same study and describing what was most important to them in sustaining recovery, female trauma survivors articulated the four most meaningful topics:

- Connection to others
- Increased self-awareness
- A sense of purpose and meaning
- Spirituality

Lack of personal control was cited most frequently as an obstacle to maintaining recovery, together with depression. While relationships provided important support for sustained recovery, some of these same relationships increased emotional stress and conflict; paradoxically impeding recovery. The study's authors concluded that women-specific risk reduction strategies should:

Place a high priority on the development of boundary management and other relationship skills; attend to negative feelings such as boredom and loneliness;
develop a range of meaningful activities that is consistent with a strong sense of identity (Harris, 2005).

We propose to address these findings in three specific ways:

- Use of the evidence-based "TRIAD Women's Project" and other curricula, which addresses trauma-related issues
- Guided Autobiography project, to develop a strong personal identity and "voice"
- Careful screening and selection of culturally compatible staff that are trained incompetencies specific to building therapeutic rapport with the "suspiciously reluctant" female offender client

The selection of staff, trained in Motivational Interviewing, will serve as the basis for developing the appropriate gender-compatible, therapeutic culture necessary to facilitate enduring change amongst female program participants reflective of each agency's belief in focusing on clients' strengths rather than their weaknesses. CCS and CEC endorse the premise set forth by resiliency researcher and past president of the American Psychological Association, Martin Seligmann, Ph.D., when in a 2001 book cover commentary he wrote, "*The keystone of high achievement and*

[3] Harris, M., Fallot, R., and Berley, R. Special Section on Relapse Prevention: Qualitative Interviews on Substance Abuse Relapse and Prevention Among Female Trauma Survivors. Psychiatric Services 56:1292-1296, (2005), American Psychiatric Association.

happiness is exercising your strengths." "What is right with you is more powerful than anything that is wrong."

Co-Occurring Disorder Consultation and Treatment, Including Voluntary Mental Health Groups
CEC, and in the multi-vendor solution with CCS, offer a unique pool of resources to be able to meet the Department's needs for a truly integrated system of care. For a detailed description of our plan for an integrated treatment approach for the treatment of offenders with co-occurring disorders please refer to **Section 2.2.16, Co-occurring Disorders**, of the proposal.

Motivation Enhancement Components – Positive Reinforcement and Graduated Sanctions
Privileges may involve symbols of status, achievement and acknowledgement or tangible rewards due to individual or group efforts and attitudes. The overriding imperative regarding privileges is simply that they must be earned and not dispensed in a manner likely to cause to them to be taken for granted or viewed as entitlements. CEC's philosophy of treatment is to "catch people growing and changing". Public acknowledgement of growth or change can be a powerful re-enforcer for continued growth and change, and can have little or no cost associated with it. Additionally, the use of such privileges as eating popcorn, the use of a karaoke machine, being allowed to stay up later on weekends, or being allowed to be first to commissary, etc. can provide powerful incentives and peer pressure for complying with program expectations. CEC acknowledges that all such use of privileges must be worked out with and approved by the appropriate DDOC administrators, both at the unit level, and at the Program Administrator level. Sanctions are used in a graduate manner as to re-direct or impose incremental penalties for violations of rules or expectations by individuals or by the community-at-large. While the utilization of privileges to acknowledge good work on the part of individuals or groups is a proven, effective methodology; by the same token, the loss of such privileges for group members not "pulling their weight" often serves to create added peer pressure to comply with treatment expectations, at least in the earlier stages of the treatment and motivational process. The goal of dispensing privileges or sanctions is always a corrective experience for the individual or the group-at-large. When an intervention involves implementation of a sanction, staff will explain to the residents the reasons behind its use, and what can be done to remove the sanction.

Examples of potential Sanctions include:

- Bans (restriction such as on speaking or contact between residents, or on activities such as watching television, etc.).
- Restrictions, like the loss of the ability to engage in certain activities for a defined period.
- Setbacks, which involve returning to an earlier phase of treatment for not making or maintaining adequate individual or group progress.
- Formal disciplinary procedures are also possible for violations of institutional rules. With regard to the use of sanctions (as with privileges), CEC acknowledges that all such sanctions and their utilization must be submitted and approved by the appropriate DDOC administrators, both at the unit level, and at the Program Administrator level.

Consistent with research findings (Latessa, Cullen, Gendreau, 2012) for "what works" at with the offender population, CEC subscribes to the 4 to 1 Rule when shaping offender behavior. That

is, the ratio of four (4) reenforcers (rewards/incentives) is applied for every one (1) corrector (sanction/punisher).

Relapse Prevention

Relapse Prevention (RP) is an integral part of all correctional therapeutic community programs. CEC's RP program was developed initially under contract with NIDA as part of a five-year study on TC retention. Four Residential Treatment Models (NIDA Project IMPACT - RO1 6165) NIDA-funded research initiative (1989-1994). The goals of this project included evaluating and comparing the effects(in terms of completion rates, retention rates and behavioral outcomes) of: (1) a relapse prevention program and a Therapeutic Community; (2) a three month relapse prevention program and a six-month relapse prevention program; (3) a six-month Therapeutic Community and a twelve-month Therapeutic Community.

This five-year study resulted in a comprehensive Training Manual, developed in consultation with Alan Marlatt, Ph.D. that provides program staff with detailed instruction for each session of the RP Training Curriculum. The key assumption of RP Training is that that destructive habit patterns and thoughts can be changed through the application of self-management and self-control techniques. Strategies and techniques in three main areas increase participant's skills and abilities in controlling life choices:

- Acquiring adaptive coping skills as alternatives to addictive behaviors and crime
- Fostering new attitudes, attributes, and expectancies to combat the nature and chronicity of habit patterns (the "habit self")
- Developing a daily lifestyle that includes pro-social behaviors, activities and non-destructive ways of achieving personal satisfaction

Relapse Prevention modules provide a solid skill-set for participants to use when encountering the challenges of release. Specific tools are used to promote self-efficacy in recognizing personal triggers, building personally valuable coping skills and managing high-risk situations specific to the participant. Each community member is required to identify anticipated high risk situations specific to his/her environment, family, peers and associates, and to identify and practice applicable coping skills learned in the previous program phases. These personal RP plans are used in the development of the Release Plan Activity Checklist (RePAC) targeted to the individual's specific release challenges and potential relapse triggers.

CEC's Relapse Prevention Curriculum - Broad Topic Areas:

- Understanding Relapse
- Building a Support System
- Work 'N Recovery
- Identifying High Risk Situations
- Coping With High Risk Situations
- Roadblocks and Body Language
- Life Balance
- Urges & Cravings
- Breaking the Behavior Chain
- Preparing for a Lapse
- Relapse Prevention Planning
- Beginning a Personal RP Plan

RP strategies and topics are provided to staff as a full written curriculum comprising 24 sessions to be used as source materials for interactive group learning, skill building, role play and discussion. The RP sessions are aimed at fortifying protective factors and building up peer support systems to enhance the durability of an offenders recovery following completion of treatment.

Discharge and Transition Planning

CEC's discharge and transition plan for inmates - the Release Preparation Activity Checklist (RePAC) is a systematic tool for ensuring comprehensive preparation for all major areas of continuing recovery after release. The RePAC covers fourteen areas, including planning for housing, work, social relations, recovery services and finances.

For a detailed description of CEC's proposed implementation of the RePAC process and other reentry-oriented transitional activities please see **Section 2.2.11, Transition Resources**, of the proposal.

2.2.15 Psycho-Educational Treatment Topics

To enhance the client's "community experience", CEC supplements the (typically) long-term, developmental process of self-discovery, maturation and internalization of recovery principles with the use of more directive, staff facilitated cognitive-behavioral skill building and cognitive restructuring curriculum (Addiction Offender Cycle, Core Skills, Principles of Recovery, Correctional Recovery Training etc.). This provides the basic communication and self-management skills many participants need to successfully negotiate the next phase of their recovery, in prison or in the community. The curriculum complements TC methods, but is not in any way, intended to replace or compromise the Program's core methodology – social learning through "community as method". Each psycho-educational treatment session is purposeful, targeted toward criminogenic need, and evidence-based. The following tables provide a sample of the evidence-based curriculum proposed for DDOC programs:

Skills Acquisition

Core Skills		
Affirming	Focusing	Resourcing
Asserting	Forecasting	Self-Listening
Brainstorming	Handshaking	Self-Presentation
Calming	Humanizing	Tension Sensing
Danger Spotting	Prioritizing	Skills Streaming (Young Offenders)

Motivational Enhancement

Principles of Recovery	Nourish Your Spirit	**Addiction Education**
Step Slow and Steady	Remember the Past	Introduction to Self Help
Your Dangerous Situations	Truthful Living	Addiction and Recovery (1-6)
Stick to Your Structure	Learn by Practice	Orientation to the TC
Getting Motivated to Change (TCU)	Make the Moment Count	HIV and AIDS

Correctional Recovery Training

Anger Focused:	**Relapse Prevention (RP) Focused:**	**Reentry Focused:**
Gang Ups	Understanding Relapse	Coping with Risky Situations
Hear it Right	Here's Looking at Urges and Cravings	Pain and Prescription Drugs
Say it Right	Breaking the Behavior Chain	Roadblocks and Body Language
Reaching Agreement	Handling More Urges and Cravings	Problem Solving
Wounding Love	Identifying High Risk Situations	Building a Support System
RP Focused Part II:	**Reentry Focused Part II:**	**Reentry Focused Part III:**
Beating The Hunger Memory	Stages of Change	Resume Writing
Beating The Pain Memory	A Working Life	Interviewing Parts I and II
Craving Skills	Self-Presentation	Learn To D.E.A.L. (Decide Examine Act, Learn)
Craving Triggers and Traps	Handling the Green Drug	Release Preparation Activity Checklist (RePac)
No Taste Tests	Job Search	
Slip Stoppers	Honesty at Work	
Warning Signs	Communication	
Taking Root in Self-Help	Resourcing the System	

Skills Building

Parenting Focused (TCU):	**Life Skills:**	**General Skills:**
Building a Partnership	Learn to Deal with It: Life	Keepin' On
Self-Care for Parents	Stop and Think	Rejoyment
Child Development	Problem Identification	Friendly Support
Family Communication: *Active Listening*	Gathering Information	Family Ties
Family Communication: *Building Understanding*	Alternatives	Old Friends
Helping Children Behave	Evaluating Consequences and Outcomes	Using Help
Sensible Discipline	Practice, Practice, Practice	New Friends

Cognitive Restructuring

Criminal Thinking Focused:		
Too Proud to Learn	Why it's Called Getting Wasted	Character and Accountability 1-8
Life is Not Fair?	Getting Over	Thinking Errors (1-12 Sessions)
Authority and Freedom	Challenge, Excitement and Danger	
Wishing up the Negative Mind	Addiction Offender Cycle 1-8	

Gender Specific

Parenting Focused	**Wellness For Women**	**Relational Issues**
Achieving Dignity	Addiction, Relapse and the Body	Intro To Women's Relational Issues
Being A Parent	Anxiety and Tension	Boundaries and Assertiveness
Building Trust	Pain and Prescription Drugs	Health Relationships
Child Abuse	Personal Time	Roots, Roles and Relationships
Communication	Physiological Effects of Anger	Sexual Recovery – Sexual Respect
Effective Discipline	Substance Abuse and Pregnancy	Violence In the Home
Handling Anger	**TRIAD Women's Group** (USF – Florida Mental Health Institute)	**Women In Recovery** (Covington)
Setting Rules and Limits	*Part I:* Mindfulness (Sessions 1-4)	Women's Way Through the 12-Steps
Parenting While Separated	*Part II:* Interpersonal Effectiveness Skills: (Sections 4-8)	Helping Women Recover
Parenting Teens	*Part III:* Emotional Regulation (Sections 9-12)	
Parenting Guide	*Part IV:* Distress (Sections 13-16)	
Motherhood and Recovery		
The Magic List		

Co-occurring Disorders

Understanding Mental Illness Series (Hazelden, NAMI):	**Psychoeductional Series:**	
Understanding Bipolar and Addiction	Understanding Depressive Disorders	Bipolar and African Americans
Understanding Depression and Addiction	Understanding Eating Disorders	Understanding Post Traumatic Disorders
Stigma: Building Awareness and Understanding about Mental Illness	Understanding Mood Disorders	Understanding Postpartum Disorders
What is Dysthymia?	Understanding Borderline Personality Disorders	ADHD: Understanding the Problem
Coping with Loss: Bereavement and Grief	Paranoia	An Overview of Psychotropic Medications
Self-Injury	Bulimia Nervosa and	Anorexia Nervosa

2.2.16 Co-Occuring Disorders

A significant number of offenders who abuse substances also have co-occurring mental disorders that make treatment more complex. Substance abuse or mental health training alone is not sufficient for dealing with the interaction of both disorders, which are constantly influencing each other. The integration of substance abuse treatment and mental health services, in combination with approaches that address criminal thinking/behavior, as well as safety concerns is necessary due to the prevalence and complexity of co-occurring disorders in prison and community correction programs. CCS and CEC are committed to working with BHCS to

implement an ***integrated approach*** to treating offenders with co-occurring disorders, and we believe that such an approach can help us to achieve the overarching goal of our shared mission; **Recidivism Reduction and Improved Public Safety**.

CEC's experience with evidence-based practices and a review of the literature on co-occurring disorders led to our conclusion that the best approach was to use an evidence-based model developed by the Substance Abuse and Mental Health Administration (SAMHSA) to guide the implementation of our integrated treatment approach for offenders with co-occurring disorders in DDOC Therapeutic Community programs.

Evidence-Based Practice Model: Integrated Approach. Evidence-based practices are validated by many randomized controlled research trials. They represent the best treatments available and should be adopted wherever possible throughout the behavioral health system. The practice of treating substance abuse separately and independently from mental illness has led to poor outcomes both clinically and in relation to cost. A growing body of research indicates that treatment outcomes are significantly improved when individuals with co-occurring disorders receive integrated care. In contrast to sequential or parallel treatment, integrated treatment involves a single, combined treatment team treating both disorders at the same time and in the same setting.
Fragmented and uncoordinated services lead to service gaps and poor outcomes for individuals with co-occurring disorders. Offenders with co-occurring disorders have a better chance of recovering from both disorders when they receive substance abuse and mental health treatment in an integrated fashion.

Research indicates that individuals in integrated treatment programs are more successful than individuals in non-integrated programs:

- Reduced substance use
- Improvement in psychiatric symptoms and functioning
- Decreased hospitalization
- Fewer arrests
- Improved quality of life (Drake et al., 2001)

Therapeutic communities, cognitive behavioral approaches, relapse prevention strategies, and peer support groups can be adapted to suit the particular needs of offenders with co-occurring disorders. Common modifications include:

- Smaller caseloads
- Shorter and simplified meetings
- Special attention to criminal thinking
- Education about medication and co-occurring disorders
- An effort to minimize confrontation (Edens et al. 1997; Peters and Hills 1997; Peters and Steinberg 2000; Sacks and Peters 2002)

Based upon the key components of SAMHSA's integrated treatment for co-occurring disorders evidence-based model, CCS and CEC are proposing to:

1. Establish multidisciplinary teams comprised of medical, mental health and substance abuse treatment staff (i.e. psychiatrist, nurse, case manager, etc.) that will work collaboratively as a co-occurring case review team.

   CCS and CEC plan to establish three (3) multidisciplinary teams (2 in New Castle County and 1 in Kent/Sussex) to perform case review functions, oversee and coordinate medical, substance abuse and mental health interventions in an integrated fashion. A regular schedule of monthly meetings is envisioned for each team. The multidisciplinary teams will promote communication between medical, mental health and substance abuse staff with regard to mental health and substance abuse diagnoses, medical conditions, psychotropic medications and other treatment related issues/concerns.

   In addition to their important case review, communication and coordination functions, the multidisciplinary teams will play an important role in the provision and monitoring:

   - Voluntary mental health groups for offenders with co-occurring needs
   - Psycho-educational classes on mental health issues and co-occurring disorders
   - Appropriate use of psychotropic medications

2. Employ Integrated Treatment Specialists - staff with specialized training in the treatment of co-occurring disorders - to work collaboratively with the multidisciplinary team, modeling integrated treatment skills and training other staff in evidence-based principles/practice.

   CCS and CEC plan to expand the number of staff with knowledge of both substance use disorders and serious mental illnesses, and the complex interactions between these disorders. It is anticipated that one or more integrated treatment specialists will participate in each multidisciplinary treatment team. Integrated treatment specialists will be trained in assessment, treatment strategies and psychopathology for both substance abuse disorders and mental illness. These specialists will work to cross-train other treatment team members to disseminate information and skills about treating offenders with co-occurring disorders. The goal is to have two (2) Certified Co-Occurring Disorders Professionals (CCDPs) on each of the three multidisciplinary teams, for a total of 6 certified integrated treatment specialists dedicated to serving the DDOC Therapeutic Community programs statewide. CEC's proposed Deputy State Director is a Certified Co-Occurring Disorders Professional Diplomate (CCDPD) who will take an active role in the development of staff with specialized training in the treatment of co-occurring disorders.

3. Use Stage-wise Interventions to ensure that all services are consistent with and determined by each offender's stage of treatment (engagement, persuasion, active treatment, relapse prevention).

Please see **Section 2.2.13, Program Requirements: Program Phases**, for a complete explanation of the phases of treatment. Services for offenders with co-occurring disorders will be tailored according to their stage of treatment. Multiple treatment formats such as individual, group (item #6 below), self-help (item #8 below) and family (item #7 below) will be available to offenders at appropriate stages. Motivational interventions provided individually (item #4 below) will be used especially in the persuasion stage to help offenders identify personal recovery goals. Cognitive-behavioral counseling (item #5 below) will be used to treat offenders in the active treatment and relapse prevention stages. Group treatment led by both professionals and peers will be available during the active treatment and relapse prevention stages. Self-help groups can help offenders feel less alone/isolated and assist them to develop peer networks. These groups offer support that is particularly useful in the relapse prevention stage.

4. Use Motivational Interventions such as expressing empathy; developing discrepancy, avoiding argumentation, rolling with resistance, instilling self-efficacy and hope as the basis for staff interactions with offenders in the co-occurring integrated treatment program.

   Please see the discussion regarding Enhanced Intrinsic Motivation in the Substance Abuse Program **Section 2.2.3, Program Description**. Regardless of the population served or service delivery environment, each of CEC's programs rely upon fundamental baseline strategies designed to enhance intrinsic motivation through use of Motivational Interviewing, Counseling and Treatment within a Stages of Change developmental framework. Motivational interventions are a critical component of an integrated treatment approach for co-occurring disorders. Trained staff with listening and counseling skills can assist offenders in identifying and achieving personal recovery goals.

5. Provide active Substance Abuse Treatment and Relapse Counseling that includes:
   - How to manage cues to substance use and consequences of use.
   - Relapse prevention strategies.
   - Drug and alcohol refusal skills training.
   - Problem-solving skills training to avoid high-risk situations.
   - Coping skills and social skills training.
   - Challenging offenders' beliefs about substance abuse.

   Detailed information regarding substance abuse treatment and relapse counseling can be found in **Section 2.2.3, Program Description**, and **Section 2.2.15, Psycho-Educational Curriculum and Treatment Topics**. Cognitive-behavioral counseling will be used to help offenders manage patterns of thought that lead them to abuse substances. Learning to identify and change thoughts/feelings that trigger the urge to use, can help offenders to avoid substances.

6. Provide Group Treatment for offenders with co-occurring disorders that is specifically designed to address both substance abuse and mental health problems.

   Group treatment is discussed in **Section 2.2.3, Program Description**, and **Section 2.2.13, Program Requirements**. Substance abuse staff will provide psycho-educational classes on mental health concerns, co-occurring disorders, treatment and appropriate use of psychotropic medications. Mental Health staff will provide voluntary mental health groups for offenders with co-occurring needs.

7. Provide Family Interventions designed to provide education about co-occurring disorders and offer coping skills training to reduce stress in the family and promote collaboration with the treatment team.

   A discussion of family interventions is included in **Section 2.2.3, Program Description**, and **Section 2.2.13, Program Requirement**. When family members are educated with regard to both substance abuse and mental illness they are better able to effectively support offenders with co-occurring disorders. The inclusion of family or other supporters in treatment can help offenders establish a non-substance using social network.

8. Promote participation of offenders in Alcohol and Drug Self-help Groups during active treatment and relapse prevention.

   Please see **Section 2.2.3, Program Description**, and **Section 2.2.13, Program Requirements**, sections for information on self-help groups and the Alumni Association. Peer networks can make a significant contribution to treatment. Peers with similar experiences can offer support and empathy that is integral to successful active treatment and relapse prevention.

9. Incorporate Pharmacological Treatment and train prescribers to:
   - Work closely with offenders and the treatment team.
   - Focus on increasing adherence to psychiatric medication.
   - Avoid prescribing medications that may be addictive.
   - Prescribe medications that help reduce addictive behavior.

   CEC proposes that physicians and nurses that prescribe medication will participate in multidisciplinary treatment team meetings, and will be trained to treat co-occurring disorders. Medical providers will work closely with other members of the multidisciplinary teams to ensure that treatment for both substance abuse disorders and mental illnesses is provided in an integrated fashion. Offenders with co-occurring disorders often take multiple medications at various times during the day. These individuals will be trained in strategies to help them remember their medication regimes.

10. Develop a co-occurring disorders training plan.

    Training is discussed in **Section 2.2.9, Treatment Staff Description and Qualifications**. CCS and CEC will implement basic co-occurring disorders training for medical, mental health and substance abuse staff at all levels. More intensive training will be provided for staff designated to provide services for offenders with co-occurring disorders (integrated treatment specialists), and medication prescribers. CEC's proposed Deputy State Director is a Certified Co-Occurring Disorders Professional Diplomate (CCDPD) who will take an active role in the development of staff with specialized training in the treatment of co-occurring disorders.

    Since effective treatment depends on integrating mental health and substance abuse treatment, it is important for all staff to develop a basic understanding of the evidence-based model for integrated treatment for co-occurring disorders. Training will be ongoing (as opposed to one-time), and will feature periodic "booster" training sessions. Intensive training for staff specializing in the treatment of co-occurring disorders is anticipated to include a group training series of at least 5 half-day sessions. Use of an on-line curriculum that will lead to certification as a Co-occurring Disorders Professional (CCDP) is also anticipated. The Focus on Integrated Treatment interactive, online training program will be used to help addiction treatment and mental health professionals develop the skills necessary to successfully deliver an integrated treatment plan for individuals with co-occurring disorders.

The goal of this evidence-based practice model is to support offenders in their recovery process. Integrated treatment supports and empowers offenders to actively participate in the definition and achievement of their treatment plan goals. The CCS and CEC treatment models already incorporate many evidence-based practices. Appropriate co-occurring related modifications will be collaboratively phased in with fidelity to the SAMHSA model discussed above. A general timeline for development and implementation of the integrated treatment model is outlined in table below. It is anticipated that a Mental Health Liaison on the substance abuse treatment provider's staff will be responsible for coordinating the implementation of the evidence-based integrated treatment model for co-occurring disorders.

Implementation Schedule Integrated Treatment Approach for Co-Occurring Disorders Evidence-Based Model				
Component	Year 1 July '12 – June '13	Year 2 July '13 – June '14	Year 3 July '14 – June '15	Year 4 July '15 – June '16
Multidisciplinary Team	Establish 2 NCC teams & 1 K/S team in July 2012		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2014	Ongoing monitoring for adherence to evidence based practice

Implementation Schedule Integrated Treatment Approach for Co-Occurring Disorders Evidence-Based Model				
Component	Year 1 July '12 – June '13	Year 2 July '13 – June '14	Year 3 July '14 – June '15	Year 4 July '15 – June '16
Integrated Treatment Specialists	1 Clinical Supervisor to become a Certified Co-Occurring Disorders Professional (CCDP)by June 2013	Total of 2 Certified by June 2014	Total of 4 Certified by June 2015 Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2014	Total of 6 Certified by June 2016
Stage-wise Interventions		Make Adjustments to Existing Treatment Model Stages by December 2013		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2015
Motivational Interventions		Make Adjustments to Existing Treatment Model Motivational Interventions by December 2013		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2015
Substance Abuse Counseling	Make Adjustments to Existing Treatment Model by June 2013		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2014	Ongoing monitoring for adherence to evidence based practice
Group Treatment for Co-occurring Disorders		Make Adjustments to Existing Group Treatment Model by December 2013		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2015
Family Interventions for Co-occurring Disorders		Make Adjustments to Existing Treatment Model for Family Interventions by June 2014		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2015

Implementation Schedule Integrated Treatment Approach for Co-Occurring Disorders Evidence-Based Model				
Component	Year 1 July '12 – June '13	Year 2 July '13 – June '14	Year 3 July '14 – June '15	Year 4 July '15 – June '16
Alcohol and Drug Self-Help Groups	Make Adjustments to Existing Self-Help Group Model by June 2013		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by June 2015	Ongoing monitoring for adherence to evidence based practice
Pharmacological Treatments	Begin training for prescribers by June 2013		Complete an Assessment of Fidelity to the Evidence-Based Model for this Component by December 2014	Ongoing monitoring for adherence to evidence based practice
Training Plan	Establish a training plan and training standards by September 2012.	Assess extent to which staff meet the established training standards by December 2013; and make adjustments as necessary.	Review annually	Review annually

2.2.17 Additional Treatment Activities

CEC acknowledges and accepts that substance abuse participants are, generally speaking, separated from the general offender population during daily routines. We also understand that participants benefit from participation in other classes, high school/GED education, work assignments, religious programs and mental health/medical services while incarcerated. CEC concurs that in doing so offenders have the opportunity to put their program "learning" into the practice of "living" within the institutional environment and thereby extending the TC's rehearsal of Right Living precepts into the broader prison "community". To support the effort, CEC will incorporate these activities within the participants' treatment plan.

2.2.18 Phase Movement

As detailed in **Section 2.2.13, Program Requirements**, of the proposal, there are four phases within the CEC residential TC continuum: Phase I, Phase II, Phase III and Phase IV (Aftercare). Each phase has underlying theoretical assumptions regarding a foundation of internalized skills acquisition and the development of cognitive awareness and emotional maturity required to progress to the next phase. In addition to the Standard Achievements described in the preceding section, other factors influencing phase advancement eligibility include:

- Time in program as determined by parameters of a client's sentencing order, individual treatment needs and type of program.

- Progress toward meeting specific treatments plan objectives and reentry readiness as determined by clinical case review inclusive of input from DDOC and other vendor provider staff (e.g. medical, mental health, education etc.).
- Residents' demonstrated understanding of the various phase specific curriculum as evidenced by passing scores on phase tests.
- Ability to behaviorally demonstrate skills acquisition through role play during cognitive behavioral group sessions and/or through day to day interactions ("walking around behavior") within the peer community setting.
- Responsible commitment to his or her therapeutic job/structure board assignment within the community's social organization.
- Frequency/recency of graduated sanctions (e.g. Learning Experiences).

Peer Review Panels

In order to establish standardized performance based criteria for phase advancement of residents participating in Delaware's TCs, CEC proposes the following operational guidelines for Self-Assessment, Peer Review Panels and Clinical Case review as clinical practice to be standardized across all programs in the state.

Policy: Phase Movement

1. It is the policy of the CEC to utilize a shared locus of control between residents and clinical staff, with the staff maintaining ultimate authority, when reviewing residents' level of preparedness for phase advancement.

2. Clinical staff is responsible to provide residents with, content and phase specific, cognitive behavioral sessions within each phase (stage) of the treatment continuum in order to assist residents in developing the necessary skills competency required for phase (stage) advancement and eventually program completion.

3. Completion of the programs' three-phase continuum is defined by measurable progress in acquiring pro-social behaviors and attitudes combined with positive community engagement, rather than time spent in program.

4. Effective programming for Phase advancement targets completion ranges between 65-85% annually. Oversight initiatives to monitor completion rates are the responsibility of the Delaware State Office.

5. Delaware CRP programs utilize the Standard Achievements Inventory in order to objectively measure skills acquisition, core clinical competencies development and the intended objectives relevant to each phase of the programs' developmental continuum.

Procedure:

I. ATTENDANCE CRITERIA

1. Residents are expected to attend each treatment session relevant to their respective phase. The frequency of attendance to each session is to be determined by the program's length of stay, intensity of service, contractual guidelines and level of custody.

2. Each resident is responsible for maintaining a weekly attendance sheet that is signed by the staff facilitator at the conclusion of each cognitive behavioral session the resident attends. Completed attendance sheets are turned in weekly to the resident's identified counselor during Self Discovery Process Group to assist with recording monthly summaries of client activities.
   a. Residents are expected to be fully accountable for this effort. Failure to submit weekly attendance will result in the resident not receiving credit for any sessions attended during that week.
   b. Any reason for a resident's absence from any scheduled sessions should be clearly documented within their clinical record in the form of a case management note.
   c. Staff is responsible for filing completed attendance sheets in section six of the resident's clinical record prior to the end of their scheduled workweek.

II. STANDARD ACHIEVMENTS PROCEDURES

A. Self-Assessment and Peer Review

1. Upon documented completion of all phase-specific, mandatory groups, each resident completes the Resident Self-Assessment version of the Standard Achievements Inventory.
   a. Master copies of the Resident Self-Assessment are to be maintained by members of the Ways and Means committee.
   b. Ways and Means are responsible to distribute copies only to those members eligible for phase (stage) testing.
   c. Staff is responsible to make reasonable accommodations for residents with learning disabilities to ensure a comparable opportunity for self-assessment is provided.

2. The client then schedules an appointment with the Leadership Committee members, in order to participate in a peer review for phase/stage testing eligibility.
   a. This peer-to-peer interview process is held weekly and overseen by the program director in order to ensure the fidelity of the review process.

3. During the Leadership Committee interview process, the resident applying for phase (stage) testing presents their reasons for their self-rated Standard Achievements Inventory and their rationale for readiness for consideration for phase (stage) testing.

a. Items # 16, 18, 19, 20, 21, 22, 23 from Standard Achievements Inventory should be presented verbally during the peer review as evidence of competency in these critical objective items.

b. Members of the peer review panel are also responsible for completing their version of the Standard Achievements Inventory as the interview proceeds.

4. At the completion of the peer review process, the senior member (Coordinator) of the Leadership Committee is responsible for forwarding a written report to the program director. The leadership report should minimally include the following items:

   a. Names of all residents interviewed and what phase the residents were applying for,

   b. Reason(s) for the leaderships' collective decision to decline or approve testing eligibility for each resident interviewed,

   c. All copies of the Standard Achievements Inventory completed by members of the peer review committee.

B. Clinical Team Case Review

5. Upon review of the Leadership Committee's report, the program director is responsible for generating a list of resident names scheduled to be reviewed at the next clinical case team review and for distributing this list to all counseling staff and to the clinical supervisor in advance of the next clinical team review meeting.

6. Prior to the clinical case review the counselors are responsible for completion of the staff version of the Standard Achievements Inventory / Case Conference form for each eligible resident.

7. During weekly clinical case review each of the residents' eligibility for phase testing is reviewed by the clinical team based upon standard achievements scoring of the resident, their peers and the residents' identified counselors.

8. The final decision regarding eligibility for phase testing is to be determined by the clinical supervisor and/or program director at the conclusion of the clinical team review process.

9. Once approved, the residents' names should be posted on the community board under "Eligible for Phase Movement" heading.

10. Residents approved for testing will take the phase/stage test at the next scheduled testing date.

    a. In the event the resident is not approved during clinical case review it is the responsibility of the resident's identified counselor to meet with the resident and outline the reasons for the team's decision and explain what performance areas need to improve prior for future phase movement consideration.

11. The clinical team approves no less than 65% and no more than 85% of residents reviewed for phase advancement per month in order to maintain the fidelity of the above referenced processes as reflective of a performance based program that expects residents work toward sufficient competency related to reducing their potential to re-offend once discharged from the program.

Additional Phase Test Procedures:

- If participant experiences difficulty taking the written Phase test, he/she will be administered the test orally.
- The primary counselor or multidisciplinary committee may recommend that the participant is tested orally.
- If the participant scores less than 90% on the Phase Test, he/she will be re-tested one week later. If the participant took a written test, the treatment team will determine if the re-test should be given orally.
- If the re-test score is less than 90%, the treatment team will make a clinical determination of whether the participant has put forth his best effort. If determination is that he is performing to the best of his ability academically and that his behavior is appropriate, he will be advanced to the next phase. If not, he will have to repeat the Phase.

2.2.19 General Requirements

Treatment Methodology

According to George DeLeon, "the therapeutic community is a unique social and psychological approach for changing individuals." De Leon articulates that all approaches to substance abuse treatment can be conceptualized as a combination of:

a. Treatment ingredients which consist of the interventions used to produce change
b. The changes these interventions produce
c. The principles or mechanisms that link individual changes to the ingredients bringing them about

In this manner, it is the multiple interventions within the TC context, consisting of the daily regimen of activities and social interactions, blended with a particular set of expectations for participation, and a corresponding process of distributing rewards and sanctions aligned to the set of expectations within the framework of the activities or social interactions, that constitute the TC methodology.

Within the TC framework, the conventional offender/counselor relationship is necessarily limited to ensure that offenders themselves are the main actors in their own treatment as they negotiate the process of pro-social change, learning to work and live together, and developing the social and problem-solving skills needed to work and live effectively outside of the prison environment.

Job functions, community dynamics, various groups and meetings, along with the use of community processes, privileges and sanctions, are the primary mechanisms for changing attitudes and behaviors. These components are implemented under the auspices of both treatment and correctional staff, working together to provide appropriate oversight as the "rational authority".

Most of these ingredients (such as the use of job functions and community dynamics) have been previously noted; however the additional ingredients of groups and meetings, as well as privileges and sanctions are outlined below:

Groups in the TC

Rationale:

In the TC, groups play a significant part in the residents' change process and can be classified as either Educational or Clinical. Group participants learn about themselves and their recovery process by identifying and coping with feelings about people and life situations. Groups focus on peer interactions reinforcing the self-help and mutual self-help process. The interplay of feedback among group members is pivotal for fostering change.

Educational Groups encourage personal growth, provide job skills and coping skills training and teach residents about other TC treatment activities. Educational groups include:

- **Personal Growth** groups are informal, staff-led sessions, for 10-20 residents. These group sessions lasting one to two hours. Personal growth groups allow residents to discuss recovery-related topics and learn how to explore concepts in an intellectual or conversational format. The group provides an opportunity for residents to measure how their thinking about a particular topic has changed over time.

- **Job Skills** groups are led by staff members and senior residents. They are designed to teach residents about specific therapeutic jobs in the TC, the proper way to carry out these job functions and their clinical purpose. Job Skills groups are designed to enhance a sense of affiliation with the TC; and to support residents in developing vocational aptitude and attitudes required for successful community re-entry .

- **Clinical Skills** groups are led either by outside volunteers or TC staff and focus on specific skills residents need in mainstream society, such as:
    - Coping Skills
    - Parenting
    - Budgeting
    - Resume writing
    - Job interviewing

- **Reentry** groups are staff facilitated and are intended to prepare residents to move back into the greater community. The chief focus of reentry groups is to address release planning, relapse prevention strategies and sober support group affiliation.

Clinical Groups provide residents with the opportunity to develop emotional awareness, and gain insight into their behavior and that of others. These groups help members relate to others experience and situations, receive healing affirmations from peers and staff and exhibit leadership. The principal clinical group in the TC is the Encounter Group.

- Encounter Groups are described by DeLeon (2000) as "the hallmark feature of the therapeutic community" and as "profoundly illustrating by example some of the TC's basic teachings: compassion and responsible concern, the necessity for confronting reality, absolute honesty, and self-awareness as the essential first step in personal change."

The value of the encounter is its therapeutic potential to bring into focus for residents the exact nature of habituated, maladaptive thinking and behavioral patterns associated with the drug/criminal lifestyle. Thus the encounter group, by its very definition, is confrontational and ultimately aimed at raising awareness of deeply ingrained behaviors and attitudes which helped residents survive in their negative lifestyle.

Residents who are offended by the action of another are encouraged to "submit a slip" (i.e. brief written outline of the concern) in order to initiate their request to speak to the offending community members. Typically this is done when the offending conduct has not been appropriately redirected by the use of another community tool – the "pull up" or if the offending behavior is of such an offensive nature, that it requires the structured, regularly scheduled, staff facilitated format of the weekly encounter group. Submitting a slip serves two essential purposes:

1. It allows the resident submitting the slip to identify and learn to appropriately express their feelings regarding the impact the offending behavior had on them.
2. It brings to light for the offending resident the impact that their behavior may have on peers and the fact that such behavior may be the due to a long-standing habit of negative behaviors/attitudes.

While a resident is being confronted they are not allowed to directly react or respond. They are first expected only to listen and demonstrate they have heard the confronting peer. Once the confronter has completed a description of the offending behavior/attitude, described its emotional impact on them, and expressed their concern, then the confronted resident is given the opportunity to explain, or "defend" themselves, or take ownership of the problem behavior and verbally make a commitment to change.

Ultimately the clinical purpose of the Encounter Group is to raise self-awareness of self-defeating behaviors and attitudes by teaching residents to:

- Show compassion and responsible concern for one another
- Confront the reality of their substance abuse problem and associated criminal sentiment
- Be honest about their feelings and commitment to change their behavior
- Seek self-awareness as the first step to behavior change
- Resolve interpersonal issues or concerns they may have with one another

Tools of the Encounter Group:
Two overarching types of encounter group tools are used during the interpersonal exchange; Provocative and Evocative interpersonal verbal communication strategies.

- Provocative tools challenge and confront residents
- Evocative tools support and encourage residents

Provocative group process tools include:

- Controlled hostility or anger: Expressing angry feelings in an appropriate manner to intensify awareness of the impact of the offending behavior
- Engrossment: Exaggerating the offending behavior to penetrate ambivalence
- Humor: Promoting laughter so residents recognize their false images, prejudices and stereotypes

Evocative group process tools include:

- Identification: A feeling of relatedness between two people who have had a common experience and share similar feelings. Identification is demonstrated when residents express they understand the feelings of another resident because they have had a similar experience.
- Compassion: A feeling of concern for a person who is suffering. Compassion is demonstrated when a resident comforts/reassures another who is experiencing painful emotions.
- Empathy: The ability to put oneself in another's shoes and convey understanding of his feelings.

Rules of the Encounter Group:
The primary guideline for encounter groups is to confront behaviors and attitudes, not people. An overarching principle in the TC is "Confront the Behavior, Not the Person". To this end the following guidelines provide group members with necessary psychological and physical safety to foster a positive and healthy sense of self and community.

Residents are allowed (and encouraged) to express both positive and negative feelings about one another to raise self-awareness, while following certain rules that prohibit:

- Explicit or implicit threats
- Deliberate or spontaneous group oral attacks on one person (e.g., "rat packing")
- Deliberately derogatory comments
- Interrupting the encounter group by coming to the aid of a confronted group resident (e.g., "red crossing")
- Name-calling, labeling, or making stereotypic references to race, ethnicity, gender, a disability, or family members

- Walking around or changing seats during the session – unless directed to do so by the facilitator
- Irrelevant or side conversations.

Repeated breaking of the rules of the encounter group can lead to sanctions, such as ejection from the group or expulsion from the program, depending on the severity of the violation. While Learning Experiences and/or other sanctions are typically not issued in response to incidents or behaviors that are revealed/exposed during the encounter, there are some exceptions where this may be the case (e.g. Cardinal Rule Violations or other serious program or institutional rule infractions). However, Learning Experiences and Sanctions may result for inappropriate conduct during the group session as with any Group or Meeting in the TC.

Phases of the Encounter Group:
The interpersonal exchange during an encounter advances through three distinct phases: confrontation, conversation, and closure/social.

During the **CONFRONTATION** phase

- The facilitator asks the residents who wrote a slip to state their observations and reactions to the resident's behavior.
- Other group members may provide additional observations.
- Group and staff members use provocative group tools to focus attention on the issues and to evoke the feelings of the person being confronted.
- The resident being confronted is expected to listen and respond to his or her peers' comments.
- The confrontation phase is over when the resident acknowledges and accepts the group's reaction to his or her behavior.

During in the **CONVERSATION** phase:

- The group encourages the resident to focus on the identified behavior or attitude and talk about his or her feelings.
- Group and staff members use evocative tools to deepen the resident's understanding of the problem and to discuss reasons for his or her rationale and defenses.
- The conversation phase is over when the resident
- Demonstrates an understanding of the confrontation
- Can label his or her feelings
- Can state his self-defeating pattern of behavior or attitude
- Can ask for help in making personal changes.

During the **CLOSURE** phase:

- Group members provide positive encouragement, feedback, suggestions, and support to the resident being confronted.

- Group members make suggestions to help the resident learn how to make positive changes.
- Group members speak with warmth, support, and affirmation to balance the first two phases.
- The closure phase is over when the resident makes a commitment to change and states what he or she will do differently.

During the **SOCIAL** phase:

- The entire TC membership participates in 30 minutes of informal socializing to continue the closure phase of supporting, affirming, and encouraging residents to change their behaviors and attitudes.
- Senior peers reach out to residents who may be upset about their encounter experience and offer words of support and encouragement to remain open to the feedback of others.
- Staff takes the opportunity to assess the overall health of the community as well as individual responses to the encounter group session.

Role of staff in the Encounter Group:

- The role of staff members during the encounter group session is to
- Supervise the preparation and selection of residents to participate in an encounter group.
- Facilitate the group process along with senior peers.
- Observe the process and residents' reactions and behaviors.
- Provide feedback to other staff members who may not have been present for the encounter group.
- Decide whether an emergency intervention is needed in order to keep the encounter group in line with established parameters.

Resident Meetings in the TC

Rationale:

"Community" is the primary means of teaching and healing in the Therapeutic Community (TC). To that end, the common purpose of all Meetings in the TC is to strengthen the sense of community. All meetings are prepared and organized components of the structured day within the TC. Participation in meetings is part of the healing and recovery process and contributes to a sense of orderliness and purpose. Meetings provide a structured way to address individual and collective concerns and to reinforce the main messages of recovery. Meetings in the TC help program staff account for each resident and assess group members' progress.

In general, the purpose of all meetings in the TC is to enhance the sense of community and contribute to the residents' healing/recovery process.

Meetings Provide Structure: Meetings are the organized components of the day. Participation in meetings is part of re-establishing interpersonal connectedness that is essential to the process of

recovery. The planned, structured nature of meetings also contributes to establishing the sense of orderliness and purpose that is absent in the undisciplined and chaotic lifestyle of addiction and crime.

- Resolve issues: Meetings provide a structured way to address both individual and collective concerns, and reinforce the main messages of recovery.
- Communicate to all members of the TC: Meetings provide an efficient means of communication in the TC because both staff members and residents are required to attend.
- Assess individual and collective moods of the TC: Daily meetings help staff members assess individual or group moods. Residents who are withdrawn and not participating are considered at risk for dropping out.

TC meetings include the following:

- Morning meetings are brief (30 to 45 minutes) and are led by residents to start the day on a positive note.
- Community Meetings are held once a week. They are facilitated by the Program Director and allow for general announcements about the program and unit operations.
- Community Awareness or General Meetings are held as needed to address community-wide problems.
- Evening Meetings are held every night to disseminate information, take care of community business concerns/needs and plan for the next day.
- Seminars are also considered meetings and are designed to:
    - Educate residents about various topics and provide intellectual stimulation
    - Help residents examine their personal values
    - Stimulate insightful thinking
    - Help residents understand the TC and its philosophy
    - Raise awareness of important recovery issues
    - Help members develop the ability to express themselves, building confidence and self-efficacy
    - Enhance residents' attention spans, listening and speaking skills

Key Elements of TC Meetings					
Meeting Type	Morning Meeting	Community Meeting	Evening 'House' Meeting	Seminar	General Meeting
Purpose:	Initiate positive outlook, motivate participation, build community	Allow for general announcements and unit operations	Manage community business, disseminate information	Cognitive behavioral, interactive sessions related to skills acquisition, criminal thinking errors and the TC perspectives	Called by Program Director to address serious problems that threaten the integrity of the community
Frequency:	Daily	Once per week	Daily	Daily	As needed
Duration:	30 minutes	1 hour	30 Minutes	1 hour	Open-ended
Staff Role:	Review preparation efforts by peers Voluntary participation	Facilitated by Director who is responsible for preparation and oversight	Review of peer preparation and oversight	Facilitator using Interactive - Experiential Training methods	Facilitated by Director, supported by staff's attendance and input
Peer Role:	Preparation by Committees, Peer Master of Ceremonies and Active member participation	Attendance and limited participation by selected Sr. Residents	Highest ranking peers responsible for preparation and implementation	Active participant taking notes, participating in interactive role play and facilitator when assigned	Attend, listen and correct the problems within the community

The Morning Meeting:

Rationale:

Morning Meetings are designed to initiate the activities of the day on a positive, up-beat note. Activities in the morning meeting should be designed to inspire, strengthen awareness of, and appreciation for, the program as a community. This *intentionally uplifting* start of the day stands in stark contrast to the unstructured, often negative start of the day often shared by drug users who perceive the routine of life in a correctional setting as boring, uninteresting and burdensome. Also for many when they were in the community abusing drugs, the only planned activities for the day involved drug-seeking or other negative, destructive activities. Therefore many residents previously resented the demands of routine life. Thus the Morning Meeting is a collective intervention and exercise designed to counter characteristically negative emotions of fear, anxiety, depression, irritability and hostility. It provides a forum for teaching the entire

community to *act as if* they are positive, motivated to engage the day and optimistic about the future.

The **purposes** of the morning meeting are to:

- Start the day in a positive way
- Motivate, inspire and up-lift participants
- Enhance a sense of community.

Elements of a Morning Meeting

Coming together ritual	All members of the community start the meeting by saying "Good morning, community" and reciting the community's creed or philosophy.
Social awareness	Current events outside the TC and local weather reports are briefly presented.
Word of the day	A word designed to focus the community on personal growth or problem-solving is presented; for example, the word "Honesty". Residents then reflect on how they will incorporate some focus on this word throughout the day.
Concept of the day	A program concept or slogan such as "To Be Aware Is To Be Alive" is considered and volunteers reflect what the slogan means to them.
Energizer	This is a group activity, such as singing or playing a game, to energize and engage members. It is not simply entertainment but is intended to reinforce recovery and concepts of right living. Music can also be employed as a means to achieve the uplifting aspects of this meeting. Activities of this nature need to be well prepared and presented to staff for review and approval in advance of the presentation on the day of the Morning Meeting. Also, some focus should be given (in the use of songs) to getting the whole community to participate in some way, whether simply through clapping their hands or joining in on the song's refrain.
Closing ritual	This is a shared activity that signals the end of the meeting. For example, some TCs have adopted theme songs that residents sing together with locked arms, while others recite the program philosophy to close the meeting.

Morning Meeting Rules

- Maintain an emphasis on the "here and now."
- Only one person may speak at a time – except during ensemble responses from the community.
- Individuals speak only for themselves, but they may encourage others to participate.

- Attention is focused on being positive and uplifting.
- All TC "business" matters, pull-ups, or growth reports should be reviewed at other times or in other meetings.

The Role of TC Staff Members in the Morning Meeting

- "Staff On Duty" sit in the back, or side, of the room to observe.
- Staff members assess resident participation, overall group energy, attitudes, and affect.
- Staff members may contribute humor or an uplifting thought.
- Staff members and resident community leaders meet later in the day to discuss
    - The degree to which the residents in charge of the meeting were prepared and appropriate.
    - The need for any treatment plan adjustments for the residents.

The Community Meeting

Rationale:

Community Meetings occur once weekly and are facilitated by the Program Director. Community Meetings are formally planned meetings of and for the entire Unit; both staff and residents. The meeting allows for general announcements about the program and unit operations such as the acknowledgement of new residents and of those who are leaving or graduating.

Community Meetings serve as "business meetings" or sessions that ensure general information about the program gets distributed in a responsible and consistent manner. As a tool of growth, the community Meeting provides opportunities to understand and address issues of general or "community" interest as opposed to issues of strictly personal interest. At the meetings residents are therefore expected to be respectful and attentive, to listen and think, and to be relevant and practical in their communications.

Announcements can be of many sorts:

- Announce major resident achievements
- Congratulate community in progress on specific areas requiring collective effort.
- Recommend positive or program-issue-related books, TV shows, community events etc.
- Announce an adjustment to the daily schedule
- The Community Meeting is not a forum for decision-making; no TC can be run as a democracy or be allowed in any way to compromise the authority of program staff. Community Meetings are forums where the reasons for staff decisions can be clarified, where resident and staff concerns can be aired in a mature fashion, and where residents can see and practice self-presentation and pro-social group behaviors.

Elements of the Community Meeting

- Led by the Program Director or by an assigned supervisor in the Director's absence.
- All staff and program residents in attendance,

- Preparation of a clear and simple agenda in advance of the meeting – (check with all staff including custody staff in order to determine what needs to be discussed or disseminated).
- Announce the agenda at the beginning of the meeting - a typical agenda might start with key announcements (e.g. recreation schedule, a statement about a visitor expected this week etc.)
- Explain the reasons for recent decisions (e.g. limited furloughs during a holiday) in order to support the Rational Authority features of the TC's staff oversight.
- Answer questions of general interest and make authoritative responses to problem areas within the community.
- Keep the meeting focused on the community as a whole; do not let the meeting be turned into a counseling session.

Community Meeting Rules

- Raise your hand and be identified before speaking
- Be attentive and respectful to everyone at the meeting
- Stick to the topic and the agenda.

Community Meeting Agenda

- All residents and staff recite the Philosophy
- Sr. Resident reviews Community Meeting Rules
- Program Director Introduces new residents and/or staff
- Staff Announcements
- "Push Ups" – Community, Staff and Individual Resident recognitions
- Monthly Birthdays
- General Pull Ups or concerns
- Phase Movements and Graduation Announcements

Evening Meeting

Rationale:

The Evening House Meeting is the primary vehicle for residents to transact the business of the TC and for Senior Residents to demonstrate their roles in the management of the community. Preparation for the Evening House Meeting requires considerable planning and effort, creating "role training" experiences for senior community members as they have to efficiently prepare coherent and accurate presentations to their peers in a manner designed to disseminate important information, relevant to the operations of the TC.

The **purposes** of an Evening House Meeting are:

- Provide opportunity for peers to conduct community business in a structured way.
- Provide opportunity for senior community members to provide encouragement and give mild 'pull ups' to their peers,

- Bring closure to the day's activities and announce the next day's scheduled activities.
- Provide staff an opportunity to observe and assess residents' moods and the overall health of the collective community.

Elements of an Evening House Meeting
Evening meetings typically are led by an expediter and a coordinator and include announcements about:

- Introduction of new residents
- Names of residents on Learning experiences
- Residents give Growth Reports to explain why they have been given a learning experience, what behavior they intend to change and how they see themselves progressing toward correction of the attitude or behavior.
- Job changes - promotions and demotions.
- Other Treatment Plan assignments.
- Affirmations of individual growth and change and mild pull ups to the community for areas requiring additional improvement.
- Schedules for the following day.
- Observations by senior residents on what went well during the day and what problems occurred, allowing senior residents to display their leadership skills.

Evening House Meeting Rules
Residents are expected to:

- Listen attentively and actively participate
- Take notes
- Obtain information
- Refrain from casual or side conversations.

Seminars in the TC
Rationale:
Seminars are information sessions with a Cognitive Behavioral orientation facilitated by staff or peers. These sessions are designed to target specific criminogenic risk factors commonly found among substance abusing offenders. The peer seminar format is designed to develop residents' planning and attention skills as well as listening and speaking skills.

Seminars are employed to enhance intellectual stimulation, strengthen residents' personal involvement in the TC and to advance the TC's goal of social integration. All seminars encourage residents to consider, discuss and rehearse utilizing pro-social and pro-sober skills that are frequently new and unfamiliar. Seminars provide staff an observational source of data to assess an individual's level of investment and engagement in the community as well as an opportunity to evaluate the collective cohesion of the peer group.

The purposes of the Seminar are to:

- Stimulate the intellect and encourage residents to rehearse skills required for pro-social decision-making –both within and beyond TC living.
- Strengthen individual participation in daily TC activities.
- Rehearse within the microcosm of the TC, the very skills required for eventual successful social reintegration.

Elements of the Seminar

Seminars are:

- Held in a classroom setting and arrangement.
- Materials include handouts, flip charts, dry erase boards and other accessories required to enhance learning.
- Peer seminars are conducted as part of an earned privilege (as in the case of a Peer Orientation Session), treatment plan assignment or special obligations resulting from staff issued Learning Experiences.
- Peer Seminars are a vehicle for providing useful clinical information about an individual's progress in treatment engagement or the functioning of the community as a whole.
- As such, they should be overseen or guided by staff and include staff as well as peer evaluation in terms of preparation or suggestions for improvement in delivery.

Seminars are designed to:

- Educate residents about various topics
- Provide intellectual stimulation
- Help residents examine their personal values
- Stimulate insightful thinking
- Help residents understand the TC and its philosophy
- Raise awareness of important recovery issues
- Help members develop the ability to express themselves by building confidence
- and self-efficacy

Various types of TC seminars may include:

- Substance Abuse Education
- Recovery Concepts
- Social Skills acquisition
- Decision making rehearsal
- Criminal/Addictive Thinking – Thinking Errors
- Introduction to Self-Help Approaches

- Health information
- Orientation sessions: Didactic presentations of TC Rules and Tools, TC process and procedures, treatment stages, etc.
- Guest speaker seminars: Outside experts speak about various topics of interest, such as vocational training, HIV prevention or health and well-being
- Seminars facilitating social integration – Relapse Prevention

Seminar Rules

- All cardinal rules, house and group rules apply
- Bring pencil and paper to take notes
- No cross-talking or leaving group without permission
- Only one person speaks at a time; raise hand to be called upon

The General Meeting

Rationale:

When there has been either a severe violation of, or continual substandard performance in adherence to community rules and/or expectations (e.g., a failure to hold each other accountable) by either an individual or the community, the Program Director may call a General Meeting. This meeting (GM) is designed to make the community aware of and address behaviors that have seriously jeopardized the well-being of either an individual resident or the community as a whole. Typically, the Program Director communicates through the Senior Leadership of the Community that there is to be a GM, or in some cases the meeting may be summoned on the spur of the moment.

The purposes of the General Meetings are to:

- Raise the Community's awareness regarding a situation, an individual's particular circumstance, or an issue regarding the community as a whole,
- To foster or prompt Community adherence to program expectations,
- To provide the opportunity for self-correction to the Community before imposing sanctions.

Elements of the General Meeting

General Meetings are:

- Called by Program Director on an "as needed" basis
- Attended by all Program Participants and Staff
- Used to address serious issues within the Community
- Sometimes the first step in the graduated sanctions process related to sanctioning the Community as a whole.

General Meeting Rules

- GM's can only be called by the Program Director,

- GM's are conducted by the Program Director,
- GM's require approval of the Warden or designee
- GM's must be attended by all staff and residents,
- GM's are always focused on increasing the level of responsibility and accountability demonstrated by the Community.

Assessments

Explicit and routine procedures will be established to ensure all offenders are screened for substance abuse disorders and mental illnesses; and to ensure that both disorders are appropriately diagnosed. Substance abuse screening will be provided to all offenders referred by mental health, medical, or DDOC staff; and to offenders identified through self-referral. Both addiction and mental health counselors will be proficient in the screening and assessment of co-occurring disorders. Clinical assessments to screen for both substance abuse and mental illness will be administered by a qualified member of the treatment team for all offenders recruited to participate in Therapeutic Community programs within 72 hours of admission. Offenders that screen "positive" for both substance abuse and mental illness will be referred to the integrated treatment program track. Emphasis will be placed on identifying all offenders that could benefit from integrated treatment for co-occurring disorders.

Assessments will include bio/psycho/social information and DDOC collateral information (e.g. sentencing orders). The electronic version of the Addiction Severity Index (ASI) will be used as a general intake screening tool for substance abuse disorders. To diagnose mental health and substance abuse disorders the Structured Clinical Interview for DSM-IV TR (SCID) will be used.

Integrated assessments will be conducted for offenders with co-occurring disorders; and two types of assessments will be used: (1) comprehensive longitudinal, and (2) contextual. Comprehensive longitudinal assessments involve collecting information about functional status, mental health, substance use and interactions between mental illness and substance abuse in a timeline. Contextual assessments examine the context of substance abuse and how it interacts with an individual's mental illness.

Treatment Planning

A Master Treatment Plan will be completed within 7 days of admission for all program participants; and Treatment Plan Updates will be completed at least every 90 days. The assessment tools discussed in the previous section will be used for treatment planning. Treatment plans will be used to outline interventions aimed at assisting offenders to meet personal recovery goals. Information from the comprehensive longitudinal and contextual assessments may be used to rate offenders' stage of change and their associated stage of treatment. Information from integrated assessments is essential for developing effective treatment plans for offenders with co-occurring disorders.

Treatment planning is a collaborative process that guides treatment. It involves working with offenders and their family members (or other supporters) to consider the assessment information, establish personal recovery goals, and specify the means by which treatment can help them reach those goals.

Initial treatment planning will typically occur during the assessment and engagement process. For offenders with co-occurring disorders, the treatment plan will address both mental health and substance abuse as well as the supports needed to achieve recovery goals. Integrated treatment plans will be:

- written collaboratively (offenders and integrated treatment specialists)
- cover mental illnesses and substance abuse disorders
- updated every 3 months

Steps for developing integrated treatment plans:

- Evaluate pressing needs.
- Determine offenders' stage of treatment.
- Select target behaviors for change.
- Determine interventions for achieving desired goals.
- Choose measures to evaluate the effects of interventions.
- Select follow-up times to review the plan.

Staff with training in co-occurring disorders will develop the integrated treatment plans and provide treatment services for both substance abuse and serious mental illnesses.

Evaluation Plan Requirement

The assessment tools discussed above will be used for outcome evaluation. For example, CAI and SAS composite scores will be used to measure how an offender's need for treatment changes over time.

Ongoing evaluation of fidelity and outcomes is anticipated as the evidence-based model for integrated treatment of co-occurring disorders is implemented. Evaluating the performance of the integrated treatment program will help document program effectiveness and ensure the provision of high quality services. Each component will be evaluated to measure the extent to which evidence-based practices are consistently applied in treating offenders with co-occurring disorders. The co-occurring evaluation is included in the Implementation Schedule table that appears in **Section 2.2.16, Co-occurring Disorders**.

Coordination Requirements

CCS and CEC recognize how important coordination with other providers is for achieving effective service delivery to the DDOC offender population. We have a reputation for working collaboratively within host facilities and for forging a "partnership" approach with contracting agencies. Please see the references provided in **Section 2.2.1** for additional information regarding our collaborative efforts with other agencies.

Our goal is to facilitate frequent, timely and accurate communications; and collaborative coordination of services with the DDOC's medical and mental health provider and with

providers outside the DDOC system, including community mental health centers, community based substance abuse/DUI programs, community shelters, probation and parole etc.

CEC believes that efficient and accurate communication at the facility level can be optimally achieved by implementing a "single point of contact" approach. We also understand the need for a secondary contact in order to ensure responsiveness to DDOC, BCHS or other agencies. Therefore, we propose a daily site level communication protocol for DDOC administrative staff and the designated CEC point of contact assigned to the facilities. Secondary contacts will also be identified as part of a contingency "back up" plan. These contact persons will be:

Facility/Program	Point of Contact
Key North - HRYCI	1st Program Director 2nd Clinical Supervisor
6 for 1 Men - HRYCI	
YCOP - HRYCI	
Crest North (Men)	1st Program Director 2nd Clinical Supervisor
Crest North (Women)	
Key Village	
Aftercare North (including Boot Camp)	
6 for 1 - Women	
Crest Primary	1st Program Director 2nd Clinical Supervisor
Crest Central	
Aftercare Central	
Key South	1st Program Director 2nd Clinical Supervisor
Crest South	
Aftercare South (Including Boot Camp)	
Boot Camp	Program Counselor
DUI Recovery Programs	Program Counselors

The contact persons identified above will be responsible for:

- Coordinating referral to other institutional providers, particularly the Medical and Mental Health provider for residents participating in substance abuse programs
- Coordinating with community providers, including reentry services and community mental health agencies
- Collaborating with administrative and security staff in each facility with respect to daily institutional and treatment activities as well as offender movement, counts, meals etc.

CEC will comply with all applicable policies and procedures when coordinating with institutional and community providers; and offender confidentiality will be respected at all times. Open lines of communication will be maintained and encouraged as an expectation of the State Director. The company's familiarity and experience with the network of community providers in Delaware will provide the basis for establishing a "web" of reentry services for offenders participating in substance abuse and DUI treatment.

CEC will ensure that information concerning its treatment philosophy, approach and operations are shared with institutional and community providers, with the aim of coordinating recovery-oriented integration of services across the entire continuum of care. The State Director will take the initiative to schedule regular meetings with other providers, both inside and outside of the correctional system, in order to advance a coordinated effort across systems.

The State Director and Deputy State Director identified for the project will keep the BCHS, DDOC and Department administrative staff informed of issues and problems, their resolution, special needs and other circumstances that may arise during the contracting period. The State Director will initiate monthly meetings with the Substance Abuse Services Administrator to discuss program operations statewide, review program reports and respond to any concerns or questions.

Release/Sharing of Offender Information

As noted in **Section 2.2.5, Referral Process**, **Section 2.2.19 General Requirements: Coordination Requirements and Confidentiality of Records**, CEC will maintain open lines of communication with DDOC and partner service providers in a manner as to assure sharing of offender information in a manner compliant with Federal and State law. CEC understands that internal communication between CCS and CEC is allowable under 42 CFR Part 2 and that neither HIPPA nor 42 CFR privacy laws prohibit communication between mental health, and substance abuse providers with the DDOC.

Program Alteration

Community Education Centers, Inc. and its partner organizations are committed to working collaboratively with DDOC to implement effective, cost efficient programs. Any significant proposed alterations to the Therapeutic Community program will be submitted in writing for pre-approval by the DDOC Substance Abuse Treatment Administrator or designee. CEC acknowledges and accepts that no significant program alterations can take place without the authorizing consent of the DDOC.

Experience

CEC's plans for recruiting and hiring certified addictions professionals with criminal justice experience are fully discussed in **Section 2.2.9, Treatment Staff Description and Qualifications**. This section also includes a description of CEC's proposed satellite extension of their existing CADC training academy to assist all non-certified staff to obtain their CAAC within one year of employment. Plans for developing staff expertise in the area of integrated treatment for co-occurring disorders is addressed in **Section 2.2.16, Co-occurring Disorders**.

Clerical Assistance

Following notification of contract award CEC is prepared to provide Clerical Assistance staff in order to support the following essential services necessary for the administration of the substance abuse treatment programs:

1. Organization of clinical records and program materials.
2. General word processing, filing, and the drafting of reports and letters.
3. Tracking and reporting of employee work hours, time off accrual and benefit time.

4. Assist with administrative handling of assessment process and record keeping, including scheduling of periodic staff performance evaluations.
5. Maintenance of facility personnel files and auditing same for required training hours, updating of professional certification, compliance with host agency requirementss, and contract compliance.
6. Monitoring of usage, repairs, and warranty files for unit equipment and property.
7. Miscellaneous general administrative duties as required by the Program Director.
8. Assists Program Director in assessing and evaluating need for office supplies and materials and supervises the cost effective purchase, delivery and distribution of required materials.
9. Data collection for required performance based outcomes and other DDOC data requests.

Data Requests

As noted in the "Reporting Requirements" section of this proposal, CEC acknowledges and accepts responsibility for the provision of accurate and timely data to the institutional warden or DDOC Substance Abuse Treatment Services Administrator upon request including, but not limited to the following data sets:

- Treatment compliance
  - progress reports
  - treatment plans
  - discharge summaries
- Treatment bed utilization management
- Case flow management of offenders through treatment continuum
- Documentation of critical incidents
- Numbers of offenders in program by phase
- Anticipated discharge dates
- Discharge data by type (i.e. successful, unexpected release, medical/mental health reasons etc.)
- Staffing vacancies and personnel management

Confidentiality of Records

CEC will implement client confidentiality policy and procedures that are consistent with federal, state and Delaware Department of Correction's requirements. A sample of the proposed policy and procedures governing confidentiality is offered below:

CEC Policy and Procedure Manual

CEC No. 500.01

Date Issued: **12/06**
Date Revised: **N/A**
Effective Date:**01/01/07**

Chapter:
Case Records

Related Standard(s):
4-ACRS-7D-08
45 CFR-164.508; 45 CFR–522 (a);
45 CFR-164.530 (c)
42-CFR Part II, et. Seq.

Subject:
Confidentiality and Release of Information

Authority:
Board of Directors/ CEO or Designee

A. PURPOSE

The purpose of this policy and procedure is to ensure that the confidentiality rights of residents at the facility are safeguarded.

B. SCOPE

This policy and procedure applies to all employees of the facility.

C. POLICY

CEC shall continuously implement appropriate administrative, technical and physical safeguards to protect the privacy of the protected health information (PHI) of our residents. These safeguards help to prevent any intentional or unintentional use or disclosure of PHI that would violate either the Confidentiality Rule of the Privacy Rule. Information shall be released in compliance with Federal Law CFR-42 Part II et. seq. regarding the treatment of alcohol and drug-abusing individuals and 45 CFR-164.530 (c) regarding personal health information (PHI). All staff, contract personnel, consultants and volunteers shall be required to maintain the strictest confidentiality level regarding information discussed and disclosed regarding the program and the residents. Each staff member shall sign an Employee Non-Disclosure Agreement (CEC Form – Adm27), stating such, upon hire. Staff members, contract personnel, consultants and volunteers who release unauthorized information may receive disciplinary actions (see CEC Policy #300.12) and legal proceedings may be brought against them. Visitors shall be notified of this policy upon entering the facility.

Release of information forms shall be signed by the resident prior to disclosing any information. CEC will not condition treatment services on the provision of an authorization. Separate authorizations must be made for psychotherapy notes and marketing purposes. The following exceptions permit information to be released without a signature:

- Internal communication among co-workers for specific reasons or needs
- Medical emergency
- Audit, in which resident-identifying information shall be withheld
- Court orders

- If a crime has been committed by the resident on the premises or against agency personnel
- If child or elder abuse or neglect is suspected

The resident has the right to request restrictions on how the facility will use and disclose this PHI regarding treatment, healthcare and payment. The facility shall be bound by any restrictions to which it agrees.

D. PROCEDURES

1. Upon admission to the facility, a resident shall execute consent for release of information forms, in accordance with HIPAA regulations. These forms, when complete, will permit staff to release information to any criminal justice agencies that are required to know the resident's whereabouts and to family members or friends the resident specifies on the form.

2. For PHI purposes, the release form must include:
   - A description of the information to be used or disclosed;
   - The name of the person or group authorized to make the request;
   - The name of the person or group whom staff may make the use or disclosure to;
   - An expiration of the use and disclosure;
   - Signature of the resident
   - Date

3. Staff shall explain the purpose of the form to the resident. The resident shall specify what information is to be released as well as a revocation date. The resident and staff member shall sign the form.

4. The form shall be maintained in both the classification and clinical files. All release of information requests regarding PHI shall be maintained only in the clinical file. Residents shall be given a copy of all release forms.

5. The release may be revoked at any time provided it is in writing. The facility shall provide the resident with the Disclosure Restriction form. The facility shall attempt to accommodate all reasonable requests. The form shall be maintained in the resident's clinical file.

6. Once the facility agrees to the restriction, it may not violate it; however, restricted PHI may be provided to another provider in an emergency situation.

7. Staff members, contract personnel, consultants and volunteers who are contacted regarding a resident shall not give information unless a release of information form has

been completed specifying the person's name and/ or agency requesting the information. Staff members, contract personnel, consultants and volunteers shall inform the person that they are not permitted to release such information due to this "Confidentiality and Release of Information" policy and procedure. This shall include protecting the resident's privacy from outside callers.

Disclosure of Information to Prison Personnel:
Information can be disclosed within a program to an entity having direct administrative control over the program. Those who are determined to have direct administrative control are considered to be part of the program and are governed by the same confidentiality laws and legal responsibility as the program.

Testimony

CEC acknowledges that on rare occasions, substance abuse treatment staff may be required provide testimony upon receipt of an authorizing court order. In such instances, the DDOC and CEC legal department will be notified of the program's receipt of an authorizing court order within 24 hours.

Prior to providing testimony, the CEC staff person compelled to testify will be briefed regarding HIPAA Privacy Rule §164.501, §164.512(e) and 42 CFR Part 2 §2.61, §2.63 as it relates to testimony for judicial and administrative proceedings. CEC assures that all DDOC privacy policies, as well as all applicable federal and state laws will be upheld in the event testimony is required.

2.2.20 Reporting Requirements

CEC acknowledges and accepts their role in assuming responsibility for the formal reporting requirements outlined in the RFP:

- Data collection for performance measure reporting/performance based budgeting
- Data entry into DDOC automated systems
- Informational reports as requested by the DDOC Substance Abuse Treatment Services Administer
- Management of an offender tracking system for follow-up/aftercare
- Routine offender progress reports, and special reports for the parole board upon request
- Written explanations when offenders who meet the written eligibility criteria are denied admission to a court ordered substance abuse program
- Written individualized treatment plans for each offender participating in substance abuse treatment
- Maintenance of a master case sort of program participants by offender name, SBI number, admission/discharge dates, mental health services, phase of treatment, urine drug testing results, and type of discharge
- Written discharge summary for each offender in aftercare within 14 days of discharge
- Monthly and weekly reports with the elements outlined in the RFP

CEC's proposed Delaware State Director, Case Flow Manager and State Office Manager will establish protocols for: performance measures, data collection, data entry, offender tracking, progress reporting, treatment compliance reports, monthly and weekly management reports. CEC is also prepared to respond to other reporting requirements that may emerge during the contract period. An example of CEC's reporting capability is included in **tabbed attachment F** in the form of the Indian Creek Correctional Center Annual Report of contract deliverables for the State of Virginia.

Specific elements of the proposed reporting plan for DDOC include:

Report Name	Content or Purpose	Review/Approval Process	Recipient(s)	Frequency
Performance Measures Reporting	Summarize Continuous Quality Improvements of programming at all program sites, including observation and staff/client interviews; and through internal administration of audits using the BCHS Quality Assurance Matrix	None Specified	DDOC and Facility Wardens	Quarterly
Data Entry Report	Use of DACS, ERMA and EHR to provide summary statistics for each program by site and level, as required by the RFP	Due within 15 calendar days after the last day of each month	DDOC and Facility Wardens	Monthly
"Other" Reports	Information relating to activities under the contract on such forms and at such times as required by the DDOC Substance Abuse Treatment Services Administrator	As requested	Substance Abuse Treatment Services Administrator and Facility Wardens	Monthly
Offender Tracking Reports	Tracking referrals from residential treatment to community based provider services and aftercare	As requested	DDOC and Facility Wardens	Monthly
Progress Report	A progress summary for each program participant regarding clinical progress at meeting goals and objective of substance abuse program and resident's treatment plan.	As requested	DDOC, Facility Wardens and Parole Board (upon request)	Within 48 hrs. of request

Report Name	Content or Purpose	Review/Approval Process	Recipient(s)	Frequency
Treatment Compliance Report	• Written explanation to DDOC or probation officer in the case of individual denied admittance to court ordered treatment program • Copy of participants treatment plan and discharge summary • Master case sort of offenders by name, SBI number, date admitted and date discharged from the program inclusive of discharge type.	As requested	DDOC, Facility Wardens and Parole Board (upon request) and Probation and Parole	Within 48 hrs. of request and/or within 14 days of aftercare completion
Monthly Management Report	• Completions by type • Average bed utilization data • Staffing vacancies • Grievance count and outcome • Offender flow from Key to Crest to Aftercare • Offender wait lists • Master case sort of all offenders in treatment • Staff credentialing log • Staff drug testing • Other data as requested	Due within 15 calendar days after the last day of each month	DDOC and Facility Wardens	Annually
Weekly Report	• Average daily beds occupied/vacant • Staff vacancies by site and overall averages inclusive of graphing • Offender wait list • Staff listing by site • Number of substance abuse screenings completed by site • Other data as requested	Due by COB each Monday	DDOC	Annually
Annual Report	Summary of all program outcomes and data collection synopsis	By fiscal year	DDOC	Annually

2.2.21 Continuing Education Requirement

As discussed in **Section 2.2.9, Treatment Staff Description and Qualifications**, CEC's proposed satellite extension of their existing CADC training academy is offered to help ensure that program directors and clinical supervisors working under the terms of the contract meet and maintain their continuing education requirements for certification as addictions professionals. CEC will notify the DDOC in writing of any staff person who allows their certification to lapse.

2.2.22 Work Schedule

CEC assures that that there are an appropriate number of treatment staff assigned to the program as noted previously in **Section 2.2.10, Treatment Vendor Staffing and Work Shift**, providing around the clock coverage seven days a week unless restricted by the RFP requirements. Treatment staff will be scheduled according to the proposed Treatment staff work schedules which are provided in **tabbed attachment F**. Below, CEC has provided a chart/schedule summarizing the number of weeks, days and total hours anticipated by position at each facility location. However, this does not take into account approved vacation, sick leave, etc.

CEC Treatment Staff Staffing Schedule									
Key North Program Howard R. Young Correctional Institution								**Capacity**	**200 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	5.60	5.60	5.60	5.60	5.60	0.00	0.00	28.00	0.70
Clinical Supervisor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Counselor	24.00	40.00	40.00	40.00	24.00	16.00	16.00	200.00	5.00
Administrative Assistant	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
TOTAL FTEs - Day								***288.00***	***7.20***
EVENING SHIFT									
Clinical Supervisor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Counselor	16.00	32.00	32.00	32.00	16.00	16.00	16.00	160.00	4.00
TOTAL FTEs - Evening								***200.00***	***5.00***
TOTAL FTEs Per Week								***488.00***	***12.20***

CEC Treatment Staff Staffing Schedule									
Key Village Program Baylor Womens Correctional Institution								**Capacity**	**58 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
Clinical Supervisor	4.00	0.00	4.00	4.00	0.00	0.00	0.00	12.00	0.30
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
Administrative Assistant	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
TOTAL FTEs - Day								***124.00***	***3.10***
EVENING SHIFT									
Clinical Supervisor	0.00	4.00	0.00	0.00	4.00	0.00	0.00	8.00	0.20
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
TOTAL FTEs - Evening								***88.00***	***2.20***
TOTAL FTEs Per Week								***212.00***	***5.30***

CEC Treatment Staff Staffing Schedule									
Key South Program Sussex Correctional Institution								**Capacity**	**120 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
Clinical Supervisor	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
Counselor	16.00	24.00	16.00	24.00	16.00	8.00	8.00	112.00	2.80
Administrative Assistant	5.60	5.60	5.60	5.60	5.60	0.00	0.00	28.00	0.70
TOTAL FTEs - Day								***172.00***	***4.30***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Counselor	8.00	16.00	24.00	16.00	8.00	8.00	8.00	88.00	2.20
TOTAL FTEs - Evening								***88.00***	***2.20***
TOTAL FTEs Per Week								***260.00***	***6.50***

CEC Treatment Staff Staffing Schedule									
Crest North - Men Program Webb Community Correctional Center								**Capacity**	**76 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
Clinical Supervisor	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
Counselor	16.00	24.00	24.00	24.00	16.00	16.00	16.00	136.00	3.40
Administrative Assistant	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
TOTAL FTEs - Day								***226.00***	***5.65***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Counselor	8.00	24.00	24.00	24.00	8.00	8.00	8.00	104.00	2.60
TOTAL FTEs - Evening								***104.00***	***2.60***
TOTAL FTEs Per Week								***330.00***	***8.25***

CEC Treatment Staff Staffing Schedule									
Aftercare North - Men Program Webb Community Correctional Center								**Capacity**	**300 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
Clinical Supervisor	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
Counselor	8.00	8.00	16.00	8.00	8.00	8.00	8.00	64.00	1.60
Administrative Assistant	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
TOTAL FTEs - Day								***114.00***	***2.85***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Counselor	8.00	16.00	8.00	16.00	8.00	0.00	0.00	56.00	1.40
TOTAL FTEs - Evening								***56.00***	***1.40***
TOTAL FTEs Per Week								***170.00***	***4.25***

CEC Treatment Staff Staffing Schedule									
CREST North - Women Program Hazel D. Plant Women's Treatment Facility								**Capacity**	**68 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
Clinical Supervisor	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
Administrative Assistant	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
TOTAL FTEs - Day								***152.00***	***3.80***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
TOTAL FTEs - Evening								***80.00***	***2.00***
TOTAL FTEs Per Week								***232.00***	***5.80***

CEC Treatment Staff Staffing Schedule									
Aftercare North - Women Program Hazel D. Plant Women's Treatment Facility								**Capacity**	**300 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	1.60	1.60	1.60	1.60	1.60	0.00	0.00	8.00	0.20
Clinical Supervisor	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
Counselor	8.00	8.00	8.00	8.00	8.00	8.00	8.00	56.00	1.40
Administrative Assistant	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
TOTAL FTEs - Day								***84.00***	***2.10***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Counselor	0.00	8.00	8.00	8.00	0.00	0.00	0.00	24.00	0.60
TOTAL FTEs - Evening								***24.00***	***0.60***
TOTAL FTEs Per Week								***108.00***	***2.70***

CEC Treatment Staff Staffing Schedule									
CREST Primary Program Central Violation of Probation								**Capacity**	**200 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
Clinical Supervisor	8.00	0.00	8.00	0.00	8.00	0.00	0.00	24.00	0.60
Counselor	16.00	32.00	32.00	32.00	16.00	16.00	16.00	160.00	4.00
Administrative Assistant	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
TOTAL FTEs - Day								***244.00***	***6.10***
EVENING SHIFT									
Clinical Supervisor	0.00	8.00	0.00	8.00	0.00	0.00	0.00	16.00	0.40
Counselor	16.00	32.00	32.00	32.00	16.00	16.00	16.00	160.00	4.00
TOTAL FTEs - Evening								***176.00***	***4.40***
TOTAL FTEs Per Week								***420.00***	***10.50***

CEC Treatment Staff Staffing Schedule									
CREST Central Program Morris Community Correctional Center								**Capacity**	**56 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
Clinical Supervisor	0.00	6.00	6.00	6.00	0.00	0.00	0.00	18.00	0.45
Counselor	24.00	24.00	24.00	24.00	24.00	8.00	8.00	136.00	3.40
Administrative Assistant	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
TOTAL FTEs - Day								***196.00***	***4.90***
EVENING SHIFT									
Clinical Supervisor	0.00	6.00	0.00	0.00	6.00	0.00	0.00	12.00	0.30
Counselor	8.00	24.00	24.00	24.00	8.00	8.00	8.00	104.00	2.60
TOTAL FTEs - Evening								***116.00***	***2.90***
TOTAL FTEs Per Week								***312.00***	***7.80***

CEC Treatment Staff Staffing Schedule									
Aftercare Central Program Morris Community Correctional Center								**Capacity**	**300 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	1.60	1.60	1.60	1.60	1.60	0.00	0.00	8.00	0.20
Clinical Supervisor	2.00	0.00	2.00	2.00	0.00	0.00	0.00	6.00	0.15
Counselor	8.00	8.00	8.00	8.00	8.00	8.00	8.00	56.00	1.40
Administrative Assistant	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
TOTAL FTEs - Day								***80.00***	***2.00***
EVENING SHIFT									
Clinical Supervisor	0.00	2.00	0.00	0.00	2.00	0.00	0.00	4.00	0.10
Counselor	0.00	8.00	8.00	8.00	0.00	0.00	0.00	24.00	0.60
TOTAL FTEs - Evening								***28.00***	***0.70***
TOTAL FTEs Per Week								***108.00***	***2.70***

CEC Treatment Staff Staffing Schedule									
CREST South Program Sussex Community Correctional Center								**Capacity**	**90 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
Clinical Supervisor	0.00	6.00	6.00	6.00	0.00	0.00	0.00	18.00	0.45
Counselor	16.00	24.00	24.00	24.00	16.00	8.00	8.00	120.00	3.00
Administrative Assistant	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
TOTAL FTEs - Day								***180.00***	***4.50***
EVENING SHIFT									
Clinical Supervisor	6.00	0.00	0.00	0.00	6.00	0.00	0.00	12.00	0.30
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
TOTAL FTEs - Evening								***92.00***	***2.30***
TOTAL FTEs Per Week								***272.00***	***6.80***

CEC Treatment Staff Staffing Schedule									
Aftercare South Program Sussex Community Correctional Center								**Capacity**	**300 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	1.60	1.60	1.60	1.60	1.60	0.00	0.00	8.00	0.20
Clinical Supervisor	2.00	0.00	2.00	2.00	0.00	0.00	0.00	6.00	0.15
Counselor	8.00	8.00	8.00	8.00	8.00	8.00	8.00	56.00	1.40
Administrative Assistant	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
TOTAL FTEs - Day								***80.00***	***2.00***
EVENING SHIFT									
Clinical Supervisor	0.00	2.00	0.00	0.00	2.00	0.00	0.00	4.00	0.10
Counselor	0.00	8.00	8.00	8.00	0.00	0.00	0.00	24.00	0.60
TOTAL FTEs - Evening								***28.00***	***0.70***
TOTAL FTEs Per Week								***108.00***	***2.70***

CEC Treatment Staff Staffing Schedule									
6 for 1 Program Howard R. Young Correctional Institution								**Capacity**	**80 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	1.60	1.60	1.60	1.60	1.60	0.00	0.00	8.00	0.20
Clinical Supervisor	0.00	8.00	8.00	8.00	0.00	0.00	0.00	24.00	0.60
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
Administrative Assistant	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
TOTAL FTEs - Day								***124.00***	***3.10***
EVENING SHIFT									
Clinical Supervisor	8.00	0.00	0.00	0.00	8.00	0.00	0.00	16.00	0.40
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
TOTAL FTEs - Evening								***96.00***	***2.40***
TOTAL FTEs Per Week								***220.00***	***5.50***

CEC Treatment Staff Staffing Schedule									
Young Criminal Offender Program (YCOP) Howard R. Young Correctional Institution								**Capacity**	**40 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	0.80	0.80	0.80	0.80	0.80	0.00	0.00	4.00	0.10
Clinical Supervisor	8.00	8.00	8.00	8.00	0.00	0.00	0.00	32.00	0.80
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
Administrative Assistant	2.40	2.40	2.40	2.40	2.40	0.00	0.00	12.00	0.30
TOTAL FTEs - Day								***128.00***	***3.20***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	8.00	0.00	0.00	8.00	0.20
Counselor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
TOTAL FTEs - Evening								***48.00***	***1.20***
TOTAL FTEs Per Week								***176.00***	***4.40***

CEC Treatment Staff Staffing Schedule									
Boot Camp Program Sussex Correctional Institution								**Capacity**	**100 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	0.80	0.80	0.80	0.80	0.80	0.00	0.00	4.00	0.10
Clinical Supervisor	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
Counselor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Administrative Assistant	0.80	0.80	0.80	0.80	0.80	0.00	0.00	4.00	0.10
TOTAL FTEs - Day								***58.00***	***1.45***
EVENING SHIFT									
Clinical Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Counselor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL FTEs - Evening								***0.00***	***0.00***
TOTAL FTEs Per Week								***58.00***	***1.45***

CEC Treatment Staff Staffing Schedule									
6 for 1 Program Baylor Women's Correctional Institution								**Capacity**	**30 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	0.80	0.80	0.80	0.80	0.80	0.00	0.00	4.00	0.10
Clinical Supervisor	2.00	0.00	2.00	2.00	0.00	0.00	0.00	6.00	0.15
Counselor	8.00	16.00	16.00	16.00	8.00	8.00	8.00	80.00	2.00
Administrative Assistant	2.00	2.00	2.00	2.00	2.00	0.00	0.00	10.00	0.25
TOTAL FTEs - Day								***100.00***	***2.50***
EVENING SHIFT									
Clinical Supervisor	0.00	2.00	0.00	0.00	2.00	0.00	0.00	4.00	0.10
Counselor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
TOTAL FTEs - Evening								***44.00***	***1.10***
TOTAL FTEs Per Week								***144.00***	***3.60***

CEC Treatment Staff Staffing Schedule									
DUI Men Program Sussex Correctional Institution								**Capacity**	**50 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	0.80	0.80	0.80	0.80	0.80	0.00	0.00	4.00	0.10
Clinical Supervisor	2.00	0.00	2.00	2.00	0.00	0.00	0.00	6.00	0.15
Counselor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Administrative Assistant	1.60	1.60	1.60	1.60	1.60	0.00	0.00	8.00	0.20
TOTAL FTEs - Day								***58.00***	***1.45***
EVENING SHIFT									
Clinical Supervisor	0.00	2.00	0.00	0.00	2.00	0.00	0.00	4.00	0.10
Counselor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL FTEs - Evening								***4.00***	***0.10***
TOTAL FTEs Per Week								***62.00***	***1.55***

CEC Treatment Staff Staffing Schedule									
DUI Women Program Baylor Women's Correctional Institution								**Capacity**	**20 Beds**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Program Director	0.80	0.80	0.80	0.80	0.80	0.00	0.00	4.00	0.10
Clinical Supervisor	2.00	0.00	2.00	2.00	0.00	0.00	0.00	6.00	0.15
Counselor	4.00	8.00	8.00	8.00	4.00	4.00	4.00	40.00	1.00
Administrative Assistant	1.60	1.60	1.60	1.60	1.60	0.00	0.00	8.00	0.20
TOTAL FTEs - Day								***58.00***	***1.45***
EVENING SHIFT									
Clinical Supervisor	0.00	2.00	0.00	0.00	2.00	0.00	0.00	4.00	0.10
Counselor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL FTEs - Evening								***4.00***	***0.10***
TOTAL FTEs Per Week								***62.00***	***1.55***

2.3 Sex Offender Programming

CCS has interviewed multiple Sex Offender Treatment providers in order to determine which company is best qualified to serve the DDOC as the CCS subcontractor. Through our interviews, CCS has selected The Counseling and Psychotherapy Center, Inc. (CPC) as our subcontractor.

2.3.1 About The Counseling and Psychotherapy Center

For over 30 years respectively, the Directors [Principals] of The Counseling & Psychotherapy Center, Inc. have been working with convicted sex offenders to develop a community based treatment and management program of the highest quality. Over the years clinicians and community corrections personnel have responded to the combination of criminal justice and clinical perspectives within our organization. This has enabled us to attract some of the most talented and experienced clinical and criminal justice staff in the field to work with us on our mission to reduce sexual victimization.

The containment approach starts in our own house. Our Board of Directors is comprised of three (3) licensed clinical professionals specializing in the treatment of sex offenders. Our fourth director responsible for the agency operations has held several key positions in the Department of Corrections in his home state of Massachusetts, including: Commissioner of Community Corrections, Executive Director of the Parole Board and inaugural chair of the Sex Offender Registry Board. These dual perspectives are evident in the CPC treatment and management program beginning with our “next generation” Containment model which includes not only the traditional three elements of Supervision, Treatment and Polygraph, but a fourth equally important element: the Victim Advocate. We are proactive in integrating stakeholders into the containment process by assigning an area coordinator to accomplish that goal in each geographic area.

Our clinicians are experts in this field and have learned how to support parole and probation in their supervision and decision-making regarding the high-risk sex offenders in the community. As an agency we have made a substantial investment in educating our clinical professionals and providing them with ongoing training and weekly supervision. This proactive approach to training and supervising our staff helps to eliminate the biases many clinicians develop while working closely with individual offenders.

CPC has enjoyed tremendous growth in our programs due to the comprehensiveness and quality of our treatment program and offender management services and our ability to provide them at a price that makes them accessible to the agencies and offenders that need them. An exciting phenomenon for us is that our programs have not only grown geographically but they have grown vertically. That means that we can treat the same offender clientele through different layers of the criminal justice system. We have programs in state correctional institutions which flow into transitional programming and on into community based management and treatment. Each additional layer in the vertical system improves the safety outcome.

As a step in our mission to bring effective and affordable sex offender treatment and management to underserved areas, we would be honored to pursue and be awarded contracts posted by our criminal justice partners consistent with our mission.

We will bring the experience we have gained in running similar programs throughout the country to your jurisdiction. The unique structure of our organization and the availability of an area coordinator dedicated to these caseload will enable us to assist in the transition of new clients from incarceration to community living by providing local resources to assist these offenders in finding housing, employment and beginning to build informed support networks all critically important factors in helping to reduce risk in these offenders.

CPC is providing sex offender management services to criminal justice agencies in seven (7) states to include secure and community programs for both adult and juvenile offenders. Following is an overview of our current programs by jurisdiction:

California

- Intensive Containment Treatment for CDCR High Risk Sex Offenders in 13 Counties statewide
- Community-based containment model group and individual treatment for juvenile and adult offenders on probation (County and Federal)
- Community-based group and individual transitional containment programs for juveniles (including several contracts with the Division of Juvenile Justice covering 7 counties)
- Residential Program in Sex Offender Group Homes for Young Males (age 18-24)
- Specialized treatment programming for developmentally delayed “Regional Center” clients

Maine

- Community-based containment group and individual treatment for adults and juveniles on probation from County Probation, Federal Probation and Parole
- Secure therapeutic community for adult male inmates at Maine Correctional Center at Windham. Program includes transitional services and community based management and treatment and is CPAI audited with the highest rating
- Group and individual treatment for non-offending partners and families
- Chaperone training program

Massachusetts

- Community-based group and individual treatment and assessments for juvenile and adult offenders in 22 locations statewide from County Probation, Federal Probation and Parole
- Specialized programming for adolescent male sexual abusers at one group home
- Sex Offender treatment and transitional programs in county jails

New York

- Community-based group and individual treatment for adults
- Contract to provide clinical evaluations for mentally retarded sexual abusers
- Consultation to Commissioner of Probation and Corrections in New York City and Long Island

North Dakota

- Intensive Community-based group, individual, family/partner treatment for high risk sex offenders transitioning from custody statewide
- Full time Victim Advocates
- Regular Training Programs for Criminal Justice Professionals
- Federal Probation Containment group and individual treatment, polygraphs, ABELS and Plethismographs

Oregon

- Community-based containment group and individual treatment for adults and juveniles on probation from County Probation, Federal Probation and Parole

Rhode Island

- Community-based group, individual, and family treatment for adults and juveniles
- Consultation contract with Special Sex Offender Parole/Probation Unit
- Specialized programming for adolescent male sexual abusers at three group homes in Providence

- Secure juvenile sexual abuser treatment unit at the Rhode Island Training School for Youth
- Psycho-educational programming at the Rhode Island Training School for Youth
    - Anger Management
    - Dangerous Decisions
    - Safe Sex
    - Personal Responsibility
    - Crime Prevention/Healthy Living
- Lead agency in "Continuity of Care Group" a partnership of group homes, treatment providers and the Division of Children, Youth and Families serving sexually abusive youth.

2.3.2 Program Overview

CPC has extensive experience operating sex offender treatment programs in a correctional setting. The Chief Operating Officer, a retired Assistant Deputy Commissioner of the Massachusetts Department of Correction, authored, implemented and maintained the Massachusetts sex offender treatment model for several years before his retirement from the Department in 2003. This program, in 1998 was identified by U.S. Justice Department's Center for Sex Offender Management (CSOM) as one of their original "Resource Sites" i.e., a program for other jurisdictions to emulate!

In 2004, the CPC Director of Operations, Timothy App, in partnership with the Maine Department of Correction, designed and implemented a residential state of the art sex offender treatment program. This program, independently audited by the Muskie Institute utilizing the internationally recognized Correctional Program Assessment Instrument (C.P.A.I.) in 2008, received the highest rating possible under the instrument, "Very Satisfactory". This is extremely important to note given that approximately 60% - 70% of programs audited under the instrument fail, 20% receive a satisfactory rating, and only 7% receive the "Very Satisfactory" rating.

This highly rated evidence based program has also lived up to its reputation relative to program outcomes! Through eight (8) years of programming, there have been 121 participants in the intensive treatment phase of programming. Fifty (50) prisoners have graduated and subsequently been released to the community, none of these offenders have committed a new sex offense and thus our collaborative mission of "No New Victims" remains intact! The success of this program to date is a tribute to both the institutional and community program standards, and a team of highly dedicated correctional, probation and clinical staff that have implemented and managed this program over the last eight (8) years.

This program is evaluated on a regular basis and is up-graded as necessary based on evidence-based research in CPC's field.

The CPC treatment program incorporates ATSA guidelines as well as NIC's best practices guidelines as well as the "Principles of Effective Intervention", a body of work developed by

Paul Gendreau and fellow researchers (colleagues) in Canada often referred to as the "What Works" research in developing "evidence based" programming. The C.P.A.I. targets these principles in the audit tool. The research indicates that implementation of multiple principles can reduce recidivism by as much as 50%. Much of CPC's success is attributed to adherence to these principles; our outcome expectations have surpassed research expectations!

If selected as the DDOC provider for the Sex Offender programming, Mr. App will directly implement and oversee the program operation. It should be noted that Mr. App, in addition to his expertise as a sex offender program administrator, during his tenure as Assistant Deputy Commissioner, was successful in achieving national ACA accreditation for all 12 institutions under his supervision and is himself, a trained ACA auditor. Our programs within all correctional institutions are operated in compliance with ACA standards.

We are proposing two (2) slightly different sex offender program plans; plan "A" which meets the minimum requirements under the RFP; and a second, plan "B" with additional program enhancements beyond the RFP specifications. Our cost proposal includes pricing for plan "A." Implementation of Plan "B" will add four (4) FTEs and an additional cost of $240,350.

In **plan "A**" which meets minimum RFP requirements, CPC will operate a minimum of three (3) 90- minute groups in each of the level five institutions (co-facilitated) and at least one group in each of the level four work release and violation of probation facilities. Additionally, this plan calls for the development of a sex offender database to track all sex offenders, identification of their initial risk screening and a comprehensive sex offender evaluation which will be provided within 30 days of the request. A more detailed outline of this plan can be found in Parts I and III of this proposal. The treatment plan is outlined as follows:

- All identified sex offenders are referred to the sex offender treatment program when they are within 3 years of their earliest projected release date. Participants may be referred sooner at the request of the Department;
- All sex offenders will receive a actuarial risk assessment (Static-99R) to determine their static risk level and will be added to CPC's sex offender database for tracking purposes;
- CPC shall utilize motivational interviewing techniques and/or amenability to treatment instruments to address those moderate to high risk offenders refusing treatment;
- All inmates who are willing to engage in treatment shall receive services at their respective institutions. Initial intakes will be performed in accordance with RFP requirements followed by the following treatment services:
    - Six – twelve months of pre-treatment (ENTRY) phase, one group weekly;
    - Pre-trial sex offender treatment programming is available for those participants who volunteer for treatment prior to sentence;
    - Six – twelve months of treatment phase; Involves one process group and one psycho-ed group weekly;
    - Comprehensive assessment for participants deemed to be ready for the advanced treatment phase and/or those referred by the Department for such an assessment;
    - Eighteen months of advanced treatment phase (equivalent to intensive treatment unit); one process and one psycho-ed group weekly;

- Aftercare/Transition Phase; One group weekly.
- Community treatment phase.
  - All of the above programming is considered non-residential.
  - All participants will be evaluated every 90 days via the R.U.L.E. Progress Report.

The second plan, **Plan "B**" includes the above noted treatment for low – low moderate risk offenders and other sex offenders deemed appropriate by the DDOC in all level 4 and 5 institutions and a separate residential track for moderate to high risk offenders. This program requires two housing units' 40-60 beds (within the same institution) each reserved for these offenders. Ideally this residential program can be established at the James T. Vaughn Correctional Center where the majority of sex offenders are currently housed (731) A more detailed outline of this plan can be found in **Section 2.3.3. Part I** and **Section 2.3.5 Part III** of this proposal. The program is delivered as follows:

Orientation Unit

All moderate to high risk sex offenders within 3 years of their earliest projected release date and agreeable to treatment shall be sent to a 40-60 bed orientation treatment unit. While these inmates are housed separate from the general population, they may still participate in work and other programming offered to the general population. Preferably in space within the housing unit, or adjacent to the housing unit, participants will receive an introduction to sex offender treatment programming, participate in discussion and community meetings in preparation for their intensive treatment experience. Participants generally spend 10-12 months in orientation treatment before advancing to the intensive treatment programming.

Intensive Treatment

Following participation in the orientation phase of treatment, participants will be sent to the intensive treatment unit where they are completely segregated from the general population. In this phase of treatment, participants will receive a full psycho-sexual evaluation, participate in 20 hours of group programming per week e.g., process, psycho-ed, drama therapy, etc. supplemented by community meetings, individual sessions, peer group assignments, and individual homework assignments. Again, preferably, all treatment is provided on the housing unit or space adjacent to the housing unit. Participants are evaluated every ninety days utilizing CPC's R.U.L.E Progress Report. Participants scoring 80 on the quarterly progress report and complete a successful polygraph examination are eligible for an appearance before the graduate panel, (a 3-4 member panel made up of both correctional and treatment unit staff quizzing the participant on their individual programs) and appropriate candidates will be advanced to the transition phase of treatment.

Transition Phase

Participants graduating from the intensive phase of treatment will return to the orientation unit, now in transition, where they will be responsible for attending weekly aftercare programming, participate in a forty hour transition workshop culminating in the completion of a community transition plan (forwarded to the perspective probation officer). Additionally, these participants

will act as role models and mentors to the orientation phase participants assisting them in their preparation for the intensive phase of treatment.

Critically important in this plan is that once removed from general population, the participant will not return to a general population setting for the remainder of their incarceration unless terminated from the program. Participants completing the full program will be released to minimum/work release facilities or directly to the community (preferably under some level of post release supervision) directly from the transition unit. Our experience, and the research relative to best practice, has found that moderate to high risk offenders are best treated in a residential program setting where the majority of their time can be dedicated to the treatment process. It also provides a safe environment conducive to good treatment practices.

On average, we have found that participants of structured residential programming can complete the entire process in approximately three years. More importantly, recidivism rates for graduates of these programs are single digits, normally less than 2%.

In addition to the above, CPC believes it is critical that correctional staff receive appropriate training in sex offender management. To that end, included in our program, plan A or B, is staff training offering for correctional personnel. The training, which can be delivered in one-two hour blocks, includes such topics as:

- Sexual assault and sex offenders, “what we know about this population”
- Principles of Effective Intervention;
- The ‘Containment Approach” model;
- Offender Assessments;
- Sex Offender theories, Characteristics and typologies;
- Treatment strategies
- Sex offender management and ethics
- The concept of sex offender registries and its operation in the state of Delaware;
- Secondary trauma.

This training can be incorporated into the staff’s in-service training program. CPC is flexible in the development of this training schedule.

In closing, CPC, Inc is pleased to offer both options to the Delaware Department of Correction. Most important, as is generally the case, programming must be tailored to meet the needs of our criminal justice partners considering staffing, physical plants, budgets, philosophy etc. To that end, we are always willing to tailor the above noted options to fit the needs and interest of your department.

2.3.3 Part I: The Counseling and Psychotherapy Center's Core Treatment Program and Philosophy

This treatment program is designed for those clients who have engaged in sexually abusive and/or inappropriate behaviors and who must participate in a specialized program to address them and to reduce the chance of a repeat of these behaviors in the future. The program makes use of treatment that is called "sex offense specific" because it uses approaches that have been found to be successful in helping people to change patterns of sexually offending, sexually abusive, and/or sexually inappropriate behavior towards others. It is difficult for some people to see their behavior as abusive or inappropriate and even more difficult for most to learn how to change ways of doing things that have been in place for perhaps years. The program has many tools in place to help participants take responsibility for their behaviors; look realistically at their means of getting needs met, and to learn more healthy and safe means of expressing themselves sexually.

The Four Principles Of Sex Offense Specific Treatment (R.U.L.E.)

Our program is guided by four principles (R.U.L.E.) (Anechiarico,1998[4], 1990[5],1998[6], 1999[7], 2011[8]) of effective sex offender treatment, which have been developed over our years of practice and program development, in both outpatient and secure settings:

- **R**esponsibility – for the impact of the offender's behavior has had on his victims, himself, as well as others;
- **U**nderstanding – how the offender's experiences and decisions in life have led him to this point;
- **L**earning – new patterns of appropriate behavior;
- **E**xperience – practicing new skills in relating to others, dealing with stress, and finding new experiences that enhance self esteem.

Responsibility

The Responsibility principle of treatment emphasizes the concepts of denial, minimization, externalization, acceptance, and empathy. This portion of treatment works to take the offender beyond acceptance of responsibility to victim empathy. This requires an understanding of both the physical and emotional experiences of their victim. In conjunction with this principle, we work to help the offender develop a sense of responsibility in all aspects of his life, not just the offense. This includes managing responsibilities of an employee, parent, child, spouse friend, resident, probationer, and group member. Other areas the offender needs to accept responsibilities for include the conditions of their court/state agency involvement which result

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[4] *Anechiarico, B,(1998) A Closer Look at Sex Offender Character Pathology and Relapse Prevention: An Integrative Approach., The International Journal of Offender Therapy and Comparative Criminology, March, 1998.*

[5] Anechiarico. B, (1990) Understanding and Treating Sex Offenders from a Self-Psychological Perspective: The Missing Piece, Clinical Social Work Journal, Fall, 1990.

[6] Anechiarico, B, (1998) Sex Offender Character Pathology. The ATSA Forum, volume X, no.2, August, 1998.

[7] Anechiarico, B. (1999) A Closer look at Sex Offender Character Pathology., Schwartz,B.K..,The Sex Offender, volume III.

[8] Anechiarico, B.(2011) A Closer look at Sex Offender Character Pathology, Schwartz, B.K. (2011) The Handbook of Sex Offender Treatment. Kingston, NJ: Civic Research Institute.

from their offenses, and conditions that need to be added as work on the offenders relapse cycle develops and needed lifestyle and personal changes become evident.

Understanding

This principle focuses on Understanding concepts of the relapse cycle that will be discussed in depth and then applied to each offender. As these concepts become clear and the offender can understand how they apply personally, he begins learning new skills that will specifically address his highest risk factors and other self-management components.

Things that must be understood include: Triggers that set off stress, which can lead to an negative, isolated and alienated emotional state; fantasies, that are used to temporarily alleviate feelings such as powerlessness but which can lead to an offense; entitlement and other thinking errors that enable progression in the cycle and justify offending behaviors; plans which begin to translate deviant fantasy and a sense of entitlement into an offending behavior; and finally the patterns that the offender engages in which are signs that he is moving closer to an offense. By understanding and applying these understandings to himself, the offender is able to interrupt his cycle at the earliest possible points and implement new healthy strategies for managing negative emotional states.

Learning

This principle focuses on **Learning** skills and strategies to prevent relapse. The offender will learn practical ways to avoid high risk situations and to interrupt the relapse cycle once it begins. Included along with this principle of treatment are cognitive and behavioral strategies that need to be employed by the offender to interrupt the cycle once it has begun, and new skills that need to be developed to provide the offender with new ways to manage cycle-triggering stress.

The development of ***interpersonal skills*** includes the following: communication skills, assertiveness training, conflict management, and sensitivity training. Learning these skills will help the offender break the pattern of isolation and disconnection and build new support networks. There are other strategies to ***interrupt the cycle, manage stress, and restore self-esteem*** that are an essential part of relapse prevention and which are addressed through the treatment program. Learning appropriate expressions of ***sexuality*** is an often overlooked component of relapse prevention but receives an important place in our program. Not only do deviant sexual behaviors need to be stopped but also appropriate sexual behaviors need to be started. Clients also learn about several ***recovery skills*** in a general way during the course of treatment. Individual needs and treatment planning may determine that a given client needs to participate more significantly in one of these counseling components. The recovery skills components that will be introduced under this principle include: anger management, empathy training, social skills training, self-esteem development, substance abuse awareness, trauma/abuse recovery, and deviant arousal reduction.

Experience

This principle respects the fact that the client needs to **Experience** the changes that come with applying what has been understood and learned. Clients need not only to practice the skills but they need to experience the differences that applying these principles makes in their lives. The key here is the offender beginning to experience his needs differently. For example: rather than

experiencing a compulsion to act out sexually as a need, the offender will be able to recognize the emotions that are triggered by a stressful event and realize that the needs can be managed in several different ways. This portion of the program asks the offender to demonstrate the different ways that he has learned to manage his emotional needs: a supportive network of people, stress management activities, intimacy, and mastery of applying his understanding and learning to interrupt his cycle and avoid situations that could progress to another offense.

Introduction to the Stage System

To guide a client through the CPC treatment program we have a series of four clinical "Stages" through which they have to progress. Stages indicate the focus of the individual's clinical treatment and marks how far they have progressed in that treatment. These stages also help to keep clients on track as they go through the array of treatment interventions and tasks that must be completed. Success in treatment, and recommendations for reduction in supervision, depends on the client working up these stages and showing that they are truly making advances in their treatment.

Clients will be placed in stage 1 at admission (unless they have previously attained another stage in a CPC program and their status is documented). Clients move up stages by completing the tasks of their stage AND by showing that they have made clinical progress on certain areas that are important to sex offense specific treatment.

How Does the Progress Get Shown

Work in the treatment program is documented on the "Stage Sheet" that clients are given. Specific tasks that need to be completed and specific competencies that must be demonstrated are listed on the sheet. When a task is completed or a competency demonstrated, a clinician will sign it off. Once clients meet the requirements for advancement to the next stage, a decision is made, via the group process that the client is ready to advance. Progress in moving along the stages is documented on the monthly report sent to the client's probation officer or other referring agency. Clients may only be said to have "completed" the active phase of treatment and be ready to move to "aftercare" when they have attained Stage Four, have completed all major assignments, have a score of 90 or better on the monthly report, and have the approval of the CPC Clinical Director.

Explanation of the Stages

Not all goals and indicators listed here are included on the stage sheet. The sheet contains the goals that specifically relate to changes in score on the monthly progress report. The additional goals and indicators here reflect the reality that there are a great number of areas that need to be attended to, we would not only confine ourselves to the specific indicators on the stage sheet. Time frames are approximate guidelines and will vary with a client's level of engagement and effort in asking the group to assist him in areas of continued deficiency. The goals and tasks of the stages are as follows:

Stage I: Pre-Treatment and Assessment

In this stage, clients will address denial and resistance that exist to the degree that it prevents treatment and they will undergo assessment to determine treatment needs.

General Treatment Goals:

- Accept responsibility that will be the starting point for treatment
- Be oriented to the treatment program
- Cooperate in intake process
- Develop an attitude of cooperation with treatment process

Tasks:

- Meet with their group leader to review disclosure and treatment goals
- Begin to attend Group
- Complete initial disclosure process and pre-treatment work if needed
- Complete initial assessment
- Complete initial treatment plan

Time Frame: 1-3 months based on client's motivation

Focus of Attention: Taking responsibility for offenses and engaging treatment.

Stage II: Beginning Treatment

In this stage, clients will be expected to learn (or demonstrate that they have learned from past treatment) the basic tools needed to be successful in treatment.

General Treatment Goals:

- To disclose offenses in detail (but still may need to take more responsibility)
- Understand what high, medium, and low risk situations are
- Understand how to identify and label emotional states
- Understand the role of fantasy in offending behavior
- Understand the connection between thinking errors and problem behaviors
- Identify deficits in interpersonal skills and begin to monitor these
- Identify triggers and be able to begin listing these
- Demonstrate a knowledge of the dynamics of the cycle (not necessarily apply it well to themselves at this point)
- Be able to vocalize concepts of healthy sexuality, male/female roles, normal sexual behavior
- To understand the concept of thinking errors and their correction (but not necessarily be able to correct all their errors at this point)
- Begin to explore life history to gain understanding of triggers
- Begin to define the areas of past victimization and trauma that will need to be addressed in Treatment.

Tasks:

- Admit some role in offenses during disclosure
- Write and present autobiography
- Complete general description of the cycle
- Complete all group assignments

Experience Indicators:

- Disclose offense to significant other and close family member(s), define goals for family therapy and/or couples counseling where needed
- Use skills learned in group in community, demonstrate responsiveness to feedback
- Participate consistently in group / develop group intimacy
- Increase the quality of social skills and interactions in the group and with others

Time Frame: 4-10 months based on client's motivation

Focus of Attention: Self, learning, and practicing learning through application

Stage III: Intermediate Treatment

In this stage, the client will be expected to use the knowledge gained in Stage II to deepen their work and apply many of the concepts more deeply to themselves. This self-application will enable them to develop interventions to prevent relapse as well as to work on many of the issues that continue to put them at risk for re-offense.

General Treatment Goals:

- To take greater responsibility for offending behaviors and for behaviors in the present which are part of personal cycle and which cause them to act in offending ways towards others.
- To take serious stock of the impact of their offending behavior on own victims, family, and others; and consider ways to make amends.
- Understand what increases own risk to offend, not just high risks but medium and low risks.
- Understand the effects that past trauma have had, and engage in individual and group to work towards resolving these.
- Understand how their own specific fantasies are related to their emotional wellbeing, risk for future offending, and abilities to form healthy relationships in the future.
- Understand effect of own thinking errors and define corrections to thinking errors.
- Improve interpersonal relationship skills, seek out feedback and training.
- Show use of stress management techniques; discover when they are needed in their case.
- Identify exits to progression in cycle, make positive plans, and intervene to exit cycle now.

- Identify own sexual orientation and explore how sexual needs can be best met.

Tasks:

- Identify low, medium, and high risk situations for self.
- Identify risky emotional states that drive behavior.
- Identify own sexual assault cognitive distortions, and other cognitive distortions to challenge. Be able to identify and correct.
- Discuss fantasies in therapy.
- Be open in discussions of own sexuality.
- Complete own acting out cycle in written form.
- Support the development of a positive treatment culture in the group.
- Complete clarification letters (victim, self, and others)
- Complete Anger Management training
- Demonstrate improved relationship skills in community interactions
- Act as a positive role model to others in group and in the community

Experience Indicators:

- Identify support network to inform – begin to inform these as much as is possible.
- Demonstrate use of exits for low, medium, and high risks on the milieu.
- Take healthy risks in bringing personal information to group.
- Be proactive in completing assignments; put increased effort in clinical work.

Time Frame: 5-12 months based on client's motivation

Focus of Attention: Community application, Family, and Skill Building

Stage IV: Advanced Treament

In this stage, the client will be expected to use the insights concerning their own patterns and the skills gained in Stage III to complete their Relapse Prevention Plan in preparation for the move to "aftercare" status and eventual end of probation/agency involvement.

General Treatment Goals:

- Continue to deepen their understanding of themselves, their cycle, and their skills
- Move the focus of attention to maintaining gains after completion of program and the end of external supervision.
- Apply understandings and skills they have learned to life that is "self managed" with support
- Increase intensity of Family Work on defined issues even if family therapy is not ongoing
- Understand and develop realistic preventions and plans for risk situations

- Understand how self esteem has been affected by events in life, openly able to discuss ways to manage risky emotional states.
- Understand techniques to deal with deviant fantasy, applies these as indicated
- Understand where thoughts and acts of self centeredness and entitlement exist, works to be more open, considerate, and other centered
- Speak to and interact with others in ways that communicate self to others in assertive/non-aggressive ways, demonstrate improved skills of expressing feelings to others.
- Use behavioral treatment for deviant fantasies (as applicable)
- Apply cycle dynamics consistently in the here and now, use exits consistently
  Develop positive and healthy sexual relationships

Tasks:

- Do focused Family Work/Therapy where applicable
- To see the world as an environment for self discovery, and to develop skills and modify *own* behavior.
- Complete Relapse Prevention Plan
- Complete assertiveness training (if not done so already)
- Complete relaxation training (if not done so already)
- Complete support network meeting as applicable
- Demonstrate overall recovery through behavior, interventions, and interactions with others
- Consistent positive role model to others

Experience Indicators:

- Is honest in disclosures to support group, can state plans for informing others, and demonstrates this ability on a regular basis
- Consistent use of exits for low, medium, and high risks
- Reaches out to others to help them, shows genuine caring for others
- Is a self-starter in clinical work, does work on his own and presents to therapist/group

Time Frame: 2-5 months based on motivation of client

Focus of Attention: Family, Community, Ongoing recovery

Clients will, of course, continue to learn on Stages II and III and will be continuing self-application on Stage IV. The stage will indicate the primary focus (although some work of other stages - higher or lower - will be touched upon). This will help focus participants on doing the work they are ready to do and keep them from focusing on RP planning and community issues too soon.

Curriculum

To help the client achieve the goals of their treatment plan, to give them the tools needed to fulfill the requirements of the program, and to help them demonstrate the competencies of the stages, a curriculum has been developed to guide their movement through the stages. Each client

is provided with a workbook to help guide them through the curriculum. This curriculum outlines:

- A series of Major Assignments that each client completes at his own pace that include some of the requirements for advancing the stages, and
- Monthly assignments to be completed in connection with the weekly group.

Clients are expected to complete monthly assignments and to participate in the weekly groups using these. Other group time is spent in processing daily behaviors or conducting group therapy interventions regarding clients' treatment issues. Clients complete the major assignments at a pace that they work out with their group leader and when completed present these to group.

The Major Assignments

There are four major assignments that are part of the CPC treatment program. Participants must complete these satisfactorily or give evidence that they have been completed successfully in another CPC treatment program. They are:

1. Autobiography – An account of the client's life that is completed using the questions in the guide that is given in the orientation folder.
2. Cycle – Clients must complete diagrams of their cycle both in past and present
3. Clarification Letters – Letters must be completed (but not sent) to Self, victim(s) and others.
4. Relapse Prevention Plan – A usable and comprehensive Relapse Prevention Plan is completed prior to completing the program or moving to a lower level of supervision.

The Group Assignments

Group leaders will give assignments each month to be completed. The series of assignments used and their order is defined in a specific list. These assignments form the backbone of the educational portions in group. They also give a place for clients to demonstrate competencies, and they are geared to develop skills that are necessary for proper Relapse Prevention Planning and healthy living in an offense-free life.

The assignments will include written work and corresponding group activities that will cycle repeatedly through the following general topic areas:

- The deviant cycle and its application in understanding client behaviors (past and present)
- Family dynamics and issues
- Sexuality and appropriate sexual relationships
- Victim empathy
- Specifics of own offenses, cycle and patterns; pre-offense patterns; current negative patterns
- Exploration of personal trauma aiming towards healthy resolution
- Developing healthy and non-abusive patterns and means of relating with others
- Properly expressing emotions and planning for future use of supports
- Recognizing and modifying deviant thought patterns
- Relapse Prevention Planning Preparation

Treatment Delivery

Assessements

All new referrals shall receive an initial intake assessment which, in part, utilizes actuarial assessment tools to determine both the client's risk, and needs, allowing the clinician to develop an individualized treatment plan targeting the client's criminogenic needs. Assessment instruments utilized may include, but not be limited to the Static 99R, Stable, 2007, Acute 2007, SRT, ABEL Screen, PPG, Polygraph, etc.

Group Therapy

Key to the delivery of intensive treatment for a sexually offending population are groups that specifically address that behavior in the context of all the other issues that the client must face. These groups are the sex offense specific group therapy that is designed to help the participant manage himself with respect to his sexually abusive behaviors and the related maladaptive behaviors that would enable him to victimize others in the future. Clients weekly attendance varies based on the setting, generally once weekly in outpatient groups for 1 – 1.5 hours each session. Intensive therapeutic communities will generally offer 15-20 hours of treatment weekly. The groups have three main types of activities:

1. To review and discuss the monthly assignments which present educational material to clients and help them to apply this material to themselves. These assignments and their review assist in increasing understanding about why one offended and how to prevent a repeat of this behavior and is a preparation for relapse prevention planning. The assignments also provide the catalyst for discussions of topics such as healthy sexuality, modifying thinking errors, developing positive activities and lifestyle, victim empathy, family issues, coping with feelings, changing current abusive/offending patterns, using supports properly, and dealing with other thoughts/behaviors that could lead to risky emotional states and warning situations in the future.

2. To provide a forum for clients to review their progress on the major assignments and to give feedback necessary for them to learn and grow from these. The review of the major assignments also helps clients to get to know about each other for more effective feedback, helps them to take increased responsibility, and shows them how to develop a relapse prevention plan when they are to that point in their treatment. These assignments will being up other issues that will need further processing in group.

3. To process daily behaviors, explore clinical issues related to the client's offending and abilities to live an offense free life, and to do more in-depth exploration of client cycles. Input from daily life is needed to go off of, but historical information may be used as well. This activity involves the flexible use of group time to explore clinically relevant patterns and issues to assist in proper resolution and management.

Supporting the core treatment groups, specifically in a therapeutic community, are those psycho-educational treatment groups that target a participant's criminogenic needs.

Individual Therapy

In outpatient settings where it is possible, clients are assigned an individual clinician who they meet with on a weekly basis. In outpatient settings the need for individual therapy is assessed and is set up appropriately. In these sessions there are many important activities that can be preformed which include but are not limited to:

1. Doing specific and/or detailed work on offending issues (e.g. fantasy) that require more intensive work than would be appropriate in the group setting.

2. Providing a safe place for the client to make disclosures that they will later bring to group. Preparing the client to bring things to group.

3. Assisting the client in day-to-day issues

4. Conducting psychotherapy for mental health concerns the client experiences.

5. Discussing the client's progress in treatment and doing treatment planning.

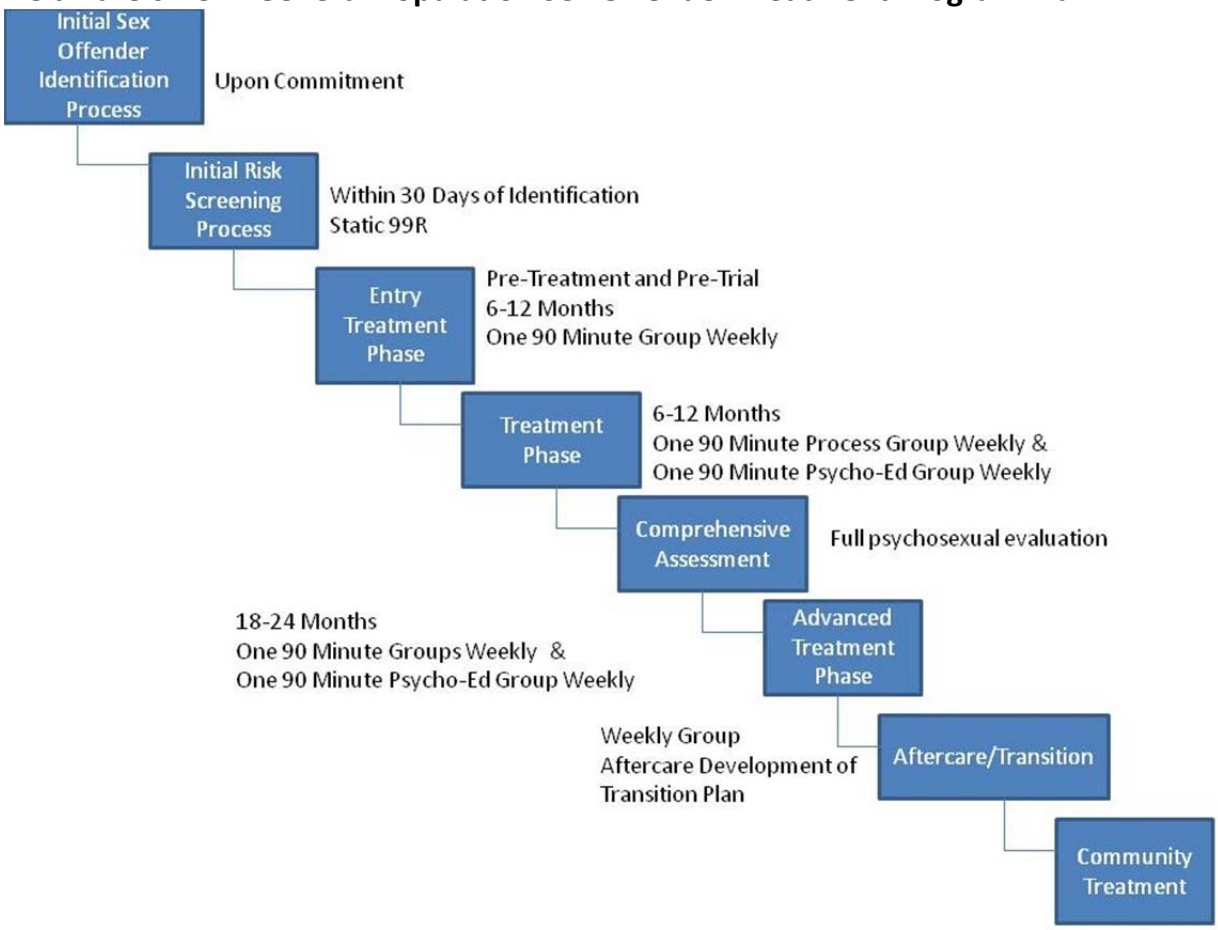
CPC's Practice and Policy Beliefs

1. We are partners with criminal justice as described in the containment model
2. We take who is referred to us and determine treatment needs.
3. We don't exclude deniers. We work towards acceptance of responsibility for the offense with our clients throughout the course of treatment.
4. We determine treatment needs either through a full assessment or an extended intake.
5. Group treatment is our primary modality of treatment but each client moves through treatment at their own rate and other modalities will be used as indicated.
6. We use full disclosure polygraphs in the first 6 months of treatment and maintenance exams every 6 to 12 months thereafter whenever possible.
7. We don't terminate people from treatment. We may suspend them back to probation and negotiate their return. We "stay in the struggle" with them in a containment strategy until their treatment needs are met.
8. We don't terminate clients from treatment for lack of participation if they are not disruptive and compliant with the treatment agreement. Benefits can be gained from being a passive observer in group. However progress cannot be shown until participation is achieved. Treatmentmotivation is a treatment intervention and part of the containment team responsibility.
9. We hold our clients accountable for their responsibility to be at treatment and pay if required. We work with probation/parole to enforce this.
10. Our Clinicians and area coordinators inform CJ about acute risk factors as quickly as they come to our attention.

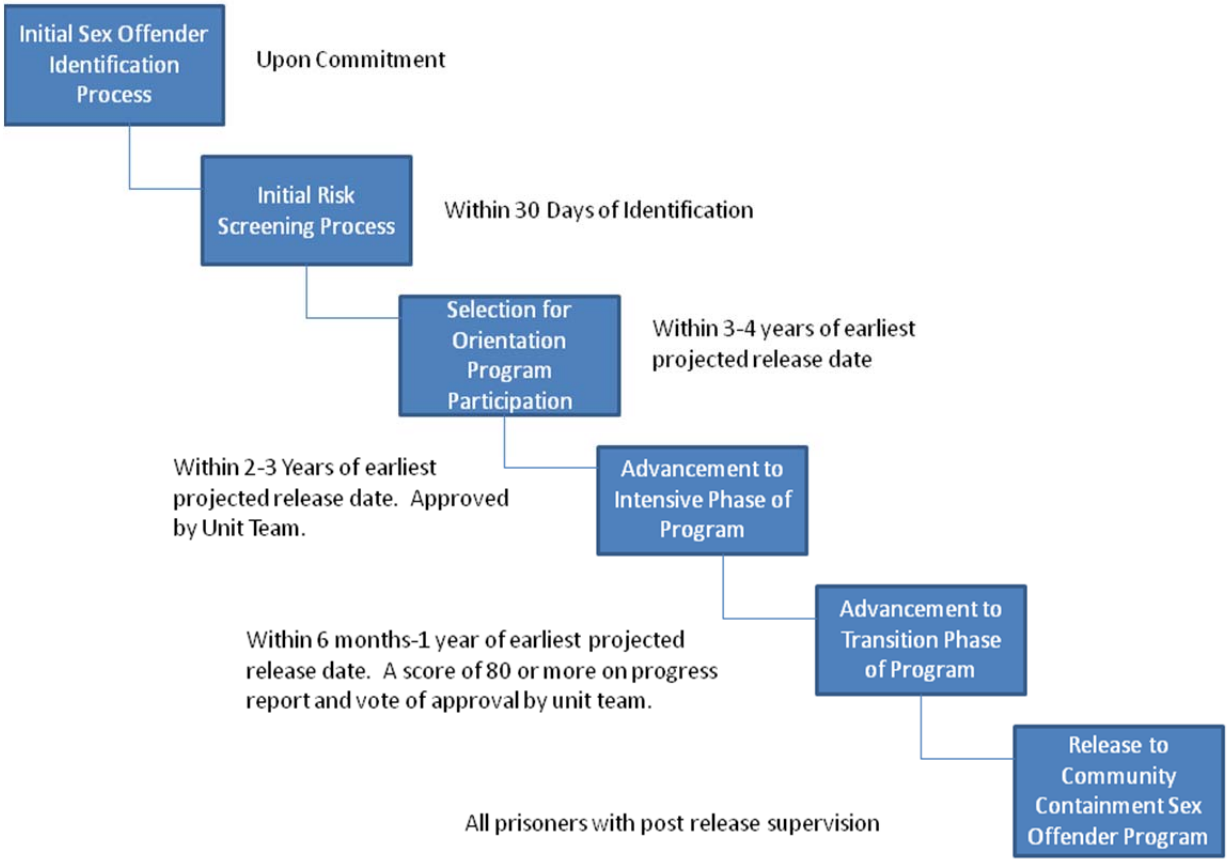
11. Progress report as well as other actuarial dynamic instruments indicate progress in treatment as well as determine deficit areas (criminogenic needs) that will be address in treatment.
12. Each client's work in group and on assignments will indicate their progress on each of the four RULE factors. Their work on ongoing assignments will continue to clarify and address their deficits until they have achieved competency in those areas. Their RULE progress score as well as dynamic risk instruments indicate their change over time.
13. Length of treatment is determined by risk reduction on dynamic factors overtime. Lower risk offender's treatment plans need to address the factors that account for their risk and progress needs to be demonstrated on those criminogenic issues as it is with moderate and high risk offenders before aftercare can be achieved.
14. "Low risk" offenders are considered to be some statutory offenders and some "non contact" internet offenders as well as "non contact" voyeuristic and exhibitionistic offenders with polygraph support. Static instrument rated "low, moderate, high risk" offenders are considered to have moderate to high criminogenic risk factors requiring a higher intensity of treatment.
15. Weekly group treatment with potentially monthly individual sessions along with CJ supervision has been found to provide a stabilizing community treatment environment. More treatment may or may not increase treatmentprogress. This should be determined in each client's treatment plan. It may not be known until after a course of treatment has been provided.
16. Individual therapy is a useful adjunct to treatment. It can intensify treatment in addition to dealing with trauma issues and should be used as resources and need allows.
17. Sex offending is not a DSM disorder but rather is a result of several disorders. Our treatment model is not a cure model but rather a recovery and risk reduction model. When risk has been reduced as measured by the RULE progress report and other dynamic risk assessment scales, we assess for aftercare status in consultation with the containment board. Clients may move from aftercare to discharge from regular treatment in consultation with the containment board. This discharge from treatment may require periodic polygraphs.
18. Our RULE workbook is a resource to our clinician and clients. It is not expected to be a linear course of treatment. The assignments are designed to assist the clinicians and clients to access the information necessary to determine their competency and deficits that need to be addressed in treatment through skill building and interventions.
19. Our confidentiality with our client needs to include the supervising CJ professionals and others who sit on the containment team. Our treatment agreement and waivers will specify this.
20. We are committed to no more victims!

2.3.4 Part II: Delaware's General Population and/or Residential Sex Offender Administrative Model Overview

Delaware's RULE General Population Sex Offender Treatment Program Plan "A"



Delaware's RULE General Population Sex Offender Treatment Program Plan "B"



The Delaware Sex Offender Treatment Program Key Compnents

Inmate Identification

It is recommended that inmates are identified as potential candidates for the residential sex offender Treatment program upon initial commitment if one or more of the following elements apply:

- The prisoner is serving a governing or concurrent sentence for a sex offense;
- The prisoner has a past sex offense conviction;
- There are sexual overtones in the reading of the prisoner's official version (e.g., police reports, grand jury minutes/indictments, or court records specific to the case turned over to the Department of Correction) of a crime for which the prisoner may have been charged with another crime not sexual in nature, or plea bargained his/her offense to another which does not reflect the sexual nature of the offense; or
- The prisoner has displayed behavior, sexual in nature, e.g., indecent assault against another prisoner, employee, contracted employee, or visitor, etc., within a correctional setting that has resulted in a disciplinary action for which he/she has been found guilty.
- They fall into the moderate to high risk range.

Note: The intent of this criterion as described above is to ensure that all inmates who have, at this time or in the past, had a propensity toward any type of inappropriate sexual behavior, receive the appropriate treatment and supervision necessary to thwart a relapse of such behavior in preparation for an eventual release to the community.

Eligibility for Participation in the Program

- CPC shall ensure that inmates' eligibility for participation in the Program is determined in accordance with the following standards:
- CPC's R.U.L.E. staff shall assess each sex offender who enters the DDOC prison system. The Agreement Administrator or designee may refer other DDOC inmates for assessment by CPC's R.U.L.E. staff.
- CPC's staff shall identify sex offenders who have engaged in contact sexual offenses and who, based on evaluation by CPC's staff, present a moderate or high risk of recidivism. DDOC will refer the appropriate inmates to the Program. CPC's staff shall identify other inmates to the Program for consideration if they determine, upon evaluation of the inmate, that the inmate needs sex offense specific treatment and could benefit from participation in the Program.
- If space is available, DDOC shall refer to the Program or to specific components of the Program sex offenders who, upon evaluation, present a risk of recidivism but as to whom the risk of recidivism would likely be further reduced as a result of an abbreviated course of treatment.
- DDOC may refer to the Program sex offenders who deny their sex offenses. Such sex offenders may continue in the Program so long as they continue to make progress on their assessed treatment objectives.
- CPC's staff shall work cooperatively with DDOC staff to arrange for treatment interventions for sex offenders whose needs may not be best met by the Program at a particular point in time, such as individuals with mental retardation, uncontrolled mental illness, or psychopathy.
- Before an inmate may participate in the Program, the inmate must sign a treatment agreement confirming that he has read the Participant's Handbook and that he/she agrees to comply with the terms and conditions set forth in the Handbook.
- An inmate may not participate in the Program unless the inmate is within the last four years of his sentence, unless other approved by the DDOC.

Sex Offender Data Base

The Counseling and Psychotherapy Center shall maintain a sex offender database listing all inmates who have been identified as a sex offender to include:

- Name
- Institution Number
- Institution location
- Home Town
- Projected release date
- Initial risk assessment score
- Institution Sex Offender Treatment Program Phases completed, if any.

The sex offender database provides valuable information when there is a need to fill vacant beds within the program.

Initial Screening Process

The Counseling and Psychotherapy Center utilizes a two tier assessment process relative to this sex offender management program. Tier one (initial screening process) takes place following the prisoner's initial identification as a sex offender. Specifically, all identified sex offenders shall receive a Static 99R assessment following identification as a sex offender which provides the inmate's initial risk level as a sex offender. This score is immediately added to the sex offender database information.

Selection of Eligible Candidates for Programming

Inmates are eligible for admission to the sex offender treatment program (Entry level in general population or orientation phase for residential) when they are within 3-4 years of their earliest projected release date. Exceptions may be made by the DDOC where appropriate. When a vacancy exists within the orientation phase of treatment, CPC's staff responsible for the sex offender database shall submit a list of eligible candidates (i.e. those who are moderate to high risk with three to four years remaining before their earliest projected release date) to the designated DDOC staff member for consideration. Candidates approved via the classification process (which weights both clinical and operational issues) and approved by the Commissioner and/or his/her designee, are then transferred to the program. When a vacancy occurs within the intensive treatment program, the R.U.L.E. Program's Unit Team, consisting of both clinical and correctional staff, review potential candidates within the orientation unit and select the most appropriate candidate for the program.

Protocols for Referrals

CPC shall maintain protocols for appropriate referrals to services not provided by the Program, such as psychopharmacological interventions. CPC shall also develop referrals for psycho-physiological assessment in the event that financial support for these services becomes available.

General Population Sex Offender Program (Plan "A" Program)

In the event the DDOC chooses to approve Plan "A", all sex offender referrals will receive a general intake and move through the phases of treatment as outlined below.

1. Entry Phase of Treatment (six – twelve months of pre-treatment)

   The primary objective of this phase of programming is to break through a participant's denial, justification, rationalization, or minimization common among sex offenders and prepare them for the treatment experience. Participants will meet once per week.

   a. Pre-trial Sex Offender Treatment Program for those participants who volunteer for treatment prior to their sentence. (Pre-trial to sentence date)
2. Treatment Phase (six – twelve months) this phase of treatment requires one process group and one Psycho-ed group per week.
3. Comprehensive Sex Offender Evaluation

4. Advanced Treatment Phase (Eighteen months in duration) this phase requires one process group and one psycho-ed group per week.
5. Aftercare/Transition Phase (Release preparation program)one treatment group and one transition planning group per week.
6. Community Treatment Phase (for inmates with post release supervision)

Residential Sex Offender Treatment Program (Plan "B")

In the event the DDOC chooses to adopt Plan "B", moderate to high risk sex offenders shall receive an intake and move through the treatment program in a residential setting as follows. Notwithstanding, it is recommended that for initial start up purposes, the program identify sex offenders moderate to high risk who are within 2-3 years within their earliest projected release date for the intensive phase of programming, and offenders 3-4 years within earliest projected release date for the orientation phase of treatment.

1. Orientation Phase of Treatment

Candidates selected for participation in the orientation phase of treatment are housed together in a unit located adjacent to or in close proximity to the intensive phase program unit. The primary objective of this phase of programming is to break through a participant's denial, justification, rationalization, or minimization common among sex offenders and prepare them for the intensive treatment experience. The expected duration spent in this phase of programming is approximately one (1) year. While these participants are housed together, they are not segregated from the general population in terms of general programming, e.g., employment, recreation, meals, visitation, etc. An overview of the treatment programming for this phase is outlined in the treatment section of this proposal.

2. Intensive Phase of Treatment

The Intensive treatment phase or therapeutic community phase, is an 18-24 month program component. Participants are housed in a unit segregated from the remainder of the institution's population. Inmate's are not permitted to work or participate in any other institutional programming. Their day is well structured and includes 15-20 hours of group therapy, individual counseling, and peer and individual homework assignments per week. All participants receive a comprehensive psycho-sexual assessment upon arrival to the unit. CPC's clinical staff then develops an individualized treatment program to address the criminogenic needs of the participant to include both process, and psycho-ed groups, individual treatment sessions as well as a host of other treatment interventions, e.g., abel screen, behavior modification treatment, etc, depending on the needs of the participant. Participants are formally evaluated quarterly utilizing the R.U.L.E. Program (goal based) progress report. Participants scoring in the 80-100 range are eligible to appear before the graduation panel where they are formally interviewed and evaluated for advancement to the program's transition phase. Members of the graduation panel include both treatment and correctional staff. Participants recommended for advancement to the transition phase of treatment by the graduate panel are then presented to the DDOC classification team or other designated DDOC personnel for advancement consideration.

3. Transition Phase of treatment

Graduates of the intensive phase of programming advance to the orientation treatment unit where they attend aftercare programming to support their new learning, become mentors for orientation phase participants, and most important, begin to transition to the community through participation in a forty (40) hour transition planning workshop culminating with the development of their personal transition plan which is forwarded to, or in some cases presented, to their perspective probation officer for review prior to release from prison. Probation staffs are routinely invited into the institution to hear a participant's presentation of their relapse prevention and transition plans just prior to release. These sessions have proven to be very successful and give the probation staff an opportunity to ask questions of the program's unit team.

Community Phase of Treatment

Approximately 80% of inmates participating in the Department's institution sex offender treatment program have post release supervision requirements upon release. In all cases where participants have post release supervision, the participant is typically assigned a sex offender specific probation officer and are managed under the containment approach model.

Under the containment approach model, a team of four specialist led by the sex offender specific probation officer, manage the case. Sex offender specific probation officers are specially trained to supervise sex offenders, and given the high risk of these offenders, maintain smaller caseloads of 30-40 probationers. The probation officer is supported by a sex offender specific clinician, polygraph examiner, and victim advocate. Together these professionals share information relative to the management of these cases assisting the probation officer in his/her daily decision making process relative to each participant.

Community Services and Treatment

CPC shall not be required to provide treatment services under this Agreement in the community to participants in the Program who have been discharged from a DDOC facility. CPC shall however assist DDOC in developing resources in the community for Program participants who have been discharged. CPC may provide treatment services in the community to discharged participants as an independent community provider. Generally CPC is willing to establish community programs in areas that are either underserved and not served at all.

Performance Measures

CPC shall maintain, in consultation with DDOC, detailed performance-based criteria to (i) examine the success of the Program and (ii) facilitate and assess prisoners' progress through the Program. The performance measures must be congruent with the following goals of the Program:

- To provide comprehensive assessments of participants.
- To increase participants' level of understanding of factors associated with sexual offending.
- To reduce risk factors associated with sexual offending.
- To enhance protective factors associated with sexual offending.

- To provide individualized treatment services.
- To provide a continuum of treatment to facilitate the successful reintegration of sex offenders into the community.
- To minimize treatment drop-outs and failures.
- To reduce the average number and seriousness of Disciplinary Reports received by participants in the Program in comparison with the participants' pre-program behavior.
- To increase the number of sex offenders who successfully re-integrated into the community.
- To decrease the number of program completers, compared with non-completers, who sexually re-offended.
- To decrease the number of program completers, compared with non-completers, who re-offended with nonsexual offenses.

Discharge Planning and Reentry Coordination

For each participant who successfully completes the Program, CPC shall provide discharge planning and reentry coordination by developing, before the participant's discharge from a DDOC facility, a pre-release plan for the ongoing treatment of participants in the Program after their discharge. The plan must include a comprehensive relapse prevention plan and must specify the roles of supervising probation officers and community-based treatment providers.

Termination from the Program

CPC, with the written approval of the Warden of each institution or their designee, may terminate an inmate from participation in the Program for one or more of the bases for termination specified in the Participant's Handbook (developed jointly by CPC and DDOC personnel).

If an inmate is terminated from the Program for security reasons, CPC shall prepare and submit to the Warden of the institution or their designee within ten (10) days after the termination (i) a summary of the inmate's participation in the Program and the reason or reasons for termination and (ii) CPC's recommendation regarding future treatment or programming that may benefit the inmate.

Program Supervision and Administration

CPC shall supervise the daily operations of the Program and perform the tasks and services necessary to ensure the effective administration and operation of the Program. CPC shall ensure appropriate supervision for any of CPC's R.U.L.E. staff whose license does not permit them to practice independently.

R.U.L.E. Program Manual

CPC shall maintain a manual containing policies and procedures for the Program. The manual must present clear guidelines relating to assessment and treatment of sex offenders and must be consistent with empirical research and national standards. CPC shall include in the Program Manual, at a minimum:

- The goals and objectives of the Program
- The treatment philosophy and approach of the Program
- Policies and procedures relating to admission to and discharge from the Program
- Procedures and protocols for assessment of sex offenders
- Components of and protocols for treatment
- Methods of treatment planning and reviews of progress
- Use of special methods for assessment and treatment
- How the therapeutic milieu will be managed
- Expectations as to participants' behavior, and consequences of participants' failure to comply with policies and procedures
- Policies and procedures relating to safety and security
- Reporting and investigating alleged violations of policies and procedures by participants and Provider's R.U.L.E. staff
- Policies and procedures relating to privacy and confidentiality and
- Quality assurance and program evaluation procedures, including client satisfaction surveys.
- CPC shall ensure that its staff read the R.U.L.E. Program Manual and that the Manual is available to participants in the Program.

CPC's Handbook and Workbook

Participant's Handbook
CPC shall maintain a Participant's Handbook to assist inmates as they progress through the Program. The Participant's Handbook shall include, in user-friendly terms and format: the rules and regulations of the Program; what is expected of participants in the Program and Program staff; reasons or bases for terminating an inmate's participation in the Program; a detailed description of the content of and time frames for the phases of the Program; possible incentives for participants as they move through each phase; and other relevant, helpful material relating to the Program. The Participant's Handbook shall be used by R.U.L.E. staff and by participants during participants' orientation and throughout their participation in the Program.

Participant's Workbook
CPC shall maintain a Participant's Workbook to assist inmates as they progress through the Program. The purpose of the Participant's Workbook is to afford inmates a place to compile handouts, homework assignments, and other Program-related material; a place to record a journal of treatment and the participant's progress in treatment; and a study guide for movement between phases. CPC's use of the Participant's Workbook shall not preclude its use of other, published workbooks that may facilitate or enhance the treatment process.

Furnishing to Participants
CPC shall furnish to each inmate participating in the Program at the time of the inmate's admission to the Program a copy of the Participant's Handbook and Participant's Workbook.

Data Collection, Offender Tracking, and Reports

Establishing the System
CPC shall maintain a system to collect and provide, on an ongoing basis to DDOC, data that will facilitate the development of the Program, permit evaluation of the different components of the Program, assist in quality assurance review, and permit assessment of the impact of the Program on recidivism. DDOC must approve all documents, forms, software programs, and other items before CPC uses them in the data collection and offender tracking system required by this section.

Quarterly Reports
CPC shall submit to the DDOC designated official quarterly reports that shall include, at a minimum, the following:

- Average number of participants in the R.U.L.E. Program;
- Number of individual and group sessions held in all phases of the program compared to the number attended by each participant;
- Number of participants successfully completing each phase of the Program;
- Number of participants dropping out of the Program;
- Number of participants terminated from the Program;
- Number of former participants re-admitted to the Program;
- Summaries of findings from the performance measures as noted above;
- Staffing vacancies; and
- Number of hours of individual and group clinical supervision provided to all staff providing direct services.

Offender Tracking Form
CPC shall maintain a form for each participant in the Program that tracks the participant's progress in the Program. The form must be approved by the DDOC designee and must include, but need not be limited to: date of entry to the Program; date of exit from the Program; assessment as to risk level; reason(s) for exit from Program; and disciplinary infractions and sanctions imposed, if any, including minor violations that result in in-Program sanctions and major disciplinary reports. CPC shall supply the information required by the form for all inmates who enter the Program, both those who complete the Program and those who exit from the Program before completion. Provider shall update and submit the offender tracking form to the DDOC designee quarterly.

Annual Report
CPC shall submit to the DDOC designee, no later than July 30th each year, an annual report that shall include an aggregation for the past 12 months (July 1 – June 30th) of the information in the quarterly reports including a summary of material information relating to staffing issues, changes in the Program, training, and supervision.

Records and Case File Reviews

CPC shall conduct case file reviews, on at least a quarterly basis, to ensure that assessments, case plans, and progress notes are complete and up to date. During the case file reviews, Provider shall ensure that assessments, case plans, and progress notes are aligned and target risk factors are identified in the initial assessments. Provider shall report out the findings of all case file reviews to the Agreement Administrator.

All treatment records relating to inmates and information contained in those records are the property of DDOC and shall remain with DDOC upon termination of the Agreement. Neither CPC nor CPC's R.U.L.E. staff may remove any treatment records from an DDOC facility, and CPC's R.U.L.E. staff may not create duplicate copies of treatment records for any reason. Provider shall comply with all DDOC Policies and Procedures relating to access to and confidentiality of the treatment records. Provider shall supply upon request of the DDOC designee, any and all records relating to inmate treatment which are in their possession.
All nonproprietary records kept by CPC pertaining to the Agreement or to services provided under the Agreement, including but not limited to those records specifically mentioned in this Agreement, shall be made available by CPC to DDOC for lawsuits, monitoring or evaluation of the Agreement, and other statutory responsibilities of DDOC and/or other State agencies, and shall be provided at the cost of Provider when requested by DDOC during the term of the Agreement or after expiration or termination of the Agreement for a period of seven (7) years or for the period for which records of the same type must be retained by the State pursuant to statute, whichever is longer.

CPC shall ensure that its staff document in the inmate's treatment record all treatment contacts in the proper format in accordance with standard clinical practice, ACA and NCCHC standards, and any relevant DDOC Policies and Procedures.
As used in this Agreement, "treatment records" includes records relating to behavioral health, R.U.L.E., and other forms of treatment.

Evaluation

CPC shall participate in any DDOC-sponsored research, program evaluation, and/or program audit directed at determining the effectiveness, or ensuring the quality, of the Program and the services provided under this Agreement.

Contract Monitoring

DDOC may employ or retain a Contract Monitor to serve as a liaison between DDOC and CPC for the purpose of ensuring that both DDOC and CPC are complying with the terms and conditions of this Agreement. If employed or retained, the Contract Monitor will be required by DDOC to submit to both DDOC and Provider, at least annually, a written evaluation of the parties' compliance with the terms of the Agreement and the performance of services by CPC. DDOC and CPC shall cooperate with the Contract Monitor.

Quality Assurance

No later than ten (10) days before the conclusion of any such reviews, assessments, audits, or investigations, CPC shall inform DDOC of any reviews, assessments, audits, or investigations being conducted by their staff or any other person or entity relating to CPC's services under this

Agreement, including issues of quality assurance, licensing, and accreditation. CPC shall furnish to DDOC copies of any and all reports within its possession and control relating to such reviews, assessments, audits, or investigations.

Evaluative Self-Assessments
CPC shall conduct ongoing assessments and surveys of the Program using tools approved by DDOC. Provider shall develop and implement an improvement plan based on the results of the assessments and surveys and shall document same in their quarterly reports.

Security
CPC and R.U.L.E. staff shall be subject to all DDOC Policies and Procedures relating to security and to the individual policies, procedures, and regulations of their respective institutions relating to security. CPC's R.U.L.E. staff shall cooperate with DDOC staff at all institutions and shall not engage in any action or omission that jeopardizes in any way security, safety, or orderly management.
Whenever a member of CPC's staff becomes aware of a potential risk to security or to the safety of any person, the member of CPC's R.U.L.E. staff shall immediately report the risk to an DDOC security supervisor, regardless of the source of the risk and regardless of whether the information was conveyed by a prisoner under treatment by the member of CPC's staff.

Audit
CPC staff shall cooperate fully with any individual or entity retained by DDOC to conduct an independent audit of the Program or of the services provided under this Agreement.

Incident Reports
CPC's staff shall be responsible for completing DDOC's Incident Reports in conformity with DDOC Policies and Procedures.

Investigations
At the request of the Chief Administrative Officer, CPC staff shall cooperate fully with any internal or external investigation into a specific case or incident at any of the DDOC facilities or involving inmates at the DDOC facilities.

Complaints
All inmate complaints shall be addressed and resolved according to DDOC Policies and Procedures.

NCCHC and ACA Accreditation
CPC shall cooperate with DDOC to the extent necessary to assist DDOC in securing and maintaining NCCHC and/or ACA accreditation for the mental health care delivery system at all DDOC facilities.

Testimony and Civic Presentations
CPC shall provide testimony regarding the Program before the Maine Legislature if asked to do so by the Commissioner or designee.

With prior approval of the Commissioner or designee, one or more members of CPC's staff may represent the R.U.L.E. Program in discussions with local civic groups or visiting officials as determined by the Chief Administrative Officer and/or the Agreement Administrator.

CPC's Cooperation

CPC shall maintain regular communications with DDOC through the Agreement Administrator and the administrations, classification staffs, unit management staffs, and mental health and medical staffs of individual DDOC facilities and shall actively cooperate in all matters pertaining to this Agreement. CPC shall maintain communication and work cooperatively with community mental health providers.

Staffing Requirements

CPC shall recruit and furnish professional staff sufficient to provide the services required by this Agreement. As to all staffing positions provided by CPC, they shall furnish the agreed-upon services at all times agreed to by CPC and DDOC.

Qualifications

CPC's R.U.L.E. staff shall have the qualifications necessary to perform this work and shall be licensed or licensable to practice their profession in the State of Delaware at all times during their provision of services under this Agreement. CPC's R.U.L.E. staff shall also have training and experience in clinical assessment and treatment, group dynamics, and cognitive-behavioral therapy. CPC's supervising R.U.L.E. staff shall have experience in supervision of personnel in a treatment setting and at least three years experience providing sex offender assessment and treatment services. If a member of the CPC's R.U.L.E. staff is eligible for licensure, CPC shall ensure that the staff member diligently pursues and obtains licensure within one year of beginning the provision of services in the Program. CPC's R.U.L.E. staff pursuing licensure shall be clinically supervised in accordance with accepted professional standards and Delaware licensing regulations. CPC shall submit written evidence to the DDOC when its staff are or become licensed in the State of Delaware.

The DDOC designee and the Agreement Administrator shall be entitled to interview any person identified by CPC as a final candidate to furnish services under this Agreement. All candidates identified by CPC shall be required to pass a background investigation conducted by DDOC. The cost of the background investigation shall be the responsibility of DDOC. CPC shall complete all due diligence when hiring any candidates to provide services under this Agreement, and any final candidate identified by them shall notify DDOC of any action taken by any agency of any state against the license of the final candidate at any time before the commencement of services under this Agreement. The Commissioner or designee shall have the right to accept or reject any candidate for any reason when the Commissioner or designee deems it in the interest of DDOC to do so.

CPC shall provide to DDOC and keep on file all required organizational and individual licenses and certifications, all renewals of licenses and certifications, and all modifications to or restrictions on any licenses or certifications of CPC and its staff.

Upon receiving notification, CPC and the member of CPC's R.U.L.E. staff shall inform the Agreement Administrator immediately if any action is taken by any agency of any state against the license of the member of CPC's staff, or if the license of the member of CPC's staff expires, during the term of this Agreement.

All staff shall meet Delaware's SOMB qualifications and be certified to conduct ABEL assessments.

Supervision

CPC shall supervise their R.U.L.E. staff in their performance of services under this Agreement and in doing so shall ensure that:

- CPC's R.U.L.E. staff carries out the tasks and performs the services that will ensure the effective administration and operation of the Program;
- The Program and CPC's staff comply with federal and state laws, federal and state regulations and rules, local ordinances, any applicable court orders, funding source directives, and DDOC Policies and Procedures;
- CPC's staff that are not licensed to practice independently are supervised in accordance with State law and/or rule when providing R.U.L.E. services;
- CPC's R.U.L.E. staff makes any reports to DDOC required by this Agreement;
- Employee evaluations are completed for R.U.L.E. staff at least annually;
- CPC's R.U.L.E. staff participates in regular staff meetings; and
- CPC's direct care staff receives regular clinical supervision and observation.

Training by DDOC

CPC's staff shall participate in all training and orientation required by DDOC, and in particular shall participate in all training and orientation relating to security, safety, and orderly management.

CPC shall ensure that all staff, before assuming their responsibilities, receive orientation regarding behavioral health and other health care practices on-site and complete the minimum DDOC training requirements for new non-security personnel.

Training by CPC

CPC shall develop and provide ongoing training for both R.U.L.E. clinical staff and DDOC staff assigned by DDOC to the Program relating to the goals and implementation of the Program.

Licensure/Insurance

CPC shall keep in force a liability policy issued by a company fully licensed or designated an as an eligible surplus line insurer to do business in this state by the Delaware Licensure Authority, which policy includes the activity to be covered by this agreement with adequate coverage to protect itself and the Department from suits.

2.3.5 Part III: Delaware's Residential R.U.L.E. Sex Offender Treatment Overview

Introduction

As noted above, The Counseling and Psychotherapy Center has been operating sex offender specific treatment programs in the community since 1989 and within secure facilities for adults and juveniles since 2004. Our Maine Intensive treatment program opened in July of 2004 and today, as independently audited evidence based program with impressive outcomes serves as a national model for evidence-based and best practices approach to the treatment of sexual abusers. It adheres to the eight basic evidence-based practices identified by the National Institute of Corrections and as noted above and draws from the "Principles of Effective Intervention" research.

1. Assess offender risk/needs levels using actuarial instruments.

   As will be described below, the R.U.L.E. Program makes use of a variety of actuarial instruments including the STATIC-99R, and the Structure Risk Assessment (SRA).

2. Enhance offender motivation. The R.U.L.E. Program utilizes the principles of Motivational Interviewing as well as research related to what works best with sex offenders.[9] [10]

3. Target Interventions.

   a. Act on the risk principle. ---Sex offenders are assessed with several different actuarials which assess both static and dynamic factors as one way of determining the level of risk. However, it is common to find out that a sex offender is actually much more at risk after he has been in treatment long enough to admit his full involvement in sexual deviance. Consequently the inmate population in this program is continuously reassessed at various stages including the Orientation Phase as to their risk level.
   b. Act on the need principle---Participants in the program receive a full psychological assessment and their treatment program is based on the needs identified therein as well as needs which may emerge during treatment. Appropriate interventions are then provided which target the criminogenic issues most related to sex offending including:
      i. Significant social influences
      ii. Capacity for stable relations
      iii. Emotional identification with children
      iv. Hostility towards women
      v. General social rejection

[9] Schwartz, B.K. (2011) The Handbook of Sex Offender Treatment. Kingston, NJ: Civic Research Institute.

[10] Dougher, M. & Garland, R. (1998) Using motivational interviewing with sex offenders. In Miller, W.R. & Rollnick, S.P. Motivational Interviewing, N.Y.: Guilford Press.

vi. Lack of concern for others
vii. Impulsivity
viii. Poor problem solving
ix. Negative emotional state
x. Pre-occupation with sex drive
xi. Using sex as a coping mechanism
xii. Deviant sexual preference
xiii. Cooperation with supervision

c. Implement the responsivity principle---Interventions in the R.U.L.E. Program have been designed to be multi-modal. They address different learning styles by using auditory, visual, tactile modalities. The program utilizes experiential treatments including drama, art and music therapy as well as horticultural therapies (where possible). -Special accommodations are made for inmates with special needs. An approach has been developed for Native Americans and cultural adjustments are made depending upon the demographics of the present population.

d. Ensure adequate program dose and duration---Participants in the R.U.L.E. Program spend over 40% of the time when they are not sleeping, eating or involved in DOC activities such as medication or counts in structured therapeutic activities. They are retained for a minimum of about thirty months in some stage of treatment.

e. Implement the treatment principle---The basic foundation of the R.U.L.E. program is cognitive-behavioral with the focus being on 1.) risk factors as well as conduct in the present 2.) changing current behavior and not just talking about it 3.) learning new skills including new ways to meet basic needs, interact with others appropriately and solve problems.

4. Provide skill training for staff and monitor their delivery of services. Staff is trained in the treatment approach and use material that is specifically prepared for this population.

5. Increase positive reinforcement---Staff are trained to give positive reinforcement in a four to one ratio and to utilize Motivational Interviewing techniques.

6. Engage ongoing support in natural communities---Participants (in residential model) live in a Therapeutic Community where they follow the “Recovery Code” vs the “Con Code. Engagement with prosocial peers in the community is encouraged, and whenever possible, these support persons are brought into the institution to meet with the staff and the inmate.

7. Measure relevant processes/practices----CPC has developed a tool which objectively measures treatment progress on a quarterly basis. In addition, inmates participating in the

most intense phase of treatment are evaluated on their ability to integrate new skills into their daily behavior.

8. Provide measurement feedback---Participants are provided with feedback through the accountability system, the levels systems and their quarterly evaluations as well as individual treatment on a weekly basis. Staff is able to monitor their efficacy of their efforts by observing the conduct of graduates who have been released into the community.

The above is a brief summary of how the R.U.L.E. Program conforms to NIC's description of an evidence-based rehabilitation program. The specifics will be described below.

Assessment And Diagnostic Services

The R.U.L.E Program conducts a multi-tiered assessment process to identify level of risk and treatment needs.

Initial evaluation for all referrals consists, at a minimum, of the following components:

- Clinical Interview
- Clinical Mental Health Status Exam
- Observational assessment
- History of functioning
- Offender Demographic information
- Evaluation Method
- Formal Account of Instant Offense
- Client's Version of Instant Offense
- Background Information
- Family and Social History
- Academic History
- Sexual History
- Drug/Alcohol History
- Criminal History
- Medical and Psychiatric History
- Sexual Functioning
- Behavioral Observations
- Risk Analysis
- Case file/document review
- Collateral information/contact interviews and
- DSM-five diagnosis

The completion of the above information will culminate in the development of a participant's individualized treatment plan. The plan will be developed by the treatment team and approved by CPC's Clinical Director.

Initial Assessment

This is designed to be used with all inmates who are identified by the DDOC as having been convicted of a past or present sexual offense. An actuarial that requires little, if any, self – disclosure is the STATIC-99R[11]. This or an equivalent actuarial instrument will be administered on this level and will, in part, determine program placement

[11] www.static99.org/pdfdocs/st-99rworkbookwithsamplesandsummary

Advanced Assessment

Upon referral to the intensive portion of the program (residential), or advanced treatment (non residential), inmates will receive a comprehensive psychosexual assessment that may include the following:

- The Structured Risk Assessment[12] which integrates dynamic factors with the stable factors identified by the Static-99R.
- Social history
- Mental status evaluation
- Identification of co-morbid conditions
- Abel Assessment for Sexual Interest[13]
- Polygraph[14]
- Cognitive-Functioning
- Mental Health
- Medical/Psychiatric Health
- Drug/Alcohol Use
- Stability of Function
- Development History
- Sexual Evaluation

Sex Offender Specific Treatment Program

The basic foundation of the R.U.L.E Program is an enhanced cognitive-behavioral approach with the focus being on:

1. Responsibility: assisting the participant to take responsibility, not only for his offense, but for his thoughts, feelings and behavior on a daily basis,
2. Understanding: comprehending the origin of his behavior as well as his risk factors and interventions
3. Learning: learning new skills to address the deficits related to his offense behavior,
4. Experience: translating the skills that the participant has learned into behaviors in all contexts.

Cognitive behavioral practices have been recognized since the 1980's as the preferred approach of treating sex offenders. Cognitive-behavioral theorists explore how thoughts mitigate actions. Beck's (1979)[15] work on depression pointed out how self-talk produces an emotional response

[12] Mann, R.E., Hanson, R.K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychological risk factors. Sexual Abuse: A Journal of Research and Treatment, 22, 191-217.

[13] Fischer L, Smith G. Statistical adequacy of the Abel Assessment for interest in paraphilias. Sexual Abuse: A Journal of Research and treatment. 1999;11(3):195–205. [PubMed]

[14] Ahlmeyer S, Heil P, McKee B, English K. The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. Sexual Abuse: A Journal of Research and Treatment. 2000;12(2):123–38. [PubMed]

[15] Beck, A, T., Rush, A.j., Shaw, B.F. & Emery, G. (1979) Cognitive Therapy of Depression. New York: The Guilford Press

that becomes self-perpetuating: an individual uses self-negating thoughts that cause him to feel depressed, which then produces more negative thoughts, and so forth.

The thought processes of sex offenders have been studied in a variety of ways. Piaget (1977)[16] presented the concept of schema, which are ways of organizing and categorizing information. These schemas form core belief systems which screen and interpret incoming information. For example, an individual who has been raised in a dangerous environment will interpret incoming information in light of that past experience. This may lead to maladaptive conclusions referred to as "cognitive distortions," "thinking errors," or "stinking thinking." These beliefs can then lead to emotional responses. Thus the man raised by an abusive mother may perceive rejection in even the most neutral of responses by females. His thinking errors about his interactions may then lead to anger and violence.

As Barriga et al. (2008)[17] points out, cognitive distortions are often used to explain one's behavior and the behavior of others. Causal attributions found in sex offenders often involve (1) "locus of control," which deals with beliefs about where the control of one's behavior is based; (2) "stability," which deals with whether behavior is stable or unstable; and (3)"controllability," which deals with whether the offender believes he can control his behavior. Different types of offenders tend to have different patterns of causal attributions. Offenders may have different patterns of blame attributions. The offender may blame internal factors such as mental illness for his behavior, or he may blame external factors such as the victim (Barriga., 2008).

A number of researchers have explored certain thought patterns found in sex offenders. Hanson, Gizzarelli, and Scott (1994)[18] discussed sexual entitlement in sex offenders. Marshall (1997)[19] explored how a combination of low self-esteem, poor attachment to others, and social anxiety lead to self-protective biases. Ward, Fon, Hudson, and McCormack (1999)[20] hypothesized that when sex offenders become aroused, their thinking processes become more and more concrete and thoughtless. Offenders may also pay attention to only that information that confirms their pre- conceived biases (Barriga et al., 2008). Sex offenders, like the rest of humanity, process information based on their individual histories. The interpretation of the behavior may be misinterpreted based on previously held schemas, memories, and mental filters which screen out information that is not consistent with the above. Offenders may also have deficiencies in their abilities to read emotional facial expressions and nonverbal social cues (Racey, Lopez, & Schneider, 2000)[21]. This type of deficit would also impair the ability of empathize with others by

[16] Piaget, J. (1952) The Origins of Intelligence in Children. London, Routledge and Kegan Paul.

[17] Barriga, A.Q., Hawkins, M.a., Carl, R.T.C. (2008) Specificity of cognitive distortions to antisocial behavours. Criminal Behavour and Mental Health, 18,2 104-116.

[18] Hanson, R. K., Grizzarelli, R. & Scott, H. (1994) The attitudes of sex offenders: Sexual entitlement and acceptance of sex with children. Criminal Justice and Behavior, 21(3), 187-202.

[19] Marshall, W. (1997) Pedophilia: Psychopathy and theory. In D.R. Laws & W. O. Donahue (Eds.) Sexual deviance: Theory, assessment & treatment (pp 152-174). New York: Guilford Press.

[20] Ward, T., Fon, S., Hudson, S.M., & McCormack, J.C. (1999) Child Molesters' Implicit Theories. Journal of Interpersonal Violence, 14, 821-838.

[21] Racey, B.D., Lopes, N.L., Schneider, H.G. (2000). Sexually assaultive adolescents: Cue perception, interpersonal competence and cognitive distortions, International Journal of Adolescent and Youth, 8, 229-239.

interfering with the first requirement, which involves emotional recognition (Marshall & Mazzucco, 1995)[22] .

Cognitive theories have helped clarify how sex offenders can rationalize and justify and thus continue their behaviors as well as how some of them may understand their worlds. Additionally, these theories have related thoughts with emotions.

Samenow (1984)[23] , studied the thought processes of criminals. They identified certain thought patterns and beliefs (including entitlement, rationalization, victim stancing, among others) that comprise "the criminal mind." These patterns are often found in sex offenders, particularly those with histories of delinquency and property offenses and those who have been in prison for prolonged periods of time. The latter often subscribe to the values of the "con code," which is grounded in the thought patterns identified by Samenow.

Relapse prevention is a cognitive behavioral technique that was developed in the substance abuse field (Marlott, 1982[24]) and quickly adapted to sex offender treatment. It focuses on helping offenders recognize patterns of their behavior and what risks might be associated with that pattern. Recently it has been recognized that there are at least four basic patterns that require different treatment approaches. Thus the Pathways method was devised. Additionally it has acknowledged that relapse prevention focuses on what not to do. However, it did not direct the offender as what to do. The Good Lives Model (GLM) is the natural complement to the "don'ts" as it helps one focus on appropriate ways to satisfy basic human needs. CPC has incorporated both of these approaches into their treatment model.

The Pathways (Yates & Kingston, 2006[25]) model is based on a self-regulation approach developed by Ward and Hudson and used to evaluate motivation and techniques of offending in sexual abusers. Four pathways have been identified which address goals (approach-avoidant) and techniques (active and passive). These different pathways require different therapeutic approaches. Research has been done at the Massachusetts Treatment Center that validated the self-regulation model with the residents therein.[26]

The Pathways Model is often paired with the Good Lives Model or self-regulation model (Ward, Yates & Long, 2006[27]). The Good Lives Model (GLM) assumes that all human beings attempt to satisfy basic human needs. (Ward & Gannon.2006) However, the means may be misdirected. This approach compliments the traditional Relapse Prevention approach in that while the latter

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[22] Marshall, W. L. & Mazzucco, A. (1995) Seelf-esteem and parental attachment in child molesters. Sexual Abuse: A Journal of Research and Treatment, 7, 249-252.

[23] Samenow, S.E. (1984) Inside the criminal mind. New York: Time Books

[24] Marlott, G.A. (1982) A self-control program for the treatment of addictive disorders. In R.B. Stuart (Ed.) Adherence, compliance and generalization in behavioral medicine. NY: Bruner/Mazel

[25] Yates, P. (2007) The good lives and self-regulation model of rehabilitation: Implications for clinical practice. Pre Presented at ATSA Conference, October, 2007. San Diego, CA.

[26] Leguizamo, A., Harris, D., & Mackenzie, L. The self-regulation model of sexual offending: Validation and relationship between offender type and criminal versatility/specialization. Presented at ATSA Conference, Oct. 22, 2010, Phoenix, Az.

[27] Ward, T., Yates, P., & Long, C.A. (2006) The self-regulation model of offense and relapse process: Volume 2: Treatment. Victoria,BC,CA: Pacific Psychological Assessment Corp.

focuses on what not to do, the GLM focuses on how to build a meaningful life and fulfilling basic human needs in an appropriate manner.

There appears to be a significant overlap between the GLM and Dialectical Behavior Therapy (Schaffer, M., Jeglic, E.L., Moster, A. & Wnuk, D., 2010)[28] Skill building to reach prosocial goals becomes a target of treatment. Thus motivation to participate in the various psycho-educational courses is enhanced. This blends nicely with the Motivational Enhancement Treatment that is utilized to encourage investment in therapy. (Tierney & McCabe, 2002[29]) DBT has been successfully applied to correctional populations (Berzins & Trestman , 2004[30]) and with sex offenders (Gordon & Hover, 1998[31]) This therapeutic approach helps individuals modulate their emotions and uses meditative techniques to integrate emotions and cognitive processes. These methods are being used increasingly in sex offender programs throughout the world. (Howells, S.M., Day, A. & Wright, S. (2004[32])

Additionally the CPC model recognizes the research which indicates that individual with traumatic backgrounds often suffer from neurologically-based deficits in higher order cognitive skills. While the normal individual may be able to think of the consequences of one's behavior, consider options and engage in effective problem solving, offenders in general and sex offenders specifically have problems utilizing the processing skills located in the frontal area of the brain. This has led to evolution of a specialized field known as "neurocriminology." (Ross, 2008)[33]. The R.U.L.E. Program Director has been trained in this model and has adapted the principles for use with sex offenders.

Another major part of the CPC model involves its development of techniques to be used in treating high risk offenders in therapeutic communities (Schwartz & Winchell, 2010[34]). Many of these techniques are based on Nonviolent Communication (Rosenberg, 2003[35]).

A particular strength of the CPC model has been its stress on the responsivity principle which stresses presenting treatment techniques in a variety of modalities which respect different learning styles. Role plays and other experiential exercises use all of the sensory modalities to convey information in a way that enhances motivation and integration.

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[28] Schaffer,M., Jeglic, E.L., Moster, A., Wnuck,D. . (2010) Cognitive-behavioral therapy in the treatment and management of sex offenders. Journal of Cognitive Psychotherapy, http://findarticles.com/p/articles/mi_7600/is_201007/ai_n54363548/?tag=content;col1

[29] Tierney, D.W. & McCabe, M.P. (2002) Motivation for behavior change among sex offenders: A review of the literature. Clinical Psychology Review, 22, 1, 113-129.

[30] Berzins,L.G. & Trestman, R.L. (2004) The development and implementation of Dialectical Behavior Therapy in a forensic population, Journal of Forensic Mental Health,, 93-103).

[31] Gordon,A & Hover, G. (1998) The Twin Rivers Sex Offender Treatment Program. In W.M. Marshall & Y. Fernandez (Eds) Sourcebook of treatment programs of sex abusers. (pp.3-15) N.Y: Plenum Press.

[32] Howells, S.M., Day, A., & Wright, S. (2004) Affect, emotions and sex offending. Psychology, crime and the law, 10, 179-195.

[33] Ross, R & Hilborn, H. (2008) Rehabilitating Rehabilitation: Neurocriminology for Treatment of Antisocial Behavior. Ottawa: Cognitive Center of Canada: University of Ottawa.

[34] Schwartz, B.K. & Winchell, G. (2010) Enhancing communication in residential sex offender treatment settings. Presented at ATSA Conference, Oct. 22, 2010, Phoenix, Az.

[35] Rosenberg, M. (2003) Nonviolent communication. Encinits,CA: PuddleDancer Press.

In summary the principles and staff of the R.U.L.E. Program represent decades of years of experience in treating individuals with sexually inappropriate behavior including males and females, adults and juveniles, outpatient and prison-based programs. They have been on the cutting edge of the development of innovative programming and have consulted with almost all states including a number of foreign countries. This RFP presents a program which incorporates the state-of-the-art thinking and research in the field of sex offender treatment.

Treatment Services/Inmates (Residential)

Orientation

The R.U.L.E. Program offers an Orientation Program which lasts from several months to over a year depending on individual needs and the length of their sentence. Men in the Orientation Program live in one unit and participate in specifically designed groups and psycho-educational classes based on the evidence-based models presented by Marshall (1999[36]) and the levels of motivation discussed by Prochaska and DiClementi (1986[37]) and addressed through Motivational Interviewing (Miller & Rollnick, 1998[38]). The initial focus of the orientation and assessment module is on teaching group therapy skills, addressing communication skills, confidentiality, and developing trust. Residents participate in a class led by Dr. Schwartz focusing on her workbook, Facing the Shadow (1996[39]) which helps men learn to interact in a group setting and presents a number of nonthreatening skill sets including stress management, learning basic treatment concepts, understanding emotions, etc. Because these men may enter the Orientation Program with varying treatment backgrounds, weekly process groups are offered based on ability to deal with offense-specific issues. One evening a week all residents of the unit are expected to attend a community meeting which addresses issues of living together as well as community building experiential activities.

Intensive Treatment (Residential)

They participate in approximately 15 to 20 hours of treatment weekly including homework assignments. Among the goals of the program are:

- Identifying of factors associated with offending including one's specific pathway.
- Identifying ways to reduce eliminate and/or effectively manage risk factors as well as how to develop or increase factors that reduce risk including ways to legitimately fulfill basic human needs.
- Learning to manage the specific risk factors such as thinking errors (cognitive distortion), mood states, and physiological factors such as deviant arousal, interpersonal risk factors, and behavioral factors including those identified through research as significant dynamic factors.

When an inmate is moved into the Intensive Treatment Program situated, he is initially given a psycho-sexual evaluation which establishes a base line and identifies the initial treatment plan.

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[36] Marshall, W.L., Anderson, D. & Fernandez, Y. (1999) Cognitive-behavioral treatment of sex offenders. Chichester, UK: Wiley.

[37] Prochaska, J.O. & DeClimenti, C.C. (1986) Towards a comprehensive model of change. In Miller, W.R., Heather, N. (Eds) Treating additive behaviors: Processes of change, N.Y.: Plenum Press.

[38] Miller, W.R. & Rollnick, S.P. (1998) Motivational Interviewing, Second Edition. N.Y.: Guilford Press.

[39] Schwartz, B. K. & Canfield, G,S. (1996) Facing the Shadow. Kingston, NJ Civic Research Institute.

Participants in the most intensive phase of treatment are housed in a Therapeutic Community. They begin the day with a community meeting where general concerns are shared. Inmates may share specific treatment concerns such as requesting the other community member for assistance in pursuing certain treatment goals and presenting Needs Identification Forms which is a process which helps inmates maintain accountability (Schwartz & Winchell, 2010)[40].

Each participant in the intensive program participates in a 1.0 -1.5 hour group twice a week. This core group is the venue for processing what is being learned in psycho-educational courses, issues which arise in the community, insights into one's current behavior and increasing awareness about dynamics of one's offense.

Additionally each man in the intensive program participates in three 1-1.5 hour long psycho-educational classes as described below each lasting twelve weeks. These classes are designed to address specific dynamic factors which have been found to be associated with reoffense including:

- Significant social influences
- Capacity for stable relations
- Emotional identification with children
- Hostility towards women
- General social rejection
- Lack of concern for others
- Impulsivity
- Poor problem solving
- Negative emotional state
- Pre-occupation with sex drive
- Using sex as a coping mechanism
- Deviant sexual preference
- Cooperation with supervision

New residents are introduced to treatment through the curriculum, Understanding Sexual Assault (Schwartz, 1992), which is based on motivational interviewing techniques and acknowledges the ambivalence that a newcomer to treatment may naturally experience. Moreover these neophytes in treatment are most frequently in the pre-contemplative or contemplative stage of change. They need to realize that sexual assault is a tragic event that leaves a lifelong scar on the victim. Furthermore they should be helped to recognize that they need to take responsibility for their inappropriate conduct but also come to believe that they can change and become productive citizens. The curriculum incorporates the voices of victims in writing and in video presentations. It also includes an introduction to basic sex offender-specific concepts such as cognitive

[40] Schwartz, B.K. & Winchell, G. (2010) Enhancing communication in residential sex offender treatment settings. Presented at ATSA Conference, Oct. 22, 2010, Phoenix, Az.

distortions, risk situations, the abstinence violation effect. These concepts are presented in ways which respect different learning styles and incorporate role plays and experiential exercises Classes target social influences, capacity for stable relations and general social rejection including those focusing on communication and social skills. As previously mentioned, the R.U.L.E Program uses Rosenberg's Nonviolent Communication (See above) to enhance communication skills. Men's Work (Kivel, 1992[41]) also helps breakdown male stereotypes which interfere with establishing intimate relations. Classes in basic social skills also assist participants in dealing with challenging social situations.

Lack of concern for others and hostility towards women are addressed in classes that enhance the ability to understand others including, but limited to, their victims. Various media presentations are used as well as role plays and training in identifying emotions, improving emotional intelligence and reading nonverbal communications. These classes include Developing Empathy, Healthy Relationships, Emotional Intelligence and Social Skills.

Impulsivity is addressed in classes which focus on emotional containment and mindfulness.

Men are taught meditation skills which they practice a minimum of one time a week. A biofeedback lab which uses programs such as "Healing Rhythms"[42] has been shown to be quite affective in dealing with impulsivity. Classes related to Dialectical Behavioral Treatment including Wise Mind are offered.

Poor problem solving is addressed in classes that have evolved from the field of neurocriminology and systematically teach frontal lobe skills such as non-impulsive thinking and thoughtful consideration of several options. These include Thinking Straight (Schwartz, 1995[43]) and Reasoning and Rehabilitation.

Negative emotional states are addressed by the above mentioned classes which promote the development of the concern for others but also by classes which target underlying emotions such as depression, fear, and shame. DBT is helpful in dealing with these emotions. Techniques such as mindfulness and emotional containment are presented in a series of classes. Classes include Mind over Mood, Grief and Loss as well as group for men who have been victims of sexual abuse themselves.

Issues including pre-occupation with sex drive, the use of sex as a coping mechanism and deviant sexual preference are addressed in a number of ways. Classes in Healthy Sexuality (Cellini, 2008[44]) encourage the development of healthy sexual attitudes. Sexual abuse via the Internet is addressed through special classes including Cybersex Unhooked[45] and Computer Safety. Stress management teaches different coping skills as does classes in meditation and

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[41] Kivel, P. Men's Work (1992). Center City,Mn: Hazelden Press
[42] CopWild Divine Project
[43] Schwartz, B.K. (1995) Thinking Straight. Bridgewater, MA: Public Resource Institute
[44] Cellini, H.R. (2008) Healthy Sexuality. Albuquerque: Training Research Institute
[45] Delmonico, D., Griffin, E. & Moriarity, J. (2001) Cybersex Unhooked: A Workbook for Breaking Free of Compulsive Online Sexual Behavior. Wickenburg, AZ: A Gentle Path

biofeedback. Deviant sexual arousal is addressed by the behavioral techniques referenced below. Men gain the confidence to establish appropriate relationships through classes which enhance self-esteem and encourage understanding one's personality dynamics.

Each participant is evaluated for presence of deviant sexual interest and/or arousal. Those identifying with such arousal patterns participate in assisted covert sensitization.

Each week the inmates participate in CPC's RULE core curriculum based on their level of progress in treatment. This group works through the R.U.L.E. Program's 225 page work book[46] which includes mandatory assignments such as:

- Offense Walk Through
- Clarification Letters
- Deviant Cycle
- Autobiography
- Relapse Prevention Plan
- Good Lives Plan
- Insight Paper

Each week residents are seen in individual therapy sessions, which can focus on assistance with assignments, developing insight into offense dynamics or coping with co-morbid conditions. Seventy-eight percent of R.U.L.E. participants have been diagnosed with a significant mental illness, not including substance abuse, at some time in their life and 49% of our current intensive treatment participants are currently receiving medication for a psychiatric condition. Thus in addition to being treated for inappropriate sexual behavior, the R.U.L.E. staff works in close cooperation with the psychiatric staff and treats individuals for depression, bipolar disorder, schizophrenia, PTSD, ADHD, etc.

All men participate in a weekly role playing sessions designed to test their abilities to identify their cycles and use appropriate interventions. Quarterly select residents will participate in a two to three day intensive drama therapy workshop led by CPC staff who has trained other programs throughout the country in this technique. Other experiential therapies include art, music, horticultural and animal-assisted therapies.

Each week participants engage in team building exercises and recovery games such as a Relapse Prevention Game developed by the inmates in the Oklahoma Department of Corrections Sex Offender Treatment Program. These games may also test thinking skills such as "considering all options," "anticipating consequences" or "creative problem solving." Several times a month movies relating to sexual assault and other relevant topics and designed to encourage the development of empathy for victims are shown.

[46] Counseling and Psychotherapy Center (2005) The R.U.L.E. Program. Natick, MA: CPC.

The R.U.L.E. Program works with families whenever possible and encourages family to meet with the staff personally at least once prior to release. Phone communication is encouraged whenever family members have concerns about a participant's treatment.

Participants in the Therapeutic Community are encouraged to participate in committees which enhance the environment such as organizing recreational activities, celebrating holidays and birthdays, giving special presentations, etc. Dorm 2 residents publish a monthly newsletter. They are also encouraged to improve their interpersonal relations by developing mediation skills and serving as tutors, mentors and peer counselors. Numerous mediations are held each week to encourage the appropriate resolution of interpersonal conflict.

Transition Program/Services (Residential)

When an individual reaches Level 4 (See below for description of level system), has completed all required assignments and, most significantly, has shown that he has integrated what he has been taught into his behavior, he may begin the graduation process which includes, when possible, presenting his Relapse Prevention Plan to his future probation officer and victim advocates, going before the Graduation Panel which is composed of the Program Director, one or more of the principle officers of CPC, the Unit Director and Unit Sargeant who question the prospective candidate for graduation on his achievements, and finally the results of the panel are forwarded to the Treatment Team for final disposition.

If approved, the man is transferred back to the orientation unit where graduates are housed. During this Transition phase, the men assist those in the Orientation Phase in learning about the program and are given a work assignment within the prison where they may be challenged to demonstrate the skills they have hopefully acquired during Intensive Treatment. Some of these men are assigned as peer counselors in the orientation classes and groups.

Given the challenges in readjusting to the community that are unique to sex offenders, the R.U.L.E. Transition Clinicians provide a number of transition services. Residents in intensive treatment and graduates participate in transition classes focusing on skills which may be needed in adjusting to the community such as job application, sex offender registration, etc. Additionally the Transition Clinician also works closely with community resources including the future sex offender therapist, probation officer and others to identify appropriate housing, treatment, medical care, etc for the sex offender.

Evaluating Treatment Progress

The progress of each participant in Intensive Treatment is monitored objectively on a quarterly basis using the R.U.L.E. assessment system which determines four privilege levels. Each level is accompanied by certain privileges (as identified by the DDOC) such as changes in mandatory bed time, use of recreation facilities, etc. Participants are assessed on the basic principles of the Program including:

- Responsibility
- Understanding
- Learning
- Experience

They are expected to be able to integrate what they have learned on a cognitive and affective level into observable behavioral and attitudinal changes. Men receive a score which ranges from 0 to 100 based on a number of specific accomplishments. A narrative of treatment progress is also included. The Quarterly Report drives the initial and updated treatment plans. It is completed by the individual's therapist but must be approved by security staff and the Treatment Team which typically consist of the Unit Director, Unit Sergeant, mental health worker, caseworkers, and Correctional Officers.

Non Residential Treatment Model

The description in part 1 of this RFP response of the CPC treatment philosophy outlines an overall approach to the treatment of sex offenders which reflects evidence-based approaches and state-of-the-art approaches including the Pathways and the Good Lives models and well as CPC's RULE program model. The program description references the approaches to each of the following issues which shall be summarized below:

Relapse Prevention	Inmates in the introductory non-residential components of the program are given a general overview of the concepts of pathways, the offense cycle, risky situation and interventions. Psycho-educational classes will be offered in the residential program which further focus on the pathways and the development of a Relapse Prevention Plan which addresses situations, thoughts, feelings and behavior to avoid as well as a Good Lives plan which directs the inmate to positive ways to fulfill basic human needs.
Cognitive Restructuring	Inmates in the non-residential components of the program will learn to recognize common thinking errors that may have contributed to their inappropriate sexual conduct by minimizing, justifying or rationalizing their behavior. These cognitive distortions will be further identified through the assessment process and challenged through the group process. Additionally neurocriminological techniques such as teaching frontal lobe, higher cognitive functioning skills will be taught.
Interpersonal Skills	Social and interpersonal skills are taught in several psycho-ed classes such as Nonviolent Communication, Men's Work, and Social Skills. The environment of the Therapeutic Community including the use of Needs Identification Forms teaches interpersonal communication skills. Interpersonal skills are often a topic of discussion in core groups. Men are also taught mediation skills.
Emotional Management	Emotional management skills are taught through DBT, meditation, biofeedback as well as classes in stress management. CPC works closely with psychiatric services in this area.

Sexual Arousal Control	Behavioral techniques such as assisted covert sensitization are used to address deviant sexual arousal. Occasionally medications which would have to be coordinated through the Medical Services can be helpful.
Accountability and Responsibility	The name of CPC's program is The R.U.L.E. Program with the R standing for Responsibility which is a core issue in the program. From the first day in the program the stress is on taking responsibility first for one's offenses and then for one's total behavior. The Therapeutic Community stresses holding oneself and others responsible and accountable. The Needs Identification Form has been developed precisely for that reason. This is a constant topic in core groups.
Drug and Alcohol Abuse Treatment	The interaction between substance abuse and sexual offending is addressed in formulating the offense cycle and the Relapse Prevention Plan. Psycho-educational classes focus on helping the individual face their issues in this area and explore the latest treatment options. AA/NA volunteers are encouraged to come into the MTC, obviously in coordination with DOC security.
Understanding Human Sexuality	This issue is addressed through the class in Healthy Sexuality which was designed by Henry Cellini, PhD for use in correctional settings.
Release Planning and Reentry	Transitional classes are offered to help inmates learn skills such as job interviewing, writing resumes, accessing community resources, etc. CPC also has a network of community providers into which releases can be transitioned.
Generalization	The primary function of the Therapeutic Community is to assist the inmate in generalizing that which is learned in groups and classes into their daily living. The Therapist Rating Scale has been specifically designed to identify deficits in the integration of information into ongoing behavior. Thus treatment plans can be continuously adjusted to address problems in actually using the tools that are being presented in therapeutic sessions.

Furthermore these concepts will be presented in a variety of sensory modalities, respecting various learning styles and academic levels. Experiential exercises will be emphasized. Treatment will be adapted for developmentally disabled based on best practices approaches. (Brown & Pond, 1999[47]; Stacken and Shevich, 1999[48]; Yokley, 1999).

[47] Brown, J. & Pond, A. (1999) "They just don't get it" Essentials of cognitive behavioral treatment for intellectually disabled sex offenders. In B. K. Schwartz (Eds) The sex offender: Theoretical advances, treating special populations and legal documents. (pp 21.1-21.9) Kingston, NJ: Civic Research Institute.

[48] Stacken, N.M. & Shevich, J. (1999) Working with the intellectually disabled/socially inadequate sex offender in the prison setting. In B. K. Schwartz (Eds) The sex offender: Theoretical advances, treating special populations and legal documents. (pp 22.1-22..13) Kingston, NJ: Civic Research Institute.

The non-residential program shall be presented, adhering to CPC's Core Treatment Program and Philosophy outline in part one of this RFP as follows:

Six-month Entry Module

CPC has developed a six-twelve month orientation and assessment module based on the evidence-based models presented by Marshall (1999[49]) and the levels of motivation discussed by Prochaska and DiClementi (1986[50]) and addressed through Motivational Interviewing (Miller & Rollnick, 1998[51]). The initial focus of the orientation and assessment module will be on teaching group therapy skills, addressing communication skills, confidentiality, and developing trust. Using motivational interviewing techniques, the curriculum, Understanding Sexual Assault (Schwartz, 1992), acknowledges the ambivalence that a newcomer to treatment may naturally experience. Moreover these neophytes in treatment are most frequently in the pre-contemplative or contemplative stage of change. They need to realize that sexual assault is a tragic event that leaves a lifelong scar on the victim. Furthermore they should be helped to recognize that they need to take responsibility for their inappropriate conduct but also come to believe that they can change and become productive citizens. The curriculum incorporates the voices of victims in writing and in video presentations. It also includes an introduction to basic sex offender-specific concepts such as cognitive distortions, risk situations, the abstinence violation effect. These concepts will be presented in ways which respect different learning styles and incorporate role plays and experiential exercises. While staff presenting the orientation group will have reviewed the official reports of the offenses, the participants will not be required to discuss their offenses until they can voluntarily take responsibility for their crimes. This minimizes denial. By the end of the six months enough information will be accumulated that the dynamic risk factors can be ascertained. By the final weeks the inmate's ability to take basic responsibility for his crime can be ascertained. At that time a decision will be made as to whether the individual should:

- Continue with the treatment phase designed for inmates who will be maintained in a non-residential setting;
- Advance to tier 2 assessment programming awaiting the intensive treatment program
- Encouraged to repeat the orientation group to work on issues of responsibility.
- Found inappropriate for programming and referred for reclassification

If at any time there are special needs inmates or inmates who speak only Spanish, a special individual or group/s interventions will be established to treat this population.

Female Sex Offenders

A similar orientation and assessment program will be conducted for female sex offenders. However, this population needs a significantly different, gender-responsive approach that will be discussed below. Their orientation group would be based on this paradigm.

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[49] Marshall, W.L., Anderson, D. & Fernandez, Y. (1999) Cognitive-behavioral treatment of sex offenders. Chichester, UK: Wiley

[50] Prochaska, J.O. & DeClimenti, C.C. (1986) Towards a comprehensive model of change. In Miller, W.R., Heather, N. (Eds) Treating additive behaviors: Processes of change, N.Y.: Plenum Press.

[51] Miller, W.R. & Rollnick, S.P. (1998) Motivational Interviewing, Second Edition. N.Y.: Guilford Press.

The orientation module will be presented at any of the facilities described in the RFP where there are eligible inmates. Pre and post-testing will measure progress on targeted issues. At the end of the orientation module, very low risk inmates may not require any further treatment. Higher risk inmates can be referred to the treatment phase.

Female sex offenders will receive hours of treatment comparable to male sex offenders; however, their treatment will be gender-responsive and will incorporate the documented differences between the two populations (Covington & Bloom, 2002). It is recognized that the dynamics of the commitment of inappropriate behavior in females has significantly different origins than in males. The Center for Sex Offender Management has identified the "building blocks of gender-responsive sex offender treatment which include:

- Recognize the heterogeneity of sexually abusive females
- Develop interventions that are based on the unique pathways to female offending
- Appreciate the similarities among and differences between male and female sex offenders
- Understand the developmental differences between adult and adolescent females who commit sex offenses
- Acknowledge the victim-offender duality that exists among many women and girls who sexually abuse
- Consider the potential impact of the unique sociocultural messages to which women and girls are exposed and which can affect their sense of identity
- Honor the role of relationships and family both in and out of the therapeutic context

Furthermore the evidence-based treatment focuses on different issues. Relational Therapy has been proven to be a valuable approach (Miller, 1976[52]) Female sex offenders have often been involved in deviant sexual behavior by male sex offenders. They have often been the victim of sexual abuse and are more likely to suffer from substance abuse and mental illness than male offenders. Their treatment needs to incorporate a focus on avoiding dysfunctional and co-dependent relationships. The material used by CPC to treat this population will be specifically adapted to a female population. Females will receive amount of treatment, depending upon their placement in non-residential or residential treatment programs.

Treatment Phase 6-12 months

In this phase of treatment participants will be expected to participate in weekly process group, 1.5 hours each. They are expected to learn (or demonstrate that they have learned) the basic tools needed to be successful in treatment. At a minimum they will be required to admit some role in their offense(s), write and present their autobiography, complete general description of the cycle, and successfully complete all group assignments issued during this phase of treatment. Additionally, participants may be required to participate in psycho-ed programming when it is determined that the module currently provided meets the participant's treatment needs. A series of psycho-ed programming will be offered throughout the course of a participants program targeting a variety of issues associated with offending behaviors.

[52] Miller, J.B. (1976) Towards a psychology of women. Boston: Beacon Press.

These programs may include:

- Anger management
- Victim empathy
- Social skills
- Problem solving
- Men's work
- Drama Therapy
- Trauma Therapy
- Behavioral Therapy
- Non-Violent Communication

For more detail on this phase of treatment, i.e., goals, tasks, see part 1 of this RFP.

Advanced Treatment Phase

This advanced non-residential program will consist of 2 weekly group sessions lasting 1.5 hours each. The group will not exceed ten participants. CPC's formal curriculum will be utilized and will be supplemented by basic psycho-educational curriculums in communication, boundaries, social skills and problem solving skills. These classes will utilize pre and post-tests to measure progress. Thought stopping skills can be taught to those inmates who need assistance in intervening in intrusive sexually deviant thoughts. The non-residential program group shall be divided into 1.5 hour of process group and 1.0-1.5 hour of psycho-educational instruction. For further details see part 1 of this RFP.

Aftercare /Transition Phase

Aftercare groups meet once per week for 1 hour and keep the participant connected to their treatment plans. The aftercare groups in the institution setting focus on the development of a transition plan which may be shared with the participant's perspective probation officer prior to release, while now having the opportunity to develop a comprehensive transition plan. A participant may be approved for aftercare programming if they meet the following requirements:

- Must achieve a score of 90 or above on the RULE Progress Report to move to aftercare.
- Must have completed a written Relapse Prevention Plan that has been reviewed by the group, CPC Clinician, Probation/Parole Officer and support network.
- Must have written letters of clarification to victim(s), self and others. The letter to victims should not be sent to the victim. These letters must be reviewed by the individual's group and approved by the clinician.
- Full compliance with classification and treatment conditions.
- A successful, non-deceptive Polygraph is required prior to less intensive services, including aftercare. The client is required for all costs associated with having Polygraphs unless covered in the contract services.
- Meeting(s) must be held with the client's support network and clinician. During this meeting, the client will review his Relapse Prevention Plan, including current life involvements.
- Must have approval from the Treatment Team to move to aftercare.
- Must demonstrate successful mastery of the RULE Program by demonstrating competence in the following areas:
    - Stable employment (if applicable)

- Financially responsible
- Informed support network (minimum of 3 individuals-families count as one)
- Stable Housing Plan
- Substance free lifestyle
- Healthy leisure activities
- Functions as a role model in group; Does not maintain secrecy, addressing other's distortions; confronts others directly, appreciates impact on person(s) he victimized and is able to demonstrates empathy to others
- Demonstrates healthy sexuality in terms of an intimate relationship or appropriate sexual outlets

- An Abel Assessment for Sexual Interest (AASI-3/ABID), VRT Measure, or a Penile Plethysmograph (PPG) may also be required.

Community Treatment Phase

The most successful treatment programs for sex offenders include post release supervision with community sex offender treatment programs utilizing the "Containment Approach" model. CPC staff will work closely with probation staff and community providers to ensure a smooth transition of services for those participants released from the institution with a post release supervision requirement. Participants with no required post release supervision will be encouraged to continue treatment once release to the community and every effort will be made to successfully place these individuals in a community treatment program.

Implementation Plan

The initial implementation plan will involve the following steps:

1. Staff training for identified correctional staff relative to treatment program to be initiated;
2. Develop the sex offender data base listing all sex offenders in level 4&5 institutions;
3. Conduct initial screening (Static 99R) for all participants listed in database;
4. Conduct orientation/intake assessments on all inmates (screened moderate to high risk as a priority followed by low risk) referred to the sex offender treatment program;
5. Formulate entry level treatment groups, a minimum of three groups at each level 5 institutions and 1 group at each level 4 institution; staff time 57 hours per week (not including preparation time); Note: all groups per RFP must be co-facilitated.
6. Once all initial groups are up and running, the remaining 187 hours of staff time shall be utilized for:
    a. Initiating psycho-sexual assessments, ABELS, etc for all clients referred by DDOC;
    b. Continue intake assessments for all new referrals;
    c. Maintaining data base;
    d. Record management;
    e. Program documentation

f. As participants begin to advance to the treatment phase of programming, establish psycho-ed programming to supplement process group work as noted on page 66 at all level 4&5 institutions. This component will add an additional 33 hours of group work per week for a total of 90 Hours weekly leaving 150 hours of staff time for tasks noted in i-v above.

Program Hours

Participants of the R.U.L.E. Sex Offender Treatment Program shall receive the following program hours during participation:

Program	Number of Hours
Initial Intake	3-5 Hours
Psycho-Sexual Assessment	8-10 Hours
Entry Level Treatment Phase	1.5 Hours Weekly
Treatment Phase	3 Hours Weekly
Advanced Treatment Phase	3 Hours Weekly
Aftercare/Transition	3 Hours Weekly

2.4 Driving a Vehicle While Under the Influence (DUI) Court Ordered Programming

CEC has reviewed the proposed sentencing guidelines in House Bill No. 168 that call for, "An intensive inpatient or outpatient drug and alcohol treatment program for a period not less than 3 months" and that, "Such treatment and counseling may be completed while and offender is serving a Level V or Level IV sentence."

The major goal of the proposed DUI Recovery Program is to help offenders take an honest and careful look at their situation, take responsibility and ownership for their current circumstances and to explore what it takes to solve the problems they've encountered.

CCS and CEC are prepared to collaborate with the DDOC to develop a program and offers to implement a "TC-Oriented" intensive DUI Recovery Program "tailored" to the needs of this class of offender. Given Delaware's history and national reputation with the TC model and CEC's experience with applying "adaptive treatment" the proposed DUI Recovery Program is intended to serve as a framework and guide for directing innovation and integrating research-based "best practices" specific to the needs of Delaware's incarcerated male and female DUI offenders.

CCS and CEC understand that the target date for implementation of the DUI intensive treatment is January 13, 2013 and is prepared to meet that deadline and to exceed it if necessary to satisfy DDOC's need in meeting this important public safety priority. To further assist with the effort, CEC has enlisted Charles Wuth, LCSW, co-author of *Assessment and Treatment of the DUI Offender (2002)* as a clinical consultant.

Should CCS be awarded a contract or contracts for the provision of these specialized DUI offender services, CEC will utilize a variety of assessments, specialized modules and curricula, as well as traditional TC elements noted earlier in this proposal. A variety of these assessment

instruments and curricula will be mentioned in the narrative that follows. What is intended, is not to imply that CEC will use *all* of these (as there is cost associated with most of them), but that CEC will collaborate with the DDOC in determining the specific assessment and curricula pieces that best fit the needs of the DDOC DUI programs. All aspects of programming will be developed and implemented in alignment with the needs and specifications of the DE Department of Correction, DDOC facility requirements and with the oversight and approval of the BCHS. Outlined immediately below are the rationale for the adaptation of the TC model to DUI offenders and the specific service elements of the proposed DUI Recovery Program.

2.4.1 Rationale: What We Know from Research

Over the past thirty years, a wealth of research in the criminal justice arena has led to the conclusion that, "Corrections-based drug treatment can be effective, but implementing new programs and improving existing ones require an understanding of *how* treatment works." (National Survey of Drug Use and Health; Substance Abuse and Mental Health Services Administration, 2005) Evidence has clearly been established indicating that a deliberate process of assessment, planning, and delivery of *tailored interventions*, along with ongoing program monitoring is fundamental to treatment effectiveness.

DUI offenders are disproportionately represented among drivers involved in accidents and are at high risk for recidivism. It is estimated that 35% - 40% of fatally injured drivers had a *prior* DUI arrest. Estimates vary that somewhere between one-in-three and one-in-five DUI offenders will be re-arrested; yet in the past, few predictors have been reliably established other than alcoholism severity. However, research has pointed out that not all DUI offenders are substance dependent. In fact, the literature indicates that a significant proportion of DUI offenders (as much as 40%), do not actually meet the diagnostic criteria for alcohol dependence (Carruth & Wuth, 2002). Therefore, CEC proposes to design and implement a program "tailored" to the complex and diverse needs of this specialized treatment population.

According to the National Survey of Substance Abuse Treatment Services (The N-SATS Report), nearly one third of DUI offenders (in 2007) were between the ages of 21 and 29. Adults between the ages of 30 and 49 made up 46 percent of all DUI offenders. This data is supportive of what research has established, and consistent with CEC's "adaptive treatment approach". In short, DUI offenders are not viewed as a homogeneous group that can be effectively served with a "one model fits all" strategy.

Therefore, a variety of treatment strategies are required to effectively respond to the needs of these offenders. The strategies, to which someone in their early 20's will respond, may be very different than someone who is in their mid-to-late 30's. The person in their early 20's is often times more likely to be the *risky driver who drinks*, or the *problem drinker who drives* as opposed to someone 10-15 years older who by virtue of the progressive nature of addictive disorders is more susceptible to having developed actual substance and/or alcohol dependence.

2.4.2 Proposed Service Elements

Comprehensive Assessment

Current national guidelines for sentencing DUI offenders recommend that all offenders should be screened to ascertain the extent of their alcohol problems and risk of DUI recidivism (NHTSA and NIAAA, 2005). Screening instruments often only examine alcohol use and do not address other factors that are associated with high risks of recidivism. Additional factors such as personality characteristics, level of defensiveness and motivation, driving-related attitudes and behaviors, and alcohol consumption patterns should also be considered (Chang, Gregory & Lapham, 2002).

CEC proposes to use a "matrix" system to determine appropriate treatment and referral recommendations. This approach has the advantage of using information obtained from a variety of sources to guide treatment, including scores from self-report instruments, blood alcohol levels at the time of arrest, prior DUI offenses, and prior treatment for alcohol abuse. Using a combination of measures and screening assessments is more likely to result in attaining an accurate portrait of the DUI offender than relying solely on one instrument or source. Assessments will be completed within three (3) days of an offender's admission to the DUI Recovery Program.

Although there are a number of tools commonly used for DUI screening and assessment, there is no nationally-identified "gold standard" instrument. Some programs utilize tools that assess only alcohol use, and were not designed to use within the DUI offender population. CEC is taking into consideration the following recommendations for selecting an appropriate screening instrument (Chang, Gregory, & Lapham, 2002):

- The screening instrument should be validated and scored based on a DUI offender population. Instruments are standardized or 'normed' to recognize issues in specific populations. Applying the same scoring guidelines to other populations may lead to inaccurate results.
- When possible, the information collected using a self-report tool should be validated with collateral data. This helps determine the actual needs of the individual and assists the assessor determine the individual's level of defensiveness.
- Matrix systems often lead to more accurate assessments than scores from a single-component instrument. However, when these multi-component systems are used to guide referral recommendations, it is important to consider meaningful measures and to use appropriate cut-off scores.

As noted, DUI offenders do not represent a homogenous population, and in view of the above-referenced recommendations CEC proposes to use a battery of specialized and general assessments chosen from the following:

DUI Instruments	Clinical Descriptions	Strengths
The ASUDS-R	• Multi-component instrument designed to screen for DUI recidivism within the criminal justice system. • 16 scales: alcohol involvement, driving behaviors, lifetime alcohol and drug use, reported alcohol and drug use, reasons for use, life disruptions, mental health concerns, defensiveness, anti-social behavior, prior criminal behavior, motivation for change, and individual strengths. • Includes collateral data: blood alcohol concentration (BAC) at time of arrest, criminal history records, and driving history reports.	• Items included are identified as strong predictors of alcohol use and DUI recidivism. • Assesses defensiveness, driving attitudes, aggression and impulsivity.
The Mortimer-Filkens Questionnaire (MFQ)	• 58 questions presented in True/False, Yes/No, and Short Answer formats. • Semi-structured interview to determine offender as; social drinker, problem drinker, or substance dependent. • Open ended questions designed to verify diagnostic indicators.	• Reliable and valid tool for detection of alcohol-related problems and risk of DUI recidivism.
The Alcohol Time Line Follow Back	• Measures daily drinking consumption using a 12 month calendar to document pattern of use.	• Accurate portrayal of drinking patterns.

Comprehensive Treatment Planning

Based on the comprehensive information gathered from a combination of assessment instruments, a Comprehensive Treatment Plan will be devised with each offender in the program that will:

- Include the counselor's and the offender's input.
- Be based on the severity and characteristics of the offender as revealed by the comprehensive assessment, review of collateral information, and the clinical interview.
- Include goals, objectives, and strategies that are based on the offender's problems/needs, strengths, and preferences. These goals, objectives and strategies are individualized, realistic, measurable, time specific, appropriate to the level of treatment, and clearly stated in behavioral terms.
- Describe the strategies to be used as well as the type and frequency of the specific services and interventions that will be needed to help the offender achieve the identified goals. These strategies, services and interventions will be appropriate to the level of intensity of the program in which the offender is receiving treatment.

- Identify the offender's primary counselor, and be dated and signed by both the offender and the counselor. Plans completed by a Counselors Intern will be reviewed and signed by a Clinical Supervisor (CADC).
- Be established within seven (7) days of the offender's date of enrollment into the program.
- Be re-evaluated on a regular basis and revised as needed to adequately reflect continuous treatment planning, re-assessment and updating,
- Be reviewed at a minimum every 30 days (or more often if needed) by the Therapeutic Team.

Department Approved Multi-Modal DUI-Specific Curriculum

DUI-specific curricula will also be offered to address the specific needs of the DUI Offender. CEC has identified several such curricula for possible use, and upon contract award will seek through joint discussions and collaboration with the Department, to implement the curriculum or curricula which best meet the goals and objectives of the offenders and the program design. A few such curricula for consideration include:

PRIME for Life

"PRIME for Life", is a research-based program developed by Prevention Research Institute (PRI) targeted to changing attitudes and behaviors. It is the mandated statewide DUI program in Georgia, Iowa, North Dakota, South Carolina, and Utah and delivered through community agencies in more than 45 states. Its content is carefully selected to achieve specific attitudinal and behavior changes.

Instructors (or trainers) receive curriculum-specific training and continuing education workshops. PRIME For Life is a 16 hour curriculum delivered in 8 sessions and includes a self-assessment, individual and group activities.

Preventing Alcohol-Related Convictions (PARC)

This program is based on a less conventional "harm reduction" model for DUI offenders. The methods focus on eliminating driving drunk vs. eliminating drinking. Traditional programs attempt to motivate offenders to control their drinking in order to avoid a future DUI arrest. The PARC program uses a strategy of controlling driving (to drinking events) rather than controlling drinking (at drinking events). The harm reduction approach grows out of research on the reasons DUI offenders fail to avoid additional arrests for impaired driving, (although the PARC program includes standard instruction on alcohol consumption and alcohol use disorders). This program is considered to be more responsive than traditional approaches to the variety of DUI offenders. *A statewide NIAAA funded random clinical trial of the PARC curriculum (2004-06) in Florida tested this protective concept: an evaluation of the first 10,000 participants with a minimum of one year of driving exposure showed the PARC curriculum was associated with a 42% reduction in recidivism. A second NIAAA clinical trial currently underway appears to confirm these results.

Driving with Care

The Driving With Care (DWC) curriculum presents a comprehensive view of cognitive-behavioral treatment for impaired driving offenders; a thorough review of theory and practice related to client evaluation; legal and cultural considerations; as well as operational procedures for assessing and matching DUI offenders to appropriate levels of education and treatment services. Guidelines are provided for developing individualized treatment plans, and implementing appropriate education and treatment curriculum protocol where clients relate to, and apply the lesson materials to their own unique circumstances and situations. Clients learn self-control over thinking and actions, responsible behavior towards others, and toward their community.

Comprehensive Release Plan

The proposed Comprehensive Release Plan (CRP) would be completed for all DUI clients prior to completion of the programming based upon the following features:

- The CRP will include input from each offender.
- The CRP will include a progress report of the offender's level of program participation as well as the quality of the program completion.
- The treatment staff shall recommend the offender for continued services (residential treatment or outpatient treatment) upon release consistent with options and/or requirements of the courts, DDOC or Delaware Evaluation and Referral Program (DERP).
- A copy of the Comprehensive Release Plan will be placed in the offender's file.
- The CRP will be made available to the probation officers, court officials, the offender, and other appropriate community agency resources with the authorization of the DDOC.

Comprehensive Curriculum

As outlined in previous sections, CEC will utilize a blend of evidence-based practices and curriculum elements integrated in a comprehensive and "tailored" manner to fit other program aspects. These curriculum elements include:

- DUI-specific curricula as approved by DDOC/BCHS
- The CEC proprietary curriculum "Orientation to TC," which is designed to reduce resistance and enhance engagement by community members new to the program.
- The Cognitive Restructuring curricula Character and Accountability and Errors in Thinking.
- CEC's Core Skills curriculum, that addresses the development of skills such as stress management, empathy for others, assertion skills, and accessing resources to prevent overwhelm.
- Substance Abuse Education classes that address various models of addiction, the development and dependence on defense mechanisms, the impact of addiction on family systems, medical aspects of addiction, and the process of recovery.
- Other specialized curricula covering topics from motivation to anger management, HIV, parenting and gender specific issues

TC "Oriented" Treatment Environment

Most DUI offenders coming into a prison setting have been conditioned not only by their previous life experience, but also by their previous time on probation (or in prison) to be suspicious and guarded. They will very likely come into the program adhering to a value system of "trust no one", "keep to yourself", "mind your own business," and "just do your time" believing that they have been victimized by the "system". They also have been conditioned to "maintain an image" of being tough and invulnerable. (This is part of the rationale for using a DUI assessment instrument like the Mortimer-Filkens Questionnaire (MFQ) that utilizes indirect questions which cannot be easily manipulated for the sake of the offender's agenda.)

Now that they are in a TC oriented DUI Recovery program (perhaps for the first time), offenders are suddenly being asked to be honest and open with one another (which requires them to drop their masks and be vulnerable), to hold each other accountable, and to "trust the process". It is no surprise then, that as they begin to understand what is expected in the TC environment, most "orientees" experience a sense of "culture clash". This culture clash is predicated on the fact that the value system and way of living required in the TC is in direct conflict with the value system and way of life experienced and internalized in their criminal or addictive lifestyles, and learned from their previous experience with law enforcement and correctional systems.

Thus, in order for any progress to be made in letting go of their antisocial value system and adapting to the right living value system of the TC, creating a sense of physical and psychological safety becomes paramount. An environment that is not free from drugs, violence, or sexual acting out undermines any efforts toward successful rehabilitation. For this reason, CEC understands the absolute necessity of working hand-in-hand with DDOC correctional staff to ensure the safety and security necessary to support the goals of the In-Prison DUI Recovery Program. It is only in such an environment that offenders can be expected to authentically engage in a constructive and meaningful treatment process. As noted earlier in the proposal, the phases of the DUI Recovery Program will mirror those of the Key/Crest TC but will be adapted as follows:

Orientation

As discussed earlier the Orientation Phase will be designed to assist DUI offenders in moving from "Compliance" to "Conformity" in the "Levels of Internalization" (De Leon, 2000, p. 359) and from Pre-contemplation to Contemplation from a Stages of Change perspective (Prochaska, DiClemente, & Norcross, 1992).

Another aspect of establishing a sense of a safety and security is predictability. That is why CEC's proprietary "Orientation to TC" curriculum goes over exactly what can be expected as the offenders move through the TC experience. By explaining what is to be expected in the process, and going over issues such as the culture clash that many are in the midst of experiencing, the CEC curriculum assists orientees in beginning to develop a sense of trust in the program and in the staff.

This "normalizes" the experience of culture clash and their struggle to work through it. In this manner, the recovery process they will be going through as members of the TC is "brought to

life". This is not simply an intellectual discussion about addiction or "the lifestyle"; rather it pertains to their direct, "here and now" personal experience. This gives credibility to the curriculum and to the program. Other aspects of establishing predictability and safety include having a structured routine, knowing what is expected, and understanding not only the processes and procedures to which one is expected to adhere, but also how to utilize them. These are also areas of emphasis in the CEC Orientation to TC curriculum.

As has been previously noted with regard to the TC approach, it is the client's relationship to the community that is the agent of change. The Orientation Phase supports opportunities for a client to develop therapeutic alliances with other residents in the community and to begin to achieve a sense of belonging. By design, orientees are assigned "less taxing," low-ranking jobs within the community social order or "structure". They are also assigned a more experienced resident as a coach or "big brother/big sister", which is a valuable tool in helping new orientees to understand the workings of the community and to become acclimated to its requirements.

Overall, during the Orientation Phase, the main focus is induction into the program. In the CEC TC Model, part of being a "rational authority" is about staff having realistic expectations of new community members, and not only understanding the natural process these individuals are going through, but being able to articulate it to them. It is expected that this phase of programming will begin with the orientee being externally as opposed to internally focused. This is only natural until he or she begins to get a sense of his or her surroundings and begins to understand the rules and how the program operates. At this point, community members are expected to be at the Compliance level of the internalization process. During induction into the TC and at the level of Compliance, community members are expected to:

- Learn the rules, tools and structure of the program
- Learn the program philosophy
- Learn expectations of program membership
- Complete a DUI autobiography focusing on the consequences of drinking and driving and the impact on the offender's family

As new members begin to gain this understanding, and begin to have some of their initial concerns and struggles validated by staff and other residents as "normal" and to be expected; they also begin to "settle in".

Main Treatment

As they experience movement into Phase Two: Main Treatment, which results in gaining acknowledgement, potentially an increase in their role in the community's hierarchy, and/or an increase in their level of privileges; the result is often a sense of beginning to "open up" ever so slightly to the TC Program. It is the process of beginning to get actively engaged in the program, that results in opening up to the program - gaining a sense of "Let's see where this goes." or "I'm willing to see where this goes." As previously noted, this is the focus in the early to mid-point of Phase II; movement from mere Compliance, into Conformity in the Levels of Internalization and Precontemplation into Action within the Stages of Change framework.

Phase II of the proposed DUI Recovery program will be characterized by intensive group treatment and greater expectations for responsible interaction within the community. This is intended to produce constructive insights and changes in the DUI offender's thought processes, attitudes and behavior, ultimately resulting in acceptance of greater levels of personal responsibility, enhanced self-management, and recognition of the negative impact of substance use and antisocial thinking and attitudes that are related to his or her patterns of DUI offending.

In Phase II, the individual becomes a "credible member" in the community by practicing the skills, and gaining the understanding and insights necessary to become credible in the program. Phase II participants will be fully introduced to group, educational and skills training; job and social responsibilities, and to peer-driven counseling interventions that support their recovery process, and help them to develop a commitment to abstain from driving and drinking. All of these activities ultimately are designed to assist them in becoming credible, productive members of the community, fulfilling a variety of roles, both formal and informal.

Relapse Prevention and Reintegration Planning

CEC understands that, to be most effective, Re-entry/Transition Planning must begin with the development of the offender's initial treatment plan and should guide goal-setting and performance criteria throughout program participation. Although formal written aftercare planning will occur during the final phase of programming, informal discharge preparation must begin at intake in to the program and inform all counseling sessions and other participant activities.

DUI Recovery Program participants will be required to take an active role in co-developing a concrete and practical Comprehensive Release Plan (CRP) that covers all of their assessed reentry needs. The role of the counselor in the planning process will be as a facilitator in the client's own aftercare planning, providing the client the experience, under close guidance, of constructing his own plan. The key to continuing success will be the client's ability to generate further options for him or herself, guided by the training received during program participation.

CEC's client-centered aftercare planning tool - RePAC (Release Preparation Activity Checklist) – is a systematic tool for ensuring comprehensive preparation for all major areas of continuing recovery after release. The RePAC covers fourteen areas, including planning for housing, work, social relations, recovery services and finances. CEC will tailor and integrate the RePAC development process, within the framework of the Comprehensive Release Plan (CRP).

Individual Discharge Planning Services	Individual Discharge Planning Services take place as individual sessions and as personal assignments. These tasks include: • Structuring and prioritizing of assessed needs within the fourteen RePAC categories; • An assessment of the individual's capability to address identified needs; • Identification of community resources to address needs; • Co-development with the client of an individual discharge plan; • Ongoing refinement and monitoring of discharge plan development with the client prior to transition to subsequent phase of continuum, or to release; • Initial and ongoing contacts with community agencies to plan for access to services post-release; • Formation of a "day plan" that provides hour-by-hour guidance for positive activities during the first few days post-release • Establishment of linkages and firm referrals to community-based substance abuse treatment services
Group Discharge Planning Services	Staff facilitated group sessions focusing on: • Ongoing relapse prevention skills training • Transitional skills • Motivational skills • The use of RePAC as a tool to generate further options • Connecting with sober support systems in the community • Scheduling a post-release evaluation with the Delaware Evaluation and Referral Program (DERP) for offenders who may become eligible for driver's license reinstatement

Continuum of Care	Aimed at DUI offender specific reentry strategies:
	• Offenders Transitioned Back to General Population
	  o With regard to continuum of care requirements, CEC agrees to ensure it that treatment staff assist any offenders who are completing the program but who have been release and subsequently are returned to general population by recommending available resources that address each offender's ongoing needs during the remainder of the offender's incarceration.
	• Offender Transitioning to the Community
	  o CEC also agrees that treatment staff shall recommend the offender for residential treatment or outpatient treatment upon parole release, as required by courts or parole. This recommendation shall be included in the CAP.
	  o Treatment staff shall recommend available community resources to all offenders who are released on parole and transition back into the community.
	  o CEC will coordinate referrals through

Release of Information for DUI Offenders

Lastly, regarding any CEC-run DUI Recovery Programs, CEC agrees that treatment staff shall ensure that a release of information form is signed by each offender, to ensure release of all necessary information to aftercare providers and/or criminal justice personnel responsible for ongoing oversight and supervision of offenders completing the DUI Treatment Program.

Community Release Plan

The CRP and/or RePAC will be part of a comprehensive discharge plan accompanying each offender on his/her release and will be sent to the Parole Board prior to program completion. The CEC DUI Recovery Program will provide Community Assessment Plans that align to the forms and guidelines provided by DDOC. It is assumed that information provided will include:

Community Agency Contact Information – A simple, personalized booklet (to be co-developed with program staff) providing all the contact information, locations, hours of operations and directions/bus routes to each community resource identified in the CAP.

Contingency Planning – CEC's RePAC will require each DUI offender to develop a "what-if" help list as a part of their personal action plan. Each offender will have identified his personal "what-if" list of potential problems or obstacles to complying with the discharge plan that may be encountered after release. These may include items such as, "What if I relapse to drinking/drug abuse?", "What if my plans for housing don't work out?", "What my family doesn't trust my intentions to stay sober, etc." The "what-if" help list and personal action plan

will be individually developed by each inmate to address his own potential problems and solutions, based on identified local resources and support systems. A group process guided by program staff and reinforced through brainstorming activities and peer support will help each inmate to develop a personal contingency plan.

Some "what if …" scenarios may be as simple as needing someone sympathetic to talk to. Personal plans that integrate community resources, including church ministries, drop-in centers, and peer support groups will play an important part in addressing transition issues as the offender nears his release date. The contingency management plan provides a psychological safety net and additional "insurance" against relapse to high risk behaviors and substance abuse. Contingency planning will be included in the program's Phase III staff-delivered group counseling sessions. The focus is on skill-building to enable each offender to apply self-management, planning and resourcing skills learned during their participation in the DUI Recovery Program.

Comprehensive Treatment Schedule

CEC will provide a comprehensive treatment schedule that incorporates at a minimum no less than 20 hours per week of staff-provided, or peer led treatment activities for each offender. Staff shall be present and shall actively participate in each session of required treatment.

The program shall provide services for the DUI Recovery Program within the frequency guidelines outlined in applicable standards, and will ensure that staff responsible for program delivery meets all such requirements.

Treatment planning, family education, volunteer services, recovery literature libraries, time and space for open meetings, study groups and sponsorship meetings, as well as individual counseling sessions – minimum of one (1) time per month, or as needed for crisis management, are other aspects to be included in DUI programming. Below is an outline of other structured treatment activities to occur within the proposed DUI Recovery Program:

Orientation

CEC Counselor will tell residents everything they need to know about the program, outline expectations for completion and assign them to a peer mentor.

Individual assessment

CEC counselors will use clinically based assessment tools to help residents evaluate alcohol/drug use. Once residents get a picture of their pattern of impaired driving and its impact on themselves and others; the focus shifts to treatment planning and making decisions about the need to change and what it's going to take to get there.

Education sessions

CEC DUI classes teach offenders about the legal, medical and social issues that come into play when people use alcohol and drugs. Residents will be assessed before starting the classes and after they finish, so that measurable progress and understanding of their personal patterns of drinking/drugging and driving can be evaluated. Classes are taught using interaction skills training approaches with central focus on the thinking behind the decision to dive under the influence. Guest instructor lectures, discussions and films will be used to reinforce learning.

Individual counseling. DUI offenders will have face-to-face interviews with their assigned counselor so he or she can assess any issues that could prevent them from completing the program.

Counseling/group sessions
Participation in counseling groups intended to encourage residents to share ideas and information. This will help them to identify and resolve any alcohol/drug-related problems. Group sessions provide needed support at an otherwise stressful time. The counseling groups provide opportunities for DUI offenders to examine their behavior and personal attitudes and identify/resolve alcohol and drug related problems.

Self-help groups
Residents will be provided the opportunity to attend self-help meetings such as Alcoholics Anonymous, Narcotics Anonymous, Secular Organization of Sobriety or Rational Recovery to ensure understanding of and experience with a mutual self-help approach to recovery.

CEC's proposed DUI Recovery program offers the State an innovative approach to addressing the needs of an anticipated population influx resulting from recent Delaware DUI legislation. Building upon the foundation of the residential TC and its Community as Method theoretical premise, CEC anticipates working closely with the DDOC in implementing an evidenced based DUI Recovery program adapted to the correctional setting. From the use of a battery of comprehensive assessment instruments normed for the DUI offender to the delivery of evidenced based curriculum and complementary service elements, the proposed model represents yet another opportunity for the Department and CEC to forge a partnership around their shared mission of quality rehabilitation programs and commitment public safety.

2.5 Standards

2.5.1 Provisions of a Constitutional System for Offender Health Care

CCS is the current Medical Services provider for the DDOC. Adding CCS as the Mental Health Services, Substance Abuse Treatment, DUI Programming and Sex Offender Treatment provider ensures that all services will be provided collaboratively and reinforce one another. This will result in enhanced communication between the multiple health care disciplines, easier contract management for the DDOC, and overall enhanced patient care. All services will be provided in accordance with applicable DDOC and CCS Policy and Procedure, NCCHC and ACA standards, CDC protocols and guidelines, OSHA guidelines, United States Public Health Services Task Force on Preventative Guidelines, the baseline performance measures outlined in the Department of Justice MOA and other DDOC recognized authorities and nationally recognized health care organizations.

2.5.2 Communications of Sick Call System

CCS understands a sick call system must be provided for all offenders allowing for direct communication of health care concerns between the offender and health/mental health care personnel. As part of the CCS receiving screening, all offenders are verbally advised of their

right to medical treatment, the procedure to register for sick call and consultation schedule, as well as medical grievance procedure.

The CCS Medical Services team will gather all sick call and referral slips on a daily basis, and will provide the CCS Mental Health Services team those slips that require management by a Mental Health Professional. Of particular importance in this process is the communication between CCS Medical and Mental Health teams and the DDOC to reach agreement on the types of slips that shall be managed by the Mental Health Services team to ensure that any sick call slips received that include inter-related medical and mental health concerns are addressed in a multidisciplinary manner.

CCS will enter all mental health documentation into the DACS Sick Call Tracking and Appointment System, as well as ERMA.

2.5.3 Personnel

CCS has extensive experience in successfully operating and managing health services programs in the correctional setting. The CCS leadership team has more than 250 years of experience in the correctional field. The experienced leadership of CCS consistently directs the company in a purposeful manner to create successful partnerships with our valued clients. The CCS philosophy is to build our company one satisfied customer at a time. The CCS team practices our philosophy by following a manageable process and concentrating all of our resources on the success of each program.

The DDOC Mental Health Services, Substance Abuse Treatment, DUI Programming, and Sex Offender Treatment Program will be designed to operate with competent, credentialed on-site staff members at each facility. Each site will be supported by the entire CCS corporate organization and by the CCS Mid-Atlantic Regional Office team located in Dover.

Key Personnel

CCS has been in communication with potential candidates to fill key positions to function as integral members of the CCS/ DDOC team.

Dr. Allyson Galloway, Ph.D.
Proposed Regional Mental Health Director

Photo Not Available

CCS has had discussions with Dr. Allyson Galloway, PsyD. Dr. Galloway is a licensed psychologist in the State of Delaware and has worked as a Psychologist in the DDOC since 2009; most recently as the Acting Mental Health Director at the Howard R. Young Correctional Institution and Baylor Women's Correctional Institution. Dr. Galloway has expressed an interest in consideration as the Regional Director of Mental Health Services under CCS. Dr. Galloway's resume can be found in **tabbed attachment D.**

Dr. Troy Thompson
Proposed Regional Director of Psychiatry

Photo Not Available

CCS has had discussions with Dr. Troy Thompson regarding interest in continuing as the Regional Director of Psychiatry for CCS. Dr. Thompson has functioned in this role for the current DDOC vendor since December of 2011. Dr. Thompson has expressed an interest in consideration as the Regional Director of Psychiatric Services under CCS. His resume can be found in **tabbed attachment D.**

CCS Home Office Support

Following is an overview of key leadership staff who will be involved with the DDOC facilities implementation and subsequent management of operations. Resumes are also provided in **tabbed attachment D**. These are more than just names in a proposal but rather faces you have seen walking the hallways of the DDOC facilities supporting our program.

Jerry Boyle
President and CEO

Prior to establishing Correct Care Solutions in 2003, Mr. Boyle was President and CEO at Prison Health Services as well as Chief Development Officer for America Service Group. In his dual role, Mr. Boyle increased revenues over three and a half years from $120 million to $550 million through acquisitions and growth. Mr. Boyle has more than 30 years of experience in the correctional environment. Mr. Boyle's experience includes 15 years of experience within a state prison system and 15 years of experience in the provision of comprehensive health care in the correctional setting. Mr. Boyle's experience includes "hands-on" service as well as management oversight to several jail and prison implementation projects. Mr. Boyle has been an engaged and active leader in ALL CCS projects and contracts. He schedules periodic visits at each of our facility operations to support our staff and to ensure client satisfaction.

Cary McClure
Chief Operating Officer

Mr. McClure is a CPA and has 30 years of experience in the Accounting and Finance fields, and earned a Bachelor of Science degree with majors in Accounting and Business Administration from the University of Kansas. His experience includes 18 years as the CFO of a 400+ bed major med/surg urban medical center in both not-for-profit and for-profit settings; CFO of the successful startup and operation of a $100 million for-profit med/surg medical center; and Division CFO for the largest for-profit psychiatric hospital company in the country. The Kansas Medicaid program selected him to serve as a consultant to assist in the design and implementation of the Kansas Medicaid DRG payment system. He has authored two articles on health care finance that were published in national health care journals. Mr. McClure joined CCS in 2003.

Patrick Cummiskey
Executive Vice President, Client Development Officer

Mr. Cummiskey brings over 20 years of comprehensive experience in marketing and operations from a variety of service related industries. Under Mr. Cummiskey, CCS business development activities stay consistently focused on understanding customer needs and developing innovative solutions to meet budget expectations. Mr. Cummiskey has an M.B.A. with degrees in Finance and Marketing. Mr. Cummiskey has been with CCS since its inception. He will work with the team to ensure necessary support provision to our internal clients and external clients. Mr. Cummiskey will work to minimize surprises for all parties by clearly understanding and documenting expectations to assist with smooth transition, and ensure a contract that provides for a successful long-term partnership.

Leilani Boulware, J.D.
Chief of Administrative Services and General Counsel

With over 20 years of proven legal and executive experience, Ms. Boulware leads the Division of Administration in the establishment and management of operational goals and objectives designed to build strong legal, risk management, human resources, and people development systems. In that role, she provides legal counsel and support to multiple operations, institutes and manages administrative policy, assures effective budget management for the Division of Administration, and assures that the mission and core values of CCS are put into practice. Since joining CCS in 2008, Ms. Boulware has demonstrated the capacity to conceptualize, develop, and drive strategic direction among CCS key stakeholders regarding CCS best practices and culture.

Bob Martin
Chief Information Officer

Mr. Martin has more than 28 years of Information Technology experience, including 17 years of leadership within the health care industry. He has exceptional foresight and expertise in operations, systems integration, software development, and networking. Mr. Martin is responsible for the development and implementation of ERMA, the CCS proprietary Electronic Records Management Application. Mr. Martin started working for CCS in 2003.

Dean Rieger, M.D.
Chief Medical Officer

Dr. Rieger is the CCS Chief Medical Officer. Dr. Rieger is a graduate of The Johns Hopkins University of Medicine and is Board Certified in Preventive Medicine and Public Health. Dr. Rieger has worked with Prison inmate populations for over 20 years, most recently as Medical Director for the Indiana Department of Corrections. Dr. Rieger works directly with all of our field clinical and mental health services. Dr. Rieger started with CCS in 2005.

He will ensure that clinical vision, tone and management of staff is consistently implemented. Dr. Rieger proactively communicates with each site to establish the level of quality care and continual compliance.

Judd Bazzel, M.D.
Deputy Chief Medical Officer

Dr. Bazzel joined CCS in 2005. He received his Medical Doctorate from the University of South Alabama College of Medicine in Mobile, Alabama and completed a residency in Family Medicine at the University of South Alabama Medical Center. He began working in correctional settings during his time as Chief Resident, and dedicated himself to the practice of correctional medicine in 2004.

Dr. Bazzel is a member of the Society of Correctional Physicians and the Academy of Correctional Health Professionals. Dr. Bazzel has special interests in the management of withdrawal from substances of abuse. He assists in leading our clinical team and provides a hands-on management style when assisting our nurses and on-site medical practitioners. Dr. Bazzel is another home grown talent for CCS: he began as our Medical Director in Nashville, TN, giving him hands-on experience with large jails.

Charlene Donovan, Ph.D.
Vice President, Behavioral Health Program

Dr. Donovan is a licensed Psychologist with her Ph.D. in Clinical Psychology. She has spent the majority of her clinical career working in the correctional behavioral health field and has responsibility for the CCS Behavioral Health program across CCS. Dr. Donovan is instrumental in developing our behavioral health programs. Dr. Donovan started with CCS in 2003.

Deborah Keller, RN
Vice President of Care/Utilization Management

Deborah joined CCS in March 2011. She is a registered nurse with 24 years of clinical experience as well expertise in managed care and clinical informatics. Deborah developed her managed care and analytics skills during her tenure with a Fortune 100 company overseeing the utilization management services for 300,000 lives. Additionally, Deborah was part of a dynamic team who wrote a successful state contract bid for a start-up organization covering 135,000 Medicaid lives. Deborah is responsible for managing and analyzing the utilization of offsite medical services by our patients. Deborah has a Bachelor's Degree from Middle Tennessee State University and holds both CCM and CPUR certifications.

Jon Bosch
Chief of Institutional Operations – Prison Division

Mr. Bosch has been in the healthcare field for more than 20 years and has more than 15 years of direct correctional healthcare experience. Mr. Bosch is a former Director of Accreditation and Quality Assurance for the National Commission on Correctional Health Care. Mr. Bosch has served in a variety of operational leadership roles to include Business Development, Operations, and Quality Improvement. Through these roles, Mr. Bosch has had the opportunity to survey and work in literally hundreds of correctional facilities. Mr. Bosch started with CCS in 2004.

Mel Waymaster
Director of Human Resources

Mr. Waymaster brings over eight years of extensive experience in all aspects of human resources. Mr. Waymaster received a Bachelor's Degree in Business Administration from the University of Central Florida and received his Master's Degree in Human Resources. Mr. Waymaster's human resources philosophy focuses on communication, training, and emphasizing the number one asset of a company...its employees. By bringing employees together to work in concert toward the strategic goals of the company, Mr. Waymaster strives to ensure CCS remains the employer of choice in the corrections industry. Mr. Waymaster started with CCS in 2003.

Kathy Kolwyck
Vice President, Network Development

Ms. Kolwyck has been in the health care environment for 17 years, with the past eight (8) years in corrections. Ms. Kolwyck has been responsible for negotiating national contracts in excess of $5 million and has developed comprehensive hospital and provider networks across the country for CCS. The CCS Network Development and Provider Relations Department is focused on creating correctional provider networks through partnerships with hospital systems and specialty physicians. Ms. Kolwyck has a Bachelor's of Science in Physical Therapy from the University of Tennessee, Memphis. Ms. Kolwyck started with CCS in 2003.

Randy Marshall, C.P.A.
Senior Financial Officer

Mr. Marshall is a CPA licensed in the state of Tennessee with 15 years of Accounting and Finance experience. He earned his B.S. in Business Administration with a major in Accounting from Tennessee Technological University. Before joining CCS in 2008, he was the Assistant Controller for Psychiatric Solutions, Inc., a $2 billion psychiatric hospital public company where he worked with corporate accounting, acquisitions and divestitures, and SEC reporting. Mr. Marshall was previously a manager at Ernst & Young LLP, focused on accounting and assurance services for healthcare organizations.

Lori Ellis-Peters, RN, BSN, CCHP
Regional Vice President

Photo Not Available

Ms. Ellis has over 12 years' experience as a correctional healthcare nurse, Director of Nursing, Health Services Administrator, and Regional Manager in the Commonwealth of Virginia. During her time as a a Regional Manager in Virginia, Ms. Ellis was responsible for up to eight (8) institutions throughout the Commonwealth. In November, 2011, Ms. Ellis started with CCS as the CCS Regional Manager in Delaware. She will taking the role of Regional Vice President in Delaware in May, and will serve in this role for both the Medical and Mental Health contracts.

Lawrence Reccoppa, M.D.
Corporate Director of Psychiatric Services

Dr. Reccoppa has worked with the Florida Department of Corrections and Alachua County Jail in clinical positions, and currently works with CCS overseeing our jail psychiatrists. He conducts peer reviews and is an on-boarding mentor for new CCS psychiatrists. He also works in conjunction with Dr. Rieger on formulary development and formulary compliance as related to psychotropic medications.

Kim Christie, BSN, RN, CCHP, CCN/M
Transition Coordinator

Ms. Christie brings to CCS 22 years of experience in correctional healthcare in both jail and prison settings. Ms. Christie is CCHP certified, ACA CCN-M certified, an NCCHC surveyor and a member of the American Correction Health Services Association and the American Jail Association. Ms. Christie has clinical experience as a R.N. in corrections and substantial experience as both a Regional Manager and Regional and Division Vice President for operations. Ms. Christie specializes in contract start-up and facility healthcare management. She has experience actively working in Delaware correctional facilities and will provide transition and start-up assistance and ongoing responsibility as a mentor and liaison to the on-site personnel and the DDOC. Ms. Christie started with CCS in 2005.

2.5.4 Contracting Out

CCS understands that the use of independent contractors does not relieve CCS of the responsibility to provide timely and adequate health care for the DDOC populations. Whether staff members are contracted or employed by CCS, it is always our goal to provide seamless performance that meets or exceeds all applicable policies, regulations and standards.

2.5.5 Healthcare Records

In accordance with DDOC Policy H-01, CCS will maintain unified medical and mental health records for offenders in the DDOC facilities. CCS initiates a healthcare record for each offender at the first health encounter following the receiving screening; healthcare records from previous stays at DDOC facilities will be integrated with the current file. Offender health records are maintained up-to-date at all times. Access to records will be controlled by CCS personnel at all times and all rights concerning the confidentiality of the medical records must be followed. CCS personnel will be responsible for all transcribing and filing of information in the medical record. Each medical record will be maintained in accordance with applicable laws, NCCHC standards, and the requirements of the State of Delaware. The medical record will comply with the problem-oriented medical record format and standards. CCS will maintain healthcare records separate from the offender's confinement record.

CCS will also maintain offender records in DACS in compliance with DDOC requirements. A complete legible copy of the applicable medical record shall be available to accompany each offender who is transferred from the facility to another location for off-site services or transferred to another institution. Medical records will be kept secure, as required by law and applicable state statutes regarding medical records. The CCS Health Services Administrator (HSA) or Charge Registered Nurse (RN) will control access to the health records. Data necessary for the classification, security and control of offenders will be provided to the appropriate DDOC personnel. Medical records will be made available to the DDOC personnel when required to defend any caused action by any offender against the DDOC.

CCS maintains a problem-oriented medical record for each offender consistent with applicable laws and NCCHC standards. Medical record policies and procedures will be in accordance with DDOC Policy and approved by the CCS Medical Director and will define the format and handling of the health records. The record will contain an accurate account of the health status at the time of admission, all patient-provider encounters, and the services provided while incarcerated.

The offender medical record will include, but not be limited to:

- Intake screening form
- Health appraisal form
- Problem list
- Physician orders/treatment plans
- Prescribed medications administered or not administered to include the date, time and by whom
- Complaints of illness or injury
- Findings, diagnoses, treatments and dispositions
- Health Service Reports
- Consent and refusal forms
- Release of information forms
- Offender medical request forms
- Medical grievance forms
- Laboratory, radiology and diagnostic studies
- Consultation, emergency room and hospital reports and discharge summaries
- Each documentation includes the date, time, signature and title of the documenter
- Discharge planning

- Medications and/or future medical referrals/appointments for the offender provided to the offender at the time of release from the facilities

While CCS is the custodian of each medical record, records themselves remain the property of the State. Inactive health records will be retained as required by applicable laws and regulations. Inactive records will be identified and reactivated if a offender returns to the system.

An EMR Designed for Correctional Healthcare!

ERMA *is a browser-based Web application designed to manage offender medical records. CCS designed* ***ERMA*** *to operate as part of the healthcare delivery system inside correctional institutions and it includes details necessary to manage offender medical records and medical care.*

Electronic Medical Records

CCS has experience in working with various electronic medical records (EMR), including our own internal system that we have developed and implemented to sites covering over 41,000 lives.

Through our on-going interaction with clients, potential clients, and employees, CCS realized that a need existed within correctional healthcare for a sophisticated yet user-friendly product to organize and manage the healthcare services being rendered to the offender population. In response to this need, CCS has developed an advanced correctional healthcare management product that provides our employees and clients with immediate electronic access to medical records, as well as powerful scheduling and utilization management components.

As the current Medical Services provider, CCS is in the process of implementing our proprietary **Electronic Records Management Application (ERMA)** throughout the DDOC. The core design of ERMA balances ease of use and operational performance with an extraordinarily low cost to implement and use.

Secure Records Transport

CCS can provide a password protected PDF version of the offender's medical record to accompany him or her upon transfer to another facility.

ERMA Advantages

ERMA provides our customers with many of the same advantages as a traditional EMR system, including reduced paper use, reduced risk of lost records, and the benefits of access from multiple locations. However, due to the advanced capabilities of ERMA, our customers also realize improved performance. The following figure demonstrates the key advantages that ERMA offers.

ERMA Feature	Benefit to the DDOC
Ease of implementation	Medical and Mental Health staff gathers information through use of standard CCS forms
Increased efficiency at intake	Staff has instant access to past patient records
UpToDate provider reference and patient education materials	CCS has integrated the UpToDate Clinical Knowledge Base and Tools set. All users are given single click access to this valuable medical resource. Client specific patient education materials can also be integrated into ERMA
Improved care of returning patients	Data on patients who are released then re-admitted are immediately available; chronic care is repopulated
Complete online medical history in one place, regardless of housing location	Through a secure connection, medical staff can access health data regardless of offender movement within the housing areas
Immediate access to medical records available from multiple locations	Providers can access data remotely, which is valuable in disaster planning
Dynamic and static documents	ERMA integrates the use of direct entry of encounter data and the ability to scan paper records and integrate them in the same workflows and patient charts. Dynamic documents are created and customized to meet customer specific requirements and needs. This flexibility allows the capture and reporting of almost limitless data types
Physician order entry	Currently, ERMA supports the integration of medication order entry and HL7 transmission to the Pharmacy. The planned enhancement for the first quarter of 2012 includes Computerized Physician Order Entry (CPOE) for all order types
Automated tracking and reporting of customer metrics	Customer specific monitoring views are used to track key events in the patient care lifecycle such as annual health assessments, dental exams, chronic care visits and any other customer specific protocols
Statistical reports	Enhanced reporting allows for better tracking of the patient's care and ease of communication with DDOC staff
Customizable Queues	Customized queues can be set up to compile data for security, medical staff, and administration
Subcontractor Record Integration	Laboratory and radiology results can be automatically integrated into the medical record easily, facilitating prompt and efficient physician review.

Figure 7: Features and Advantages of ERMA. *ERMA offers the DDOC many features and benefits that traditional paper records cannot offer.*

ERMA Training

Many EMR systems require intense training sessions, after which staff feel overwhelmed and unsure of how to work the system into their everyday processes. CCS staff report ease of use with ERMA and Medical and Mental Health staff are also trained to integrate ERMA into their workflow, so that data is captured as close to the time of service as possible.

ERMA is Easy to Learn and Use

Due to the user-friendliness of ERMA, personnel can be trained as competent beginner users in as little as ten minutes.

A Customizable System

CCS developed the various capabilities and components of ERMA to enable easy customization to the needs of each client. EMR and utilization management functions can each run separately within the system, based on the requirements and goals of the DDOC.

Figure 8: The Separate Modules of ERMA. *ERMA has several separate modules all integrated together to provide a multifunctional health record.*

ERMA Organization

ERMA organizes offender records in a manner that allows record indexing and retrieval by offender number, social security number, patient name, date of birth, incarceration date, or other identifiable data elements. ERMA organizes data into a virtual medical chart within each patient record. While sections of the medical chart are customizable to each client's needs, CCS has created various standard sections, including:

- Assessments & Intake Screening
- Chronic Care
- Master Problem List
- Patient Consent Forms
- Sick Call Notes
- Provider Orders

- Patient Grievances
- Mental Health
- Dental
- Off-Site Care
- Medication Administration Records
- Lab Results

ERMA Dynamic Documents and Patient Profile

In today's correctional setting the need to collect data has never been greater. Through the use of Dynamic Documents, ERMA allows mental health professionals to document their encounters quickly and easily. The concept of dynamic documents (sometimes called "Templates") allows each facility to create a library of custom forms that are used for documentation. Forms are created through an administrator tool with strict business rules applied. Administrators determine requirements, options, explanations, and other desirable elements to capture.

2.5.6 Outside Care

CCS always seeks to provide as much care as possible on-site without sacrificing health, community safety or quality of care. CCS will ensure any medically necessary consultations, treatments or ancillary services outside the scope of onsite capability will be made available to offenders. When feasible, CCS will consider the use of telemedicine consultations as a viable alternative to off-site transports. CCS will utilize the DACS application to track and set appointments. CCS will coordinate all off-site appointments with DDOC staff for security and transportation arrangements.

2.5.7 Facilities and Resources

CCS agrees to adequately maintain all space and supplies in order to meet the healthcare needs of the institutional population.

2.5.8 Quality Improvement, Accreditation and Compliance with Standards

Continuous Quality Improvement

In accordance with NCCHC Standard P-A-06 and ACA Standard 1-HC-4A-03, CCS has an established Continuous Quality Improvement Program (CQIP) falling under the authority of Dean Rieger, M.D., our Chief Medical Officer. The goals of the CQIP are to improve the quality of care provided to patients by intervening where opportunities for improvement exist and to ensure that systems and programs work effectively to make certain that quality health care services are provided to patients, as medically indicated. The CCS CQI program is described in detail in **Section 2.6.8.**

Accreditation

We are very clear on our role and obligation in operating an accredited program. CCS structures all of our policies and procedures around NCCHC and ACA standards. Our accreditation history experience illustrates our high quality program standards. You can read about our accreditation history and success in **Section 2.5.28** of this proposal. CCS is prepared to assist the DDOC in its endeavor to seek ACA accreditation.

Quality Assurance Metrics

CCS will work closely with the DDOC Quality Assurance Administrator and provide Quality Assurance metrics (QAM) for BCHS monitoring of the Mental Health Services system as stipulated. CCS understands that the QAM, set forth by BCHS, incorporates clinical, fiscal, operational, and other data to facilitate comprehensive monitoring of the Mental Health Services system. CCS is aware that a failure to meet the standards set forth in the QAM may result in a financial penalty or other off-set. CCS has reviewed the metrics in Appendix B of the RFP and the following matrix shows how CCS plans to meet or exceed the established DDOC Compliance goals for all Mental Health related metrics.

Subject	Indicator	DDOC Compliance Goal	CCS Compliance Goal
Human Resources			
Mental Health Staff Training – Orientation	All Full-time staff complete in-depth orientation within 90 days of employment	95%	95%
Mental Health Staff Suicide Prevention Training – Initial	Staff complete initial suicide prevention training within 30 days of start date	95%	95%
Mental Health Staff Suicide Prevention Training – Renewal	Staff complete suicide prevention renewal training annually	95%	95%
CPR & First Aid	Staff maintain CPR certification	95%	95%
Staffing Vacancies – Mental Health	Number of filled mental health FTEs (percentage of minimum staffing filled)	95%	95%
On-Call Psychiatric Coverage	On-call Psychiatric services are available 24 hours a day/7 days a week; on-call psychiatric staff respond within 15 minutes of notification	95%	95%
Sick Call			
Face-to-Face Encounter Timeliness	Non-emergent requests for sick call are seen in a face-to-face encounter within 72 hours	95%	95%
Referral to Practitioner Timeliness	If patient is referred to practitioner from sick call, visit occurred within five (5) business days (unless emergent/urgent)	95%	95%
Segregation			
Mental Health Rounds at Least Weekly for All Offenders on Segregation	Mental health staff provide cell-to-cell rounds no less than weekly for segregated offenders who do not have a mental health condition	95%	95%
Mental Health Rounds Three Times per Week for Segregation Offenders on Mental Health Roster	Mental health staff provide cell-to-cell rounds three times a week for segregated offenders who have mental health conditions	95%	95%
Evaluation to Rule Out MH Decompensation Prior to Segregation	Mental health staff evaluate offenders with serious mental illness who are placed in segregation within 24 hours of notification of such placement	95%	95%
Care and Treatment			

Subject	Indicator	DDOC Compliance Goal	CCS Compliance Goal
Mental Health Referral	Offenders with non-emergent positive screening for MH problems are seen by qualified mental health professionals within 72 hours	95%	95%
Psychotropic Medication Bridge Orders	Offenders on verified psychotropic medications will have medication(s) ordered within 24 hours of intake	95%	95%
Psychotropic Medication Reorder	No lapse in psychotropic medication reorders	95%	95%
Suicide Observations Assessment	Offenders on suicide observation are seen daily for assessment by a qualified mental health professional	95%	95%
Suicide Observations Discharge Follow-up	Offenders released from suicide watch are seen by mental health professional within 24 hours after release	95%	95%
Psychotropic Medication Labs	Laboratory testing for patients on psychotropic medications that require monitoring is completed every 90 days (or more frequently if clinically indicated)	95%	95%
Psychotropic Medication History Follow-up	Offenders on psychotropic medications prior to intake are assessed within 10 days of intake	95%	95%
Serious Mental Illness Psychiatric Services	Psychiatric staff conduct face-to-face or tele-psych contact at least every 30 days for offenders with serious mental illness	95%	95%
Routine Psychiatric Services	Psychiatric staff conduct face-to-face or tele-psych contact at least every 90 days for offenders who are prescribed psychotropic medication but do not have a serious mental illness	95%	95%
Medication Management	All medication changes and discontinuations include documented face-to-face evaluations by psychiatry staff	95%	95%
Treatment Plans – General Population	Individualized treatment plans are completed at least every 180 days for general population offenders receiving mental health services; treatment plan includes discharge planning	95%	95%
Treatment Plans – SCU	Individualized treatment plans are completed at least every 90 days for offenders receiving mental health services in SCU; treatment plan includes discharge planning	95%	95%
Routine Mental Health Services	Case Manager/Primary Therapists/Mental Health Clinicians conduct face-to-face contacts with offenders on the mental health caseload at least every 30 days	95%	95%
Suicide Prevention Program – Suicidal Offenders	Continuous observation of offenders on PCO I is documented	95%	95%
Suicide Prevention Program – Potentially Suicidal Offenders	Potentially suicidal offenders are monitored on an irregular schedule with no more than 15 minutes between checks	95%	95%

Subject	Indicator	DDOC Compliance Goal	CCS Compliance Goal
Suicide Risk Assessment	Formalized suicide risk assessment by a qualified mental health professional within 24 hours of the initiation of suicide precautions	95%	95%
Discharge Medication	When notified of an offender's release date to the community, psychiatric staff write an order for a 30 day supply of psychotropic medications or prescription for same, except when such a supply would risk harm to the offender if taken in sufficient amount	95%	95%
Medication Administration			
Tegretol & Valproate Monitoring	Patients with MH score of 3 or above receiving tegretol or valporate who had drug level(s) measured as clinically indicated and in the therapeutic range (4.0-12.0)	95%	95%
Coumadin- INR Monitoring	Patients in Coumadin clinic have INR maintained in the appropriate range, have Coumadin levels checked as clinically indicated, and a Coumadin clinic and lab log are maintained for each patient on Coumadin	95%	95%
Substance Abuse			
COWS			
COWS – Vital Signs Monitoring	A nurse takes and documents the vital signs of every inmate on COWS protocols on every shift (3 times in a 24 hour period).	95%	95%
COWS – Discharge	If COWS protocols are stopped before 72 hours, there is an order from a physician.	95%	95%
COWS Scales	CIWA scales are completed on each shift (3 times in a 24 hour period).	95%	95%
COWS - Referral to Provider	Any flow sheet score higher than 10, is communicated to a physician promptly and addressed appropriately.	95%	95%
Greentree Program			
SA Treatment - Admission	Substance Abuse Staff complete bio-psycho-social assessment within 10 days of offender's admission to Greentree Program	95%	95%
SA - Face-to-Face Encounter	Counselors conduct face-to-face contacts with program participants at minimum every 60 days at Greentree Program	95%	95%
SA - Treatment Plans Completed	Individualized Treatment Plans are completed within 14 days of offenders admission to a Greentree Program	95%	95%
SA – Treatment Plans/Updates	Individualized Treatment Plans are updated at minimum every 180 days in the Greentree Program	95%	95%
Key Programs			
SA Treatment - Admission	Substance Abuse Assessment is completed within 3 days of offenders admission to a Key Program.	95%	95%
SA - Face-to-Face Encounter	Individual face-to-face encounter with offender minimum every 30 days by assigned Counselor.	95%	95%
SA - Treatment Groups	Offenders attend self-discovery caseload groups at minimum once per week. Key Program	95%	95%

Subject	Indicator	DDOC Compliance Goal	CCS Compliance Goal
SA - Treatment Plans Completed	Substance Abuse Treatment Plans are completed within 7 days of offenders admission to a Key Program.	95%	95%
SA – Treatment Plans/Updates	Substance Abuse Treatment Plans/Updates are reviewed and signed by a Clinical Supervisor within 72 hours of offender signing the Treatment Plan.	95%	95%
SA - Treatment Plans Updated	Substance Abuse Treatment Plans will be updated every 30 days in the Key Program.	95%	95%
SA – Mental Health Referrals	Mental Health referral sent within 7 days when offender reports current or recent mental health treatment upon intake into substance abuse program.	95%	95%
SA – Mental Health Documentation	All Mental Health diagnosis and psychotropic medications prescribed are documented in substance abuse chart for offenders receiving mental health treatment.	95%	95%
SA – Co-occurring Disorder Treatment	Offenders enrolled in Substance Abuse Programming that also receive Mental Health treatment have documented Mental Health goals and objectives incorporated into their treatment plan.	95%	95%
SA – Discharge Planning	Discharge Planning completed with offender and placed in chart prior to offender's scheduled completion. (Including: Relapse Prevention/Recovery Plan and Re-entry Plan).	95%	95%
Crest Programs			
SA Treatment - Admission	Substance Abuse Assessment is completed within 3 days of offenders admission to a Crest Program.	95%	95%
SA - Face-to-Face Encounter	Individual face-to-face encounter with offender minimum every 30 days by assigned Counselor.	95%	95%
SA - Treatment Groups	Offenders attend self-discovery caseload groups at minimum once per week.	95%	95%
SA - Treatment Plans Completed	Substance Abuse Treatment Plans are completed within 7 days of offenders admission to a Crest Program.	95%	95%
SA – Treatment Plans/Updates	Substance Abuse Treatment Plans/Updates are reviewed and signed by a Clinical Supervisor within 72 hours of offender signing the Treatment Plan.	95%	95%
SA - Treatment Plans Updated	Substance Abuse Treatment Plans will be updated every 30 days in the Crest Programs.	95%	95%
SA – Mental Health Referrals	Mental Health referral sent within 7 days when offender reports current or recent mental health treatment upon intake into substance abuse program.	95%	95%
SA – Mental Health Documentation	All Mental Health diagnosis and psychotropic medications prescribed are documented in substance abuse chart for offenders receiving mental health treatment.	95%	95%
SA – Co-occurring Disorder Treatment	Offenders enrolled in Substance Abuse Programming that also receive Mental Health treatment have documented MH goals and objectives incorporated into their treatment plan.	95%	95%

Subject	Indicator	DDOC Compliance Goal	CCS Compliance Goal
SA – Discharge Planning	Discharge Planning completed with offender and placed in chart prior to offender's scheduled completion. (Including: Relapse Prevention/Recovery Plan and Re-entry Plan).	95%	95%
Aftercare Programs			
SA - Face-to-Face Encounter	Individual face-to-face encounter with offender minimum every 30 days by assigned Counselor.	95%	95%
SA - Treatment Groups	Offenders attend self-discovery caseload groups at minimum once per week.	95%	95%
SA - Treatment Plans Completed	Substance Abuse Treatment Plans are completed within 7 days of offenders admission to an Aftercare Program.	95%	95%
SA – Treatment Plans/Updates	Substance Abuse Treatment Plans/Updates are reviewed and signed by a Clinical Supervisor within 72 hours of offender signing the Treatment Plan.	95%	95%
SA - Treatment Plans Updated	Substance Abuse Treatment Plans will be updated every 90 days in the Aftercare Programs.	95%	95%
SA – Co-occurring Disorder Treatment	Offenders enrolled in Substance Abuse Programming that also receive Mental Health treatment have documented MH goals and objectives incorporated into their treatment plan.	95%	95%
SA – Discharge Planning	Discharge Planning completed with offender and placed in chart prior to offender's scheduled completion. (Including: Relapse Prevention/Recovery Plan and Re-entry Plan).	95%	95%

Table 1: Quality Assurance Metrics: *CCS will meet our exceed the Quality Metrics listed in Appendix B of the RFP. CCS understands that the metrics are subject to change at the discretion of the DDOC, and CCS is responsible to meet compliance at all times.*

2.5.9 Special Accommodation Population

CCS recognizes the fact that there are many offenders with special physical and mental health care needs. It is a goal of CCS to provide special needs offenders with health care services that promote health maintenance and health improvement. "Special Needs" refers to offenders who require health care services over a period of time for ongoing conditions. CCS will provide multidisciplinary treatment plans and customized treatment and case management programs for all offenders in need of special accommodation to help ensure necessary care and continuity of care throughout incarceration. Medical and Mental Health recommendations for housing in the Special Needs Unit per DDOC policy G-04.1, program and work assignments are communicated to facility administration and communicated in writing to classification.

Disabled Offenders

In Delaware, CCS has developed multidisciplinary treatment plans for physically and developmentally disabled offenders and will extend these treatment plans to incorporate the mental health services, substance abuse treatment, DUI programming and Sex Offender treatment aspects of the DDOC. CCS will involve correctional staff regarding housing and

accommodation needs. CCS is aware that "handicapped" cells are available at the JTVCC for male offenders. Offenders with time limited disabilities will be regularly re-evaluated for efficacy of care.

CCS has an established system for tracking offenders with disabilities during their incarceration which will include periodic reviews. Facility staff will be notified when special accommodations may be required but not available.

Elderly Offenders

CCS recognizes that frail and elderly offenders require special attention and consideration regarding their unique needs. CCS providers will develop treatment plans to specifically meet those needs. Oftentimes elderly individuals can be hesitant to engage with mental health services out of stigma concerns; CCS is sensitive to these issues and understands the need to tailor interventions and services in ways that increase the likelihood of receptiveness by the client.

Mental Health and Veterans Court

CCS will identify points of contact at each facility who will be responsible for working with Mental Health and Veterans Court (or any other specialized court docket) to provide continuity of care. CCS successfully engages with specialized court programs in many jurisdictions to provide the level of personnel involvement and information needed for the specific program.

Mentally Ill Offenders

Offenders identified as seriously mentally ill will be housed appropriately and enrolled in our Mental Health Special Needs program and an individualized treatment plan will be developed. Participation in this program includes treatment opportunities in both group and individual formats, with an emphasis on identifying and developing coping, problem solving and emotional regulation skills. Those clients with trauma histories, a common presentation in the correctional population, will be evaluated for continuing issues from these experiences, and a treatment focus will then be developed accordingly. Both the Intake and Sick Call process are entry points to our proactive approach to mental health care. One of the essential elements in both processes is accurate assessment and recognition of a client's need for services, particularly if the client presents with issues that will require ongoing services for a period of time, if not through the length of the client's incarceration. It has long been our experience that regularly scheduled visits with clients who are coping with serious mental health issues offer significant rewards not only for the facility but most importantly for the client. The ability to develop rapport with a primary MHP who adheres to an agreed upon appointment schedule offers the client a source of security. We all experience a greater sense of comfort when we believe our treating professional takes our issues seriously, treats us with respect and dignity, and appears invested in helping us reach a higher level of functioning. Some providers see follow-up visits as brief check-in opportunities, which CCS believes short-changes potential benefits from a special needs program. It is certainly ideal when our clients involved in the special needs program are "having a good day" and not trying to cope with any particular acute stressor. However, instead of prematurely ending these "good day" visits and moving on to the next appointment, CCS views these visits as opportunities to move forward the client's treatment plan. These are invaluable opportunities for teaching new skills, rehearsing recently learned ones, and reinforcing efforts to engage in more adaptive behavior patterns. While these sessions are an essential component to our special needs

program, we find that many clients are in need of social skills development and utilization of group treatment programs can serve to address both a focus on social skills development while also offering a focus on a more specific target area for treatment. Treatment interventions are offered to clients based on their individual needs, and must be in accord with the treatment plan that has been established. Our goal is to provide a comprehensive program of services, including individual and group services, along with psychiatric and psychotropic medication services that are thoughtfully planned for each client in order to effectively address presenting clinical issues and allow each client to reach stability in functioning that can be maintained across time.

Offenders in a Diagnostic or Therapeutic "Pipeline"

CCS will provide comprehensive case management of offenders who are in the process of receiving either diagnostic or therapeutic procedures and consultations, or other critical treatments. These patients will be identified during regularly scheduled multidisciplinary special needs meetings, and case management services will be offered while the offender is in a "pipeline" status. CCS will provide the Bureau Chief with monthly case management reports.

2.5.10 Special Needs Population

CCS acknowledges the DDOC definition of special needs populations as those offenders with complicated medical and/or mental health issues. In order to most effectively manage such complex presentations, it is essential that treating team members have formally established avenues for communicating the progress toward treatment goals (or the lack of such progress) for each client. Without such formal communication pathways, clients are at risk of "falling through the crack" or team members being unaware of key information about a client's presentation. To ensure timely communication, CCS participates in multidisciplinary team meetings to discuss treatment and management of these offenders. The meetings identify and produce objective entry criteria for the special needs programs at DDOC, the measures of treatment progress, plans for amending treatment plans to achieve better outcomes, and specific exit criteria.

2.5.11 Emergency Services and Maintenance of Automatic Electronic Defibrillators

CCS personnel will respond to emergent or urgent mental health events involving employees and visitors to DDOC facilities, in addition to our primary focus of care provision to offenders. Scope of services to employees and visitors will focus on stabilization and coordination with our medical providers and DDOC staff to arrange for any necessary transport to community facilities for further evaluation and treatment.

Emergency psychiatric care for offenders covers a wider scope of services, to include an enhanced focus on treatment at the site level, and use of interventions such as emergency psychotropic medications and therapeutic restraints if all other less restrictive treatment options for managing the psychiatric emergency have not been successful. CCS has developed thorough policy and procedure directives for managing these types of interventions should they occur. These events are considered Critical Clinical Events (CCEs), and each occurrence is reviewed via the CCS Continuous Quality Improvement program.

CCS will maintain Automatic Electronic Defibrillators (AEDs) at each facility and will provide AED and Cardiopulmonary Resuscitation (CPR) training to all mental health care staff during the Correctional Employee Initial Training (CEIT) classes.

2.5.12 Suicide Prevention

CCS understands the importance of a Suicide Prevention Program that is based on written, defined policies and procedures and is consistent with DDOC Policy G-05. Our program policies address education, screening, on-site intervention, special needs treatment plans, and scheduled on-going care.

As part of the Program, a suicide assessment questionnaire will be completed by health care staff on offenders when they are taken into the custody of any DDOC facility. Referral to our mental health team will be performed when indicated. An in-depth suicide evaluation is completed by mental health staff on all offenders exhibiting abnormal behavior.

Review of the Suicide and Self-Harm Prevention Policy will be made on no less than a quarterly basis, to assess adherence to the program as a part of our Quality Improvement Program.

The CCS Suicide Prevention Program

CCS takes suicide awareness and prevention very seriously, indeed suicide prevention efforts are the primary focus for all CCS Mental Health Professionals. We offer a thorough onboarding program to new team members, as suicide prevention issues are unique within a correctional setting. All CCS staff having regular contact with offenders will have an initial eight (8) hour Suicide Prevention Training. The onboarding program includes attendance at the new employee orientation sessions, review and discussion of our Suicide Risk Assessment and Prevention Manual, which is a two-hour CEU program, and direct supervision for new Mental Health Professionals as they engage in responsibilities related to suicide prevention issues. Direct oversight continues until the supervisor and the Mental Health Professional agree that the Mental Health Professional is ready to undertake such duties independently, with consultation from the supervisor and/or the site Psychiatrist for all cases that involve self-harm risk issues. In addition to annual training on suicide prevention issues, two other in-services are offered yearly that cover topics related to suicide prevention issues. CCS has developed a thorough Suicide Prevention Policy that meets NCCHC and ACA standards and also addresses education, screening, on-site intervention, special needs treatment plans, and scheduled on-going care. At a fundamental level, suicide prevention must be a consideration in all client encounters, and all personnel, not just mental health staff, play a role in preventing suicide in correctional settings. As is evident at each level of the program, suicide prevention efforts will be less successful if multi-disciplinary cooperation and communication fails to occur.

The CCS Suicide Prevention Program includes the following elements:

Identification	The Intake screening process includes a comprehensive assessment for suicide risk.
Training	CCS and correctional personnel are trained in suicide prevention during the initial new employee orientation and annually thereafter. It is important to review the training curriculum each year so that information can be updated as needed and the content can remain fresh for attendees.
Assessment and Housing	Immediately following recognition that an individual is at risk for suicide, the individual will be assessed and placed in an observation cell for monitoring. Appropriate CCS and DDOC personnel will be notified of the need for safe housing.
Treatment	Treatment plans addressing suicidal ideation and its re-occurrence are developed and clinical follow-up occurs as clinically indicated. Clients on suicide watch status on seen on a daily basis.. Psychiatric providers should be actively involved in all suicide watch cases, to include evaluation and assessment and consultation throughout the course of care.
Monitoring	CCS staff will monitor offenders on suicide/special observation watch: • Level I - Continuous Watch – Constant observation of the client. • Level II - 15 Minute Watch – Full sight of the client at least every 15 minutes on a staggered schedule.
Referrals and Follow-Up	Offenders identified with suicide potential will be referred to Mental Health personnel for evaluation. Offenders demonstrating self-injurious behaviors and those identified with suicide potential will be placed under constant observation until the mental health evaluation can be completed and an appropriate disposition determined.
Community Referral	The BHCS will be notified if an offender identified with suicide potential is scheduled for release. CCS will work with the BHCS to ensure the necessary level of community care is in place, to include hospitalization if clinically indicated, at the point of release.
Communication	An offender may report suicidal ideation to medical, mental health, or correctional personnel. Concerns from family members and correctional personnel will prompt follow up from CCS staff.

Intervention	Suicide gestures and attempts are taken seriously and personnel respond appropriately.
Notification	The Director of Mental Health Services will be informed when there has been a suicide attempt or if an offender has been placed on suicide watch.
Review	Suicide attempts are considered a critical clinical event and a retrospective review is completed.
Support	Mental Health personnel will be available to support anyone who may have been affected by a suicide and who may need help in adjusting to the situation. This includes responding staff, and other offenders in the housing area who may be impacted by the event.

2.5.13 Research

CCS policy prohibits the use of offenders for medical, pharmaceutical or cosmetic experiments. CCS does not preclude offenders from individual treatment based on the need for a specific medical procedure that is not generally available. Facilities electing to perform research will comply with state and federal guidelines. An offender's treatment with a new medical procedure by their own physician is undertaken only after the offender has received a full explanation of the positive and negative features of the treatment and only with informed consent.

When offenders who are participants in a community-based research protocol are admitted to the facility, procedures provide for:

1. Continuation of participation; or
2. Consultation with community researchers so that withdrawal from the research protocol is done without harming the health of the offender.

CCS does not endorse enrolling offenders under our medical management into human research studies. Requests to enroll offenders in medical research studies will not ordinarily be approved; however, any requests to enroll an offender into such a study must be approved by a Human Subjects Review Board approved by the Bureau Chief, the CCS Chief Medical Officer, Corporate Legal Counsel, and the Commissioner of Correction. The conditions under which the research will be conducted will be strictly governed by State and Federal guidelines, and by written guidelines approved by the DDOC. In every case, the written, informed consent of each offender who is a subject of the research will be obtained prior to the offender's participation.

2.5.14 Drug Free Workplace

CCS will continue to operate a drug-free workplace in accordance with Federal and DDOC policies, and will continue its practice of requiring initial drug testing (urinalysis) on new employees, as well as implementation of a random testing program. CCS will comply with any future DDOC drug test initiatives.

2.5.15 Vendor Employee Orientation

Prior to beginning work, all new CCS staff assigned to DDOC will attend a program, at CCS expense, to orient mental health and administrative/non-clinical staff to security and classification procedures, OSHA Bloodborne pathogen regulations and any necessary CPR/First Aid training. All personnel will complete 40 hours of pre-service training within the first 30 days of employment. All orientation training will be customized to each assigned facility. For additional details on our training programs, please see **Section 2.6.3.**

2.5.16 Medical Auditing Committee (MAC) Meetings

CCS Mental Health staff will participate int Medical Administration Committee (MAC) meetings at least monthly, on a scheduled basis with distributed agendas and in coordination with the Medical Staff, BCHS and facility Warden or designee. The Regional Mental Health Director, Director of Psychiatry or Regional office designee will attend the MAC meetings at each site. The purpose of the MAC meetings is to evaluate the health care program, ensuring that quality services are available to all offenders in all scopes of care (medical, dental, mental health). Discussions will include monthly health services statistics by category of care, current status of the health care program, costs of services, coordination between security and health services and identified environmental issues and program needs/recommendations for corrective action. Our CCS QI/MAC Committee will also review and categorize grievances to identify potential issues and determine if patterns exist or develop.

2.5.17 Inspections

CCS will participate in monthly facility environmental inspections to ensure that offenders live, work, recreate and eat in a safe and healthy environment. The I or designee conducts a monthly inspection of the kitchen, housing and work areas at DDOC facilities. Mental Health staff will participate as indicated. The QI committee will make recommendations for improvements and track deficiencies identified during routine environmental inspections through resolution. A record of all findings will be kept and provided to the Medical Administrative Committee.

2.5.18 Disaster Plan

CCS has established contingency and emergency procedures in the event of an unexpected event, disruption, or man-made or natural disaster. The CCS plan is coordinated with DDOC policies A-7.1, A-7.2, 9.25; NCCHC P-A-07, J-A-07, P-E-08; ACA 4-4351 and the institution plans and incorporated into the DDOC overall emergency plan. All CCS personnel will be aware of and familiar with the disaster plan. A review of the mental health aspects of the disaster plan will be part of the initial orientation of new personnel and drilled bi-annually with all staff. CCS will participate in disaster and man-down drills in accordance with applicable standards. CCS will perform a critique of the disaster drill and man-down drills on an annual basis.

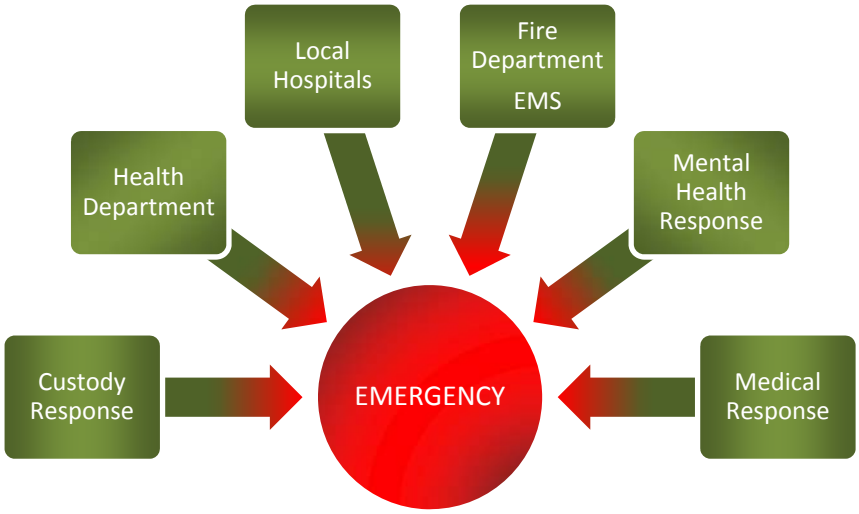

Figure 9: CCS Emergency Response.

The **CCS Emergency Preparedness Plan** contains the following aspects:

- Evacuation routes and means of transport for injured, ill, disabled, or restrained individuals out of the institution
- Triaging plan
- Outline of where care will be provided, including alternative sites
- Location of community resources
- Continuity of care and safety of patients
- The protection of patient care information (EMR data) and accessibility to patient information at predetermined locations
- Prevention of interruption in medication
- Contingency pharmacy and medical supplies plan

The **CCS Emergency Preparedness Plan** addresses at a minimum:

- Training modules
- A communications system and procedures
- Recall process for mental health personnel
- Emergency assignment of health services staff
- Establishment of a command post
- A method to ensure safety and security of the patient and staff areas
- Use of emergency equipment and supplies
- Establishment of primary and secondary triage areas
- Triage procedures
- Transportation Guidelines
- Evacuation procedures in coordination with security personnel
- Procedure for conducting man-down and emergency drills
- Back-up assignments for each of the contingency elements
- Emergency treatment documentation

CCS is committed to ensuring Mental Health Staff are adequately trained to respond to a crisis situation. CCS Mental Health staff will be introduced to the CCS/DDOC Disaster Plan during

initial orientation and again annually during "disaster drills." Mental Health staff should be included in any facility emergency procedure drills. Mental Health staff will provide a debriefing to all staff and offenders as needed in the event of a disaster.

The CCS Emergency Response Plan is thoroughly outlined in the CCS Policies and Procedures Manual.

2.5.19 Telepsychiatry Expansion

CCS recognizes tele-mental health and telepsychiatry services may be a highly useful solution for the DDOC in the delivery of mental health care to patients throughout the state, and especially within rural facilities or facilities with a high utilization of mental health services. CCS supports the use of Telepsychiatry for the delivery of mental health care services to reduce the incidence of offender travel, as well as to increase access to providers and specialists. CCS currently includes telehealth services at twenty-three (23) sites across the country. Fifteen (15) of these sites are prisons in Kansas and Vermont. Eight (8) of these sites are county jails.

If awarded the contract, the CCS would like to begin discussions as soon as possible regarding potential target facilities at which telepsychiatry could have the most immediate beneficial impact. CCS will work with the DDOC to evaluate the potential for tele-mental health and telepsychiatry services and will develop a plan for deployment to includes target sites and timelines to be submitted for approval by DDOC within a timeframe agreed upon during the initial discussions noted above. This program will be regularly monitored and evaluated with the DDOC.

The following information is provided as an initial basis for discussion of future tele-mental health and telepsychiatry services.

End-User Equipment

With the goals of driving down cost through (1) reducing the amount of off-site traffic necessary to administer essential mental health care and (2) creating better access to mental health care providers, each facility may receive a dedicated telehealth conferencing system comprised of the following equipment or substantially similar equipment with the same level of functionality:

Item	Specification
CPU	Dell Optiplex
Monitor	Dell 190S 19" Monitor
LCD Monitor	LG - 32LK450 - 32" LCD TV - 1080p
Video Camera	Logitech Quickcam Orbit AF
Speakerphone/Microphone	Polycom MS Commincator
Cables	9' HDMI/Video (x3)
Monitor Bracket	AL-316 LCD Monitor Bracket
Software	MS Office/Windows v7/Linc

Figure 10: End-User Equipment: *The total cost for this equipment is approximately $2,000 per site.*

The total cost for this equipment is approximately $2,000 per site.

Additional peripherals can be added to a tele-mental health suite to increase its functionality as necessary. All peripherals will exist on the patient-side of the consultation, within DDOC facilities. Remote providers, outside the DDOC network of facilities, will require a PC, with a stable internet connection and a camera to conduct patient consultations; it will be incumbent upon these remote healthcare providers to supply this equipment. CCS will coordinate with these providers to ensure appropriate connections and hardware are in place. CCS will review the technological capacity of each provider prior to entering into agreements for the delivery of care and, when possible, leverage the experience of existing CCS providers.

CCS will also deploy Microsoft Lync and HD cameras on PCs as a teleconferencing platform to provide a flexible and portable option for performing telehealth conferencing. Lync will also be available for adhoc collaboration between providers, CCS leadership, and others requiring simple accessible sharing and conferencing. Additionally, providers will be given access and ability to manage telehealth peripherals using the web-based software, AGNES, on an as needed basis.

Following the implementation of telehealth services, all equipment within the facilities will become the property of DDOC.

Environmental Considerations

In addition to specifying the types of equipment used in the provision of telepsychiatry services at each facility, CCS recognizes that it is beneficial to establish guidelines for where and how equipment will be installed within each DDOC facility. Ideally, each clinical space should meet the following criteria:

- Minimum of 120 square feet, to allow space for tele-mental health equipment and to accommodate patient, provider and custody staff, as necessary
- Room painted in a neutral, non-distracting color such as white or beige
- Room to be free from an excessive amount of art, posters or photography
- Room must have adequate access to power
- Room must have access to secure IP-based internet connection
- Seating must be available for both tele-mental health staff and patient
- 30 square feet of work surface
- Tele-mental health clinical space is ideally located adjacent to a patient “holding space” where custody can oversee patients waiting to be seen.

Based on space available within each facility, CCS will determine the exact placement of equipment, seating and other clinical elements.

Telehealth Implementation

CCS understands the importance of maintaining continuity of care during the transition to tele-mental health services. To best facilitate a smooth transition during the implementation of tele-mental health services, CCS will first take five deliberate steps:

1. CCS will visit each potential tele-mental health site to determine the location of and to understand the availability to network access. CCS will provide any new network and/or electrical requirements to the DDOC so service can be initiated prior to implementation. CCS will also compile site-specific orders for new equipment.
2. Next, CCS will order all equipment, schedule training for site-level staff and coordinate installation with the DDOC staff.
3. Equipment will be staged, configured, and packaged for distribution to individual sites by CCS "Telehealth Installers." An installation template and individualized site design will be developed for the Telehealth Installers to utilize as they perform the site installations.
4. CCS will deliver and install all tele-mental health equipment.
5. CCS will provide all necessary training and each site will conduct tele-mental health test consultations to ensure that the installation was effective.

The successful implementation of tele-mental health services among DDOC sites will be predicated upon a systematic and organized roll-out of training and equipment, as well as establishing a shared sense of expectations. The CCS tele-mental health roll-out program will be developed to fit the unique needs of Delaware's correctional facilities, taking into account the scale and complexity of the project.

End-User Training

Effective day-to-day administration of tele-mental health services is contingent upon having engaged and well-trained staff, both within the DDOC facilities, as well as among the remote providers and specialists with whom patients interact.

Follow-up Training

Following the installation of equipment, the CCS tele-mental health team will continue to visit individual tele-mental health sites to provide additional training to all appropriate staff members, including:

- Nursing staff - Assisting with clinic administration
- Medical records staff - Ensuring coordination of patient information with providers
- Clinical Coordinators - Regarding scheduling of appointments
- Director of Nursing - Monitoring clinic administration
- Mental Health Director - Reviewing treatment and prescribing by remote providers
- Custody staff - Managing patient flow and supervision

Remote Telehealth Providers

Remote providers will maintain, at their own expenses, any PCs and cameras as well as the stable internet connections necessary to interface with DDOC sites. CCS will review these

specifications with providers prior to contracting with them to provide support. CCS will provide access to an internet-based telehealth tool and/or a license for Lync teleconferencing software to each remote clinician. Instructions on the use of teleconferencing and telehealth software will be delivered via phone and video conference directly to individual providers. Notes and steps for use of equipment will be given to remote providers in written form, as well through the CCS website. Remote providers may also access to the same Help Desk support that is available to facility staff.

Custody Staff

DDOC custody staff will receive an initial on-boarding orientation to ensure that they are clear on the expectations attached to operating an efficient tele-mental health clinic. Custody staff has a critical role in managing the flow of patients from housing areas to the tele-mental health area. Without the timely flow of patients to scheduled appointments or clinics, the tele-mental health program cannot function effectively.

Telehealth Coordinators

One key to the successful implementation of tele-mental health services will be a designated Telehealth Coordinator at each site. These individuals will act as the "subject matter expert" for the DDOC tele-mental health program, managing:

- Patient interaction
- Flow of documentation
- Ensuring the process for scheduling of appointments in appropriate
- Coordination between off-site provider and on-site Mental Health Director
- Communication with custody
- Monitoring of equipment and connectivity
- Coordination with CCS
- Training of new staff regarding telehealth utilization and best practices
- Flow of documentation
- Scheduling of appointments
- Coordination between off-site provider and on-site Mental Health Director
- Communication with custody
- Monitoring of equipment and connectivity
- Coordination with CCS regional and Home Office.
- Training of new staff regarding telehealth utilization and best practices

The Telehealth Coordinator will have other responsibilities within the clinical area, typically as a clerk or an administrative assistant. Depending on the number of consultations per site per week, the utilization of the dedicated Telehealth Coordinator will vary.

Clinic Processes

To ensure the consistent provision of tele-mental health services, CCS will require the following steps be followed related to all remote consultations:

1. Referral is made to a tele-mental health specialist.
2. Specialty consultation is scheduled by designated on-site Telehealth Coordinator, using an on-line scheduling tool.
3. Telehealth Coordinator provides remote physician access to relevant patient information via fax/email or electronic medical record (EMR).
4. Custody escorts patients from housing area to clinical holding area where patients are seen individually by the remote provider. CCS will provide appropriate on-site staff, as required, to monitor the tele-mental health session and to assist the remote provider as necessary with vitals and with physical patient interactions.
5. Patients are seen one-at-a-time and returned, as a group, to housing once all tele-mental health consultations are completed.
6. Following consultation, CCS staff will follow-up with remote provider to collect patient information, ensure that the consultation has been sufficiently documented and that referrals are reviewed by the on-site mental health director.
7. Follow-up consultations, additional lab work, treatment and prescribing are arranged as necessary.
8. Patient chart is updated as necessary.

Technical Support

CCS will make Help Desk services available to all DDOC locations, for telehealth inquiries, Monday through Friday 8 a.m. to 4 p.m. Using a dedicated toll-free number, clinical staff can contact an IT representative directly regarding their telehealth questions. Support staff will be equipped with a full telehealth suite, similar to those at each DDOC site, and will be able to walk employees through the various steps necessary to operate their telehealth equipment.

Beyond the provision of IT telehealth support, CCS operates a regular Help Desk call center that is available to employees for a broad range of purposes. The CCS helpdesk accepts calls 24 hours a day, 7 days a week, 52 weeks per year. After hours and weekend staffing is reduced to accommodate lower call volume; some specialized help services are not available during these times. In the event a request is made that can’t be serviced by the on-duty agent, the ticket is escalated to the appropriate resource during the next business day. Critical issues are always escalated immediately.

Maintenance

Regular maintenance will be performed on all telehealth equipment, pursuant to the manufacturer’s recommendations. CCS staff will ensure equipment receives all necessary on-going maintenance to keep it functioning correctly.

2.5.20 DACS Data Entry Mandatory

CCS acknowledges the requirement to use the DACS medical module and all components. As your medical services provider, CCS is familiar with DACS and will provide any follow-up training for our personnel.

2.5.21 State/DDOC Ownership of All Documentation

CCS acknowledges that all documents, charts, data, studies, surveys, drawings, maps, models, photographs and reports or other material, in paper, electronic or other format, are the property of the State of Delaware and remain as such at the end of the contract. CCS shall ensure that the DDOC has immediate access to all records on demand.

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2.5.22 Maintenance of Records

CCS acknowledges its responsibility for maintaining the offender records in compliance with all federal and state laws, policies and regulations including 1 Del. C. §4322.

2.5.23 Offender Insurance

If a patient has personal health insurance, CCS will attempt to have the insurance carrier pay the provider for all covered services. CCS is unable to collect funds from insurance carriers; however, CCS has the capability to track patients that have personal health insurance through the Care Management portal of our electronic medical record system (ERMA-CM). Using ERMA-CM, CCS can ensure that service providers bill insurance carriers for the provided services and that neither CCS nor the DDOC bear the responsibility for covered costs. CCS will provide the DDOC information detailing pursued claims and funds recovered because of health insurance for auditing and inspection purposes.

Claims management is a core competency of CCS. Under the umbrella of Utilization Management, CCS has an experienced internal team of claims examiners. This team specializes in claims adjudication and third party recovery, reporting and determination of individuals' eligibility. CCS is currently employed by over 50 different facilities to simply handle claims adjudication. Our experience in this area originates from the fact that CCS was originally spun off from a Third Party Administrator (TPA) company.

We utilize a state-of-the art claims system. Our experience in both the TPA and the corrections worlds provide us unique insight on offering the DDOC the very best in customer service, reporting and timely, accurate claims payments. Our system can handle a limitless number of provider contracts with varying methodologies including Medicare DRG, Per Diem, and Percentage Discount from Billed Charges.

2.5.24 Transition Plan between Existing and New Vendor

Combining our experience transitioning the Medical Services Program in Delaware with our experience transitioning statewide DOC mental health care systems in Kansas and Vermont, and the experience our Substance Abuse partner has with the DDOC, CCS is confident we can deliver a seamless transition from the existing vendor. To ensure this, CCS has developed a

Strategic Implementation Plan, an outline of which is included in this section. We have also included a sample of our expected implementation items with key dates.
Accomplishing a successful implementation means looking beyond the tasks themselves, and placing experienced CCS team members "on the ground", working hand-in-hand with our new staff. CCS plans to have various teams in place throughout the state, responsible for ensuring that programming follows the tenets of the contract between DDOC and CCS, CCS protocols, and industry standards.

CCS DDOC Mental Health Care Transition Team	
NAME	**TITLE**
Jon Bosch, RN, CCHP	EVP, Chief of Institutional Operations
Lawrence Reccoppa, M.D.	Director, Psychiatric Services
Charlene Donovan, Ph.D.	Director, Mental Health Program
Michelle Reed, M.S.	Behavioral Health Manager
Kim Christie, BSN, RN, CCHP, CCN/M	RN Transition Coordinator
Mel Waymaster	Vice President of Human Resources
Tim App	CPC Director of Sex Offender Treatment
Jim Elder	CEC Director of Prison Substance Abuse Treatment

Figure 11: The CCS Transition Team for the DDOC Mental Health services Contract.

Once the contract has been awarded, CCS will complete a detailed multi-facility Transition/Implementation Plan to ensure proper delegation of responsibility and completion of tasks. The CCS Transition/Implementation Plan provides a comprehensive listing of tasks, individuals responsible and projected dates for completion. For additional information about our specific areas of responsibility as they relate to transition and implementation, please refer to the following sections:

- Hiring of key personnel, recruiting: **Section 2.6.2**
- Implementation / Development of Policies and Procedures: **Section 2.6.7**
- Staff Education and Training: **Section 2.6.3**

CCS Implementation Schedule and Strategy for Multi-Facility Operations

CCS is prepared to initiate the full range of required services within 30 days of the contract commencement date. We believe that 30 days is the minimum amount of time necessary to ensure a smooth transition. We have provided an initial implementation schedule for the DDOC as well as some key milestone dates. There will be four (4) key aspects of our 30-day transition period that will help ensure success. Specifically, we will React, Listen, Plan, and Be Accountable.

React

Within 72 hours of award or intent to award, a CCS senior manager will be on-site to ease any tension or anxiety and meet with vendor and agency staff. Addressing questions in small meetings before or immediately after shift changes eases anxiety and ensures everyone continues to remain focused on the job at hand.

Key points of these initial meetings are:

a. *Pay*. Anyone offered a job will not go backwards;
b. *Benefits*. Start on Day 1 if currently receiving benefits;
c. *401k*. Immediate eligibility if currently receiving benefits;
d. Vacation time payout;
e. *CCS*. Who we are and how we are different. Who to call with questions, etc.
f. *Timeline*. What happens next, due dates for paperwork, etc.

Any on-site trips will only occur with permission from the DDOC BHCS Chief, facility administration, and other relevant DDOC administrative members.

Listen

Ideally during this first visit we will also meet with administration staff to better understand areas of concern and expectations. We will also discuss any potential contractor employees that you prefer not be retained.

Plan

CCS will customize an implementation plan to meet the specific needs of the DDOC and the required timing of start-up. All information will be completed and shared in weekly updates, or as requested. CCS will also have operations people on-site observing mental health processes and coordinating with the Medical staff prior to start-up so CCS can begin integrating into the multi-disciplinary program on the first day of contract commencement.

Be Accountable

CCS continues to be successful because we clearly communicate responsibilities and hold all team members accountable.

A sample schedule with key milestones assuming a 30 day start-up:

May 28 – June 1, 2012	• CCS will be on-site to ease anxiety over award by meeting with current staff. • CCS will begin interviewing all staff. CCS will conduct meetings with DDOC staff to ensure clear understanding of expectations and channels of communication. • Issue first implementation plan with all items to be completed, expected due dates and person responsible. This plan is a working document and will be provided weekly to appropriate BHCS and facility staff.

June 4 – 8, 2012	• CCS will begin meeting with Medical and Pharmacy personnel at each facility, to establish lines of communication and begin coordination efforts to integrate into the multi-disciplinary health program. • Human Resources will process all staff paperwork. • Operations team will have finalized travel schedule and begin creating all binders and training materials. • Begin recruiting process for any new positions or expected openings. • Offer letters will be delivered. • Any declination letters will be delivered in person and in private. This list will be discussed with BHCS staff prior to ensure no issues arise. • Orientation schedule will be posted and sign-up will begin. • Updated implementation plan provided to BHCS staff, many items will be marked as complete and travel schedule for CCS Senior Management Team will be provided.
June 11 - 15, 2012	• Work schedule for July will be complete with any potential openings identified. • Clinical team will review all scheduled chronic care clinics for July and August. • In person benefit enrollment sessions.
June 18 - 22, 2012	• Orientation will occur for all employees. Orientation will occur outside of work schedule and all staff will be paid for these hours on first CCS paycheck. Orientation will cover CCS policies, culture and expectations. Orientation is conducted by members of Senior Management and any DDOC/BHCS staff members are welcome to attend. • All credentialing and new hire paperwork completed • Updated implementation plan provide to BHCS staff.
June 25 - 29, 2012	• Multiple people on-site to ensure smooth start-up and to begin laying out specific responsibilities for all employees on all shifts. CCS start up team mobilizes. • Computers, equipment, etc. are all delivered and inventoried.

July 1, 2012	• CCS takes over operations and is on-site at 12:00 AM, July 1. Above are just a few of the many milestones and tasks associated with the start-up. CCS plans to coordinate start-up activities with DDOC BHCS to ensure consistency at each of the DDOC facilities. We are confident in our ability to ensure a seamless transitions.

Once the contract has been awarded, CCS will complete a detailed multi-facility Transition/Implementation Plan to ensure proper delegation of responsibility and completion of tasks. The CCS Transition/Implementation Plan provides a comprehensive listing of tasks, individuals responsible and projected dates for completion.

2.5.25 Multidisciplinary Offender Healthcare Conferences

As the current Medical Services provider, CCS leads multidisciplinary conferences to ensure proper case management of patient care for all segments of the contract for which we are selected. CCS will continue to lead these conferences and the Mental Health Services team will participate in these conferences.

2.5.26 Boot Camp Clearances/Other Clearances

CCS will provide mental health clearances for Boot Camp within five (5) days of the DDOC request for clearance. CCS will also provide other requested clearances within the specific time periods.

2.5.27 Security

CCS agrees that no security/privileged information pertaining to the DDOC, institutional security, or offender health care, will be released without DDOC authorization or pursuant to law.

CCS will be responsible for ensuring that its personnel, including subcontractors, adhere to DDOC security and clearance procedures. Any CCS personnel accessing DDOC and/or State information systems must adhere to all clearance procedures. Violations of information system clearance procedures may be subject to criminal or civil penalties.

CCS agrees that it and its personnel will be subject to and will comply with all DDOC and institution security operating policies and procedures. CCS understands that violations may result in the employee being denied access to the institution. In this event, CCS agrees to provide alternate personnel (subject to DDOC approval) to supply uninterrupted services.

2.5.28 NCCHC and ACA Accreditation

CCS has developed a mental health program for the DDOC that is in accordance with ACA and NCCHC standards.

CCS offers our experience and qualified team to obtain and maintain all accreditations during the contract. CCS has never failed to obtain nor lost accreditation status at any of our client facilities. We are very clear on our role and obligation in operating an accredited program. CCS structures all of our policies and procedures around NCCHC and ACA standards. Our accreditation history experience illustrates our high quality program standards.

Indianapolis Accreditation Success!

Our Marion County Jail client in Indianapolis, IN was recently ACA accredited for the first time, just seven (7) months after transition to CCS services from CMS (now Corizon). This accomplishment gained them "Triple Crown" status.

When CCS transitioned services from CMS (now Corizon) at the Shelby County Jails in Memphis, TN, the client had been under a Department of Justice consent decree for more than 12 years. Before CCS began providing services to Shelby County Jails, the medical program relied heavily on agency nursing due to serious retention problems. Within a short time of implementing our contract with Shelby County, CCS completely discontinued the use of agency nursing leading more consistent, effective care, and on-site capabilities. This led to better patient management. As a result, only 24 months into our partnership, the Department of Justice released Shelby County from the consent decree and **today they are one of only 38 agencies in the nation to be a Triple Crown accredited agency!** Shelby County has also benefited from the indirect cost value of significantly lower amounts of litigation and grievances.

CCS also has success in state-specific accreditation standards. In Stanislaus County, CA, CCS inherited a healthcare program that had lost accreditation from the Institute for Medical Quality (IMQ), a California-specific accrediting agency, had paper medical records, and had grown stagnant after being with the same provider for over 25 years. CCS installed an electronic medical record system, implemented policies and procedures specifically designed for the site, and obtained IMQ accreditation **within 18 months**.

Unique Perspective

The CCS Chief of Institutional Operations, Jon Bosch, is the former Director of Accreditation for the NCCHC. Additionally, CCS personnel have been successful in meeting state and local standards addressing the provision of correctional health care services. We typically send over 50 staff members to NCCHC each year for training. On February 18, 2012, CCS hosted a CCHP examination at our Home Office in Nashville, TN, where 14 of our team members took and passed the examination.

Through Mr. Bosch's experience with NCCHC, CCS has a unique perspective into the NCCHC accreditation process due to participation in the following NCCHC activities:

- Standards development
- Standards interpretation
- Conducting on-site accreditation surveys
- Training NCCHC lead surveyors

CCS is familiar with the documentation required as indicators of standards compliance, and we will offer our expertise to assist with policy development. We conduct mock NCCHC surveys at each of our facilities prior to the actual on-site inspection by the audit team. We will discuss our findings and recommendations from the mock surveys with the DDOC staff.

Additionally, our on-going CQI programs and the internal audits we complete for all CCS sites guarantee that we meet and maintain all NCCHC and ACA standards.

CCS is also proud to include the current ACA President, Sheriff Daron Hall from Davidson County, TN, among our clients.

CCS Facilities with Accreditations	
Accreditation Type	Number of CCS Facilities
NCCHC, ACA, and CALEA (Triple Crown)	7
NCCHC Only	40
ACA Only	9
NCCHC and ACA	11
CMA/IMQ	4
In Progress	5
No Accreditation Requested	7

Figure 12: Outstanding Record of Accreditation Success. CCS has never failed to attain or retain accreditation for any of our clients who have requested it. CCS currently maintains some form of accreditation at 71 of the 83 facilities where we provide services.

2.5.29 Offender Sick Call

CCS will provide sick call services for all offenders, in accordance with DDOC policy E-07, NCCHC standard P-E-07 and ACA standard 4-4346.

Sick call is of primary importance to an effective correctional health care delivery system. The CCS sick call process includes standardized procedures and will ensure timely access to any necessary mental health care services. The CCS sick call process uses combinations of licensed Mental Health Clinicians, Psychiatric Nurse Practitioners, and Psychiatrists as the primary providers of sick call services, with any care provided falling within each professional's scope of practice and in accordance with DDOC policy E-07.

CCS uses a triage process at our sites to coordinate timely care to all patients. This process will be available as a site-specific, written plan. CCS will provide:

- Sick call triage seven (7) days a week, including holidays, conducted by a nurse.
- Sick call visits seven (7) days a week for urgent/emergent issues. All facilities will have an on-call 24/7 contact for emergencies.
- Psychiatrist mental health sick call visits are conducted sufficient to meet the needs of the offender population and on-call 24/7 for emergencies.
- All Mental Health care providers will be properly trained, qualified, credentialed and licensed to practice in the State of Delaware.

Policy and procedure includes information regarding access to health care be communicated to offenders orally and in writing in a language the offender comprehends upon arrival at the facility. Provisions will be made to assure that non-English speaking offenders understand how to obtain health care.

The plan also includes a means for identifying, assessing, treating and/or referring any offender who appears to be in need of medical, dental, behavioral health or developmental disability treatment at any time during his/her incarceration subsequent to the receiving screening.

Resources will be sufficiently allocated to the sick call process to allow all offenders to be seen in a timely manner after they request such services. Sick call services and clinical encounters are conducted in a private setting. When indicated a chaperone is present.

Should the need arise outside the scheduled sick call, offenders needing urgent or emergent medical services will be seen on the same day as they request such services. When an offender is unable to attend a sick call session due to custody status or physical condition, CCS will make arrangements for sick call services to be conducted at the offender's cell.

2.5.30 Daily Triaging of Offender Care

CCS will collect referrals and sick call slips on a daily basis from the CCS Medical Services team or designated lock box, and will triage each slip within 24 hours of the form being collected to determine key points: first, is the referral suggestive of an emergent need that requires immediate attention. If the referral is not emergent, the triage professional will then determine if the referral is of an urgent or routine nature. Second, the referrals will be noted in DACS and scheduled for the next available sick call clinic. If the Mental Health Staff is not on duty at the time of the urgent request, the on-call Mental Health Professional or psychiatrist will be contacted regarding the specific concern.

Clients assigned to Special Confinement Units who submit referrals will be seen by a Mental Health Professional in that unit, utilizing the same time frame for responses as patients assigned to general population.

2.5.31 Discharge Planning

CCS believes that discharge planning and continuity of care begins at intake where a thorough medical and mental health history is obtained. A release of information for any past reported mental health and psychiatric treatment is obtained and the process for gathering necessary data from community providers begins. Individuals identified with mental health issues at intake, or at any point during incarceration, are assigned to a primary mental health professional whose responsibilities include development of a treatment plan and provision of necessary clinical services. These services include consideration of discharge planning needs, taking into account the length of the client's expected incarceration. Planning for discharge needs should begin well in advance of an expected release date, preferably up to nine months prior to release; for those clients whose release dates cannot be definitively determined in advance, information regarding community resources will be communicated verbally and also in writing in the form of a pamphlet that outlines service information including contact names and telephone numbers for community providers for post incarceration mental health services.

Thorough discharge planning often requires a multidisciplinary approach, and recognizing this CCS mental health team members will review cases requiring intensive discharge planning during the regularly scheduled special needs multidisciplinary meetings. Such discussions will ensure that all facets of the client's needs are considered and that all necessary services are arranged prior to release. Clients will be fully apprised of all potential assistance programs and eligibility requirements, and assistance completing applications/enrollment tasks will be provided.

CCS works diligently in all communities to provide as many resources as possible to enable discharged patients to continue their treatment plans, hopefully enhancing their state of health and reducing the likelihood of recidivism. We will develop a program for DDOC to make community referrals and appointments, to assist with Medicaid/Medicare applications and to provide continuity of medications either through prescription or up to a 30 day supply of medication upon consultation with the Pharmacy Services provider in compliance with DDOC policy E-12 (Continuity of Care). A psychiatrist will review all psychiatric medications prior to discharge.

The discharge program for DDOC will also include a written discharge plan and related discussion with the offender, and the request for their social security number for coverage needs, if it is not already available.

CCS has made contact with NAMI and held initial discussions regarding the coordination of discharge planning activities and post incarceration medical and mental health services utilizing existing community resources. CCS is committed to the continued development of partnerships in Delaware to assist in the discharge planning process.

CCS is experienced in working with community providers to establish community linkage programs and is committed to ensuring an effective process exists to provide continuity of care for the offenders incarceration and in their transition back to the community. We understand the collaboration needed between the CCS medical and mental health teams, Correct Rx and the local community groups and community medical and mental health centers.

CCS will work with the DDOC and the community health centers to develop protocols for a discharge plan that develops a plan of care and establishes a follow-up appointments as soon as possible after the client's release from DDOC custody. . The plan will also provide direction regarding the provision of bridge medications. In addition, with the CCS automated medical records program (ERMA) it will be possible with the client's consent to provide a CD of his or her health care record that can be taken to the community health center to ensure immediate availability of pertinent medical and mental health information. At the very least a documented discharge plan will be provided to the offender to facilitate continuity of care.

Upon offender transfer to another facility, a medical transfer form will accompany the offender. This form provides all necessary information required for the continuation of treatment.

CCS will collaborate with the DDOC BHCS staff and with any other appropriate local agencies to best manage offender release planning. CCS promotes a strong focus on discharge planning, establishing a referral network and consolidation of patient information into a concise folder for staff use when coordinating linkage for care upon release/transfer.

2.5.32 Confidentiality/Exchange of Information

Health records will be kept confidential by CCS, and the CCS Health Services Administrator controls access to the health records. Our entire system is encrypted, and HIPAA-compliant. As the current Medical Services provider, CCS will ensure that mental health records and medical records are integrated and all records will be made readily accessible for any other DDOC health care partners.

2.5.33 Resolution of Disputes

In all roles awarded under this contract, CCS will facilitate a cooperative environment for the resolution of problems and disputes among DDOC health care services partners.

2.5.34 Coordination and Communication with DDOC

We believe that continuous communication between CCS, BCHS, and facilities' staffs will minimize surprises and errors and ensure a mutual understanding of decisions and protocols. CCS will regularly communicate with DDOC regarding sick call, medication distribution, off-site transportation, security and other issues that may arise. As the current Medical Services provider, CCS has demonstrated its dedication to working with the DDOC and any other health care partners to ensure the highest level of patient care. By adding CCS as the Mental Health Services provider, the DDOC will take a step towards reducing separation between vendors.

2.6 Human Resource Management

At CCS, we recognize that our people are our greatest asset. We also understand that continual work stress has a negative impact on morale and on staff retention. Our Human Resources and management teams are adept at maintaining cost and staffing efficiencies while minimizing stress levels for our people. The best means to lower stress is to ensure all staff are properly

trained on their job responsibilities and complete a thorough orientation program. If trained properly, they will be prepared and feel confident in their work which is the best means to lower stress.

The CCS philosophy and values infrastructure holds our people in high regard as a potent ingredient to our success. Even with our proven processes and efficient systems in place, outstanding performance and responsiveness truly depend on ***motivated, happy employees***. We invest in each team member's professional training and long-term career development.

For our leadership positions, we will ensure all scheduled time off is backfilled with appropriate people. At no time will staff not know who to call in the case of an emergency or critical clinical event. CCS will provide a written job description or protocol to each employee to outline responsibilities and duties of the position held. Position descriptions for our staffing plans will be provided to the DDOC for approval.

CCS takes great pride in the expertise and proficiency of our team, from our leadership ranks to the grass roots level health care providers who perform at our sites every day. Our personnel have the necessary experience and established programs to ensure an efficient and effective health care system. We encourage conversations with the clients in our Reference Section to learn how CCS has improved mental health staffing at their facilities.

2.6.1 Obligation for Facility Health Unit Administration

CCS will appoint a management-level staff member, either regionally or by facility to serve as administrator and liaison to the Bureau Chief and BCHS regional administrators.

2.6.2 Recruitment and Retention

Personnel recruitment and management is a CCS core competency. It is our goal to provide stable and responsive professional mental health care staffing to the DDOC institutions. CCS utilizes our highly-skilled, professional Human Resources Department for recruitment, development, and retention of health care professionals in our client communities. The CCS Home Office already provides a dedicated team of HR Professionals to support the medical recruitment and retention strategies for the DDOC facilities and this team will also provide mental health recruiting as well. Human Resources has a strong partnership with Regional management, enabling CCS to conduct continuous recruitment and retention efforts and staffing initiatives through local, state, regional, and national advertising campaigns. CCS has an excellent record in recruiting quality, motivated health care professionals.

Pride in Our People

In speaking with our clients, or reading our references, you will find a consistent message on CCS improving retention for all of our locations.

CCS currently has over 96% of all positions filled with CCS employees!

Once awarded the contract, we will individually contact all qualified current staff and ideally meet in person with each one. With permission from the DDOC, we will set up meetings at each institution to meet all current staff members to introduce them to CCS while also explaining the

implementation and hiring process. We value the input of the Bureau Chief and correctional staff regarding current employees and we will seek input before discussing employment with any current employees. Our goal is to retain all qualified, properly credentialed individuals who have the attributes to succeed as a part of the DDOC/CCS team. We are prepared to begin recruiting efforts for any vacant positions immediately, both within the DDOC and within CCS through internal postings.

CCS has dedicated a full-time Human Resources Recruiting Team in the Nashville Home Office to work with the Regional and site managers to understand the current staffing levels and vacant job opportunities.

The recruiters will monitor the success of the recruitment efforts and will adjust the recruitment strategy accordingly. Hiring leaders will be able to view applications for their openings via the CCS online applicant database. Screening and interviewing of applications, as well as the hiring decisions, will take place at the site level, with the support of the Delaware Recruitment team.

The following figure identifies the five (5) major steps of the CCS recruiting process.

Figure 13: The CCS Recruiting Process. *The five (5) major steps of the CCS recruiting process ensure that recruiting efforts are targeted to meet operational needs.*

The CCS recruiting program employs a variety of techniques and resources, including:

- Direct mail recruitment to targeted groups (i.e., letters, postcards, flyers). This method of recruitment has been particularly effective in recruiting psychiatristsand mental health professionals. By targeting a specific market, the CCS recruitment message is effectively communicated to all potential candidates in a designated area.
- College and University on-site recruitment and career fairs
- Internet Recruiting – we utilize a variety of Internet recruiting strategies, including niche websites for targeted professional groups.
- Advertising in local and regional newspapers and publications.

- Participating and sponsoring of local, state and national professional conferences (NCCHC, ACHSA, ACA, AJA, etc.).
- Advertising in nationally distributed business or professional publications (i.e., various physician specialty journals, American Nurses Association, Society of Correctional Physicians).
- Maintaining a resume databank, as well as subscribing to national searchable databases including CareerBuilder and Recruit Military.
- Using employment agencies and other third-party search firms, including locum tenens agencies, as needed for emergency situations. Any agency employees/contractors would follow the same security clearance procedures that would be required of CCS employees.
- Building relationships with public interest groups, educational institutions and trade/professional organizations (i.e., National Commission on Correctional Health Care, American Correctional Association).
- Employee referral programs.
- Networking and building relationships with our competitive sets in the area, including cold calling passive job seekers.

College and University on-site recruitment

In the States of Kansas and Nebraska, mental health professionals have completed internships working with our CCS Mental Health providers. We have found that by increasing community interest and education regarding corrections, we have been able to attract and recruit health care providers who may have otherwise overlooked a career in corrections.

National Searchable Databases

CCS currently utilizes a wide variety of National Recruiting databases that provide access to mental health professionals throughout Delaware and surrounding states (i.e. Maryland, New Jersey, and Pennsylvania). These databases also provide access to other professionals throughout the nation who are searching for mental health careers in Delaware. Some of the databases we use include:

- CareerBuilder.com
- Monster.com
- MiracleWorkers.com
- PracticeLink.com
- RCI Recruitment Solutions

CCS also uses resources that blast job postings and information across dozens of other recruiting databases and job sites through a single source. The result from all of these national databases is a continuous feed of the newest resumes and candidates into the Workforce System that our recruiters use to find the best candidates in the shortest amount of time.

Rural Area Recruiting

In addition to our standard, extensive recruitment efforts, CCS participates in the National Health Service Corps loan-repayment program for approved sites in Health Professional Shortage areas. This assists in attracting clinicians to work in rural, under-served communities.

Although recruiting mental healthcare professionals in rural settings can be challenging, CCS is experienced with this issue by virtue of our current DOC clients in rural areas such as Kansas, Delaware, Nebraska, and Vermont. Networking and partnering with local hospitals and other healthcare organizations, as well as tailoring recruitment packages to individual needs, especially when recruiting physicians, can make the difference and bring quality healthcare professionals on board. Additionally, certain circumstances may require the use of temporary and/or Locum tenens physicians to meet patient care needs and CCS has strong relationships with multiple agency and Locum partners.

Internal Recruiting

It is CCS practice to post all job openings within the company so internal team members have the opportunity to be considered for opportunities before any external offers are made. Team members are eligible to apply for an internal opportunity after completing six months in their current role. If a team member is interested in transferring to another position and/or location, they complete an internal transfer request form and submit to their supervisor for signature. Interviews are typicially conducted by the hiring leader and/or regional staff. CCS would welcome BHCS input and involvement during the interview process for key positions.

Employee Retention

Our organization is comprised of dedicated professionals whose mission is to provide compassionate patient care, execute sound ethical business practices, and support each other in all of these endeavors. We also know that to maintain our competitive advantage in the marketplace, especially in an environment like the State of Delaware, where there are a variety of opportunities for quality mental health professionals, we must effectively engage and retain our people. We are confident that we will be able to ensure a personnel pool to meet the demands of the DDOC.

2011 Mental Health Turnover Rates in Kansas and Vermont

*On our Kansas DOC contract, CCS has kept the turnover rate of our Mental Health Staff to **2.8%** and on our Vermont DOC contract, our Mental Health Turnover rate is only **0.7%**!*

CCS has an excellent retention rate with low turnover and we react swiftly to vacancies and other potential staffing crises to ensure there are no long-term staffing holes. Our overall retention rate for 2011 was 88%.

In order to recruit and retain quality, full-time staff, CCS works to show our employees that they are valued, through our retention and benefits programs, as well as through the following CCS employee initiatives.

Employee Recognition

CCS has a formal Employee Recognition Program (dubbed "R^3 Recognition", the program is based on our employee slogan of *"The **Right** People Doing the **Right** Things **Right**"*) to reward employees for outstanding performance and exemplary service. CCS presents recognition awards each quarter. Awards are based on attendance, customer service, teamwork, and overall performance. The purpose of the Employee Recognition Program is to motivate positive job behavior and build a sense of pride in each employee through recognition.

Company Newsletter

CCS provides an internal company newsletter, which serves as a valuable tool to keep employees informed of changes within the correctional healthcare industry and stay connected to company news. The newsletter includes a letter from Jerry Boyle, CCS President and CEO, updates on CCS news and events such as benefit open enrollments, and employee recognition winners. The CCS newsletter enhances our connection through communication with our employees.

Professional Development/Tuition Assistance

CCS encourages employees to take advantage of opportunities for advancement and professional growth. The CCS education and training program facilitates professional development and provides tuition assistance to employees as an opportunity to advance their skills and their career. In addition, on an annual basis CCS employees and their children who graduated high school are encouraged to apply for two CCS sponsored college scholarships. In 2011, two $2,500.00 scholarships were awarded.

Human Resources Hotline

CCS offers a 24/7 Human Resources hotline in the event guidance regarding an issue is needed outside of regular business hours.

GPS-Great People Skills

This People Development program aims to measure employee satisfaction, as well as learn how to best create amicable solutions to conflict. CCS believes it is important to LISTEN to our employees, as they have valuable perspective. Recently, we conducted a survey at our sites in Kansas, as well as our Kansas Regional Office. The responses were positive, with many employees excited about having an official avenue to express their thoughts.

★★★★★★★★★★

Responses from a Recent Employee Survey

"Working for and with CCS has been a great opportunity for me. I enjoy everything the company does for the sites as a whole as well as on an individual basis. They continue to help us grow and develop as a group through effective communication, patience, and understanding."

"When I started in corrections, I worked for REDACTED because they had the Kansas DOC contract. I know CCS has a vested interest in my success and personal well-being. I have the tools needed to do my job, and through CORE and startups I have been able to expand my knowledge and believe my opinion and talents are important. This is the company I want to retire from."

★★★★★★★★★★

Continuing Education Program

CCS maintains a continuing education program providing medical and nursing personnel with access to programs on a monthly basis. The program ensures the availability of at least forty (40) hours of continuing education training annually. Mental Health Professionals are provided with both in-house and community opportunities for continuing education programs that are relevant to their work as correctional mental health providers.

Flexible Scheduling

When possible, CCS attempts to establish flexible scheduling to meet the needs of our employees. Through our backfill program, in Delaware, CCS will utilize part-time and per diem personnel to provide coverage for scheduled absences and to supplement the full-time staffing matrix.

Dare to Care

Correct Care Solutions is dedicated to helping its employees during times of crisis. Through the establishment of the Dare to Care Employee Assistance Fund, employees of Correct Care Solutions, and their eligible dependents, who are experiencing difficult times, can apply for economic assistance. Employees may be eligible for assistance when they experience economic hardship, are unable to afford housing, utilities, food, clothing and other basic living expenses because of a natural disaster; life-threatening illness or injury; and death or other catastrophic or extreme circumstances beyond the employee's control.

The fund was initiated by CCS with a generous gift of $50,000 and Dare to Care will be sustained by the combinations of employee with matching donations, of up to $20,000 annually provided by the company.

The Community Foundation of Middle Tennessee is responsible for managing all funds and awarding gifts. Using The Community Foundation of Middle Tennessee keeps the application process private and assures that requests for assistance are reviewed by an impartial and experienced third party.

CCHP and ACA Certification

CCS encourages our professionals to obtain certification through the National Commission on Correctional Health Care. CCHP professional certification provides immeasurable benefits and is highly regarded by management, peers, staff and others. It is a step toward increased knowledge, greater professional recognition and identification as a leader in the complex and ever-changing field of correctional health care. Health professionals working in correctional settings face unique challenges: working within strict security regulations, dealing with crowded facilities, understanding the complex legal and public health considerations of providing care to incarcerated populations and more. Achieving professional certification is the surest way to prove to yourself and to others that you have the tools to meet these challenges. CCS reimburses the cost of testing to employees who successfully pass.

Wellness Program

CCS believes in pursuing health aggressively and encourages staff to participate in the CCS Wellness Program. Incentives, exercise programs, healthy eating, and healthy lifestyle initiatives are provided to all employees. Smoking cessation and weight control programs and contests encourage site participation in their pursuit of a healthier staff.

Features of the Program:

- **Wellness Assessment –** An online tool participants use to learn what their wellness score is with practical suggestions to reduce the risk of illness and injury.
- **Preventive Exam Screening –** Participants will be encouraged to have routine physical exams or preventive screenings with their physician or other healthcare provider.
- **Preventive Care Self Screening –** Participants administer a self-care screening. Examples include self-breast exam, self-testicular cancer exam, blood pressure check, and skin and/or foot exam.
- **Healthy Living Programs** –These interactive, personalized six-week online programs help each person take important steps to reduce risk and improve health. When the participant completes the Health Assessment, those programs for which he or she has the greatest needs and the greatest interest (based on risk and stage of readiness) are presented as recommendations.
- **Online Monthly Wellness Seminars –** Participants spend 12-15 minutes learning how to get and stay healthy each month.

2.6.3 New Employee/Contractor Training and Unit Orientation

CCS knows that the cornerstone of the organization is our people. Our organization is comprised of dedicated professionals whose mission is to provide compassionate patient care, execute sound ethical business practices, and support each other in all of these endeavors.

The lives and health of our patients depend on the knowledge, practice skills, and competencies of the professionals who care for them. Caring for and respecting patients in correctional facilities requires ethical, competent, professionals.

CCS provides a comprehensive 3-phase training program designed for new staff (onboarding) as well as continuing training and annual skills/knowledge assessment.

1. Onboarding
2. Performance Enhancement
3. Leadership Development

All CCS staff members are required to participate in each phase of training. The frequency and focus of each training phase will be determined by the position and the capacity of the learner.

Phase 1: On-boarding

Critical to the future success of any new employee is her or his initial experience with the organization. To start the employee off on the right foot and to ensure a smooth transition, CCS offers a three-part on-boarding process: Orientation, On-the-Job Training, and Follow-up.

On-boarding Step 1: Orientation

Each new hire is scheduled to participate in an eight (8) hour learning experience (the physician orientation program has additional requirements) where they are introduced to the Correct Care Solutions culture, policies, and procedures. The program is designed to clearly establish expectations and to involve the new staff in the success of the Company.

Areas discussed will include, but are not limited to:

- Company culture
- Goals
- Benefits
- The correctional environment
- Deliberate indifference
- Correctional healthcare standards
- Governance
- Forensic information
- Informed consent
- Grievance mechanisms
- Emergency services
- Interacting with offenders
- Safety and security
- Universal and Standard precautions
- Segregation
- Biohazards
- CQI
- Infection control
- Offender health services
- Mental health assessments
- Client/customer service
- The Prison Rape Elimination Act
- Appropriate documentation utilizing the SOAP format
- Suicide prevention and risk assessment
- Emergency procedures
- Compliance with DDOC security regulations, policies and procedures
- Notification procedures for staff discharges and resignations
- DDOC required sign-in and sign-out procedures

In addition to the CCS training, all staff having regular contact with offenders are required to undergo eight (8) hours of suicide prevention training.

We have provided a New Hire Welcome/Orientation Package and DVD in the rear binder pocket of this proposal for your reference.

On-boarding Step 2: On-the-Job Training (OJT)
This step is guided by standards, detailed checklists, and a qualified preceptor. While there are time schedules with expected milestones, the preceptors will work with the new employees to ensure that the expected knowledge is transferred. This portion will not be considered compete until the new employee feels capable and comfortable to perform the job.

On-boarding Step 3: Follow-Up
Follow-up is the last component of the on-boarding process. During this component, the new employee has an opportunity to provide feedback about his or her experience with his/her Supervisor. During this discussion, the Supervisor also shares information about her or his leadership style and performance expectations.

Phase 2: Performance Enhancement
CCS provides our employees with opportunities to enhance performance through our continuing education programs. Our Continuing Education Program is described in detail in **Section 2.6.19** of this proposal.

Phase 3: Leadership Development
These learning experiences are tailored to the audience. For example, Foundations of Leadership is designed for our emerging leaders, Managing the Operation for our mid-managers, and The Business Behind The Business for our top leaders. In addition, we have a Leadership Academy designed to further develop our top performers. Each series is run with the collaboration of our Home and Regional office as well as the site leaders. They vary in delivery and duration.

Training for our Mental Health Professionals will be designed and conducted through the collaborative efforts of our Director of Psychiatry, Vice President of Behavioral Health, our People Development and CQI team, and the site leaders. They will participate in step one of the orientation (see above). Additionally, our Psychiatrists and Psychiatric Mid-level Providers will be mentored by our Director of Psychiatry – providing guidance and sharing expectations.

CCS Leadership Development Approach
The continued success of any organization is its leaders' abilities to effectively lead their people, maximize customer and client experience, and make sound business decisions. Correct Care Solutions is committed to enabling its leaders to be the best in their current roles and to preparing them for future opportunities within the Company.

Correct Care Solutions Leadership Development centers on five (5) leadership competency themes:

Figure 14: The Five Leadership Competency Themes: *The five themes of the CCS Leadership Development Approach guide performance assessment, development initiative,s and promotional selection.*

Educational experiences are designed to strengthen the leadership competencies of all our staff members. These experiences are tailored to the audience. Examples of leadership programing include:

Title of Program	Objective	Target Audience
Foundations of leadership	Multi-venue learning experience designed to Introduce high-performer/potential non-leaders to the role of manager	Emerging Leaders
Boot Camp	Home Office learning experience designed to introduce to the Correct Care Solutions way – expectations of a leader, policies, best practices	New Leaders (less than 4 months)
New Leader Transition	Interactive discussion session designed to encourage communication between the new leader and the staff	Leader who joined the staff (less than 6 months)
Acceleration	On-line learning experience designed to strengthen leadership skills	All CCS Leaders
Leadership Academy	Multi-focus, multi-delivery learning experience designed to enhance the understanding and effectiveness of our leaders	Front-line Leaders (Foundation of Leadership) Mid-level Leaders
Train the Trainer	Enable trainers to successfully deliver training courses to the highest standard	D.O.N.s/Identified Nurse Trainers

Figure 15: Leadership Training Programs. *CCS invests in the growth of its employees to develop and grow leaders from within.*

CCS Leadership Boot Camp

Boot Camp provides all of our new leaders an opportunity to learn about our values, policies, practices, and culture. To enhance the benefit of the fast-paced Boot Camp learning at the Corporate Home Office (Nashville, Tennessee), CCS sends all new leaders a pre-work instruction e-mail. This is essential in preparing each attendee to benefit fully from the program. The pre-work consists of interactive, customized eLearning programs and paper assignments aimed to educate our leaders in their various responsibilities. Examples of some of the content that would appear in the pre-work as well as in the Boot Camp sessions are: Legal and risk management, setting SMART (specific, measurable, attainable, realistic and timely) goals, interviewing skills, finance, correctional healthcare, employee evaluation/improvement meetings, leadership, operations, and conflict management.

CCS immerses leaders in multiple formats of learning: PowerPoint presentations, senior staff panel discussions, group debate, and visits to the various department heads for a Q&A session. The Boot Camp program is educational, fun, and participatory. Our goal is to help our RIGHT employees ALWAYS to do the RIGHT things. Our past, present, and future success is because of the investment in our CCS Family. CCS aims Boot Camp to continue that tradition as we grow!

2.6.4 Credentialing and Privileging of Professional Staff

All mental health care practitioners (employees, subcontractors, as well as locum tenens) providing on-site service for CCS on the DDOC contract will complete a criminal history check and credentialing process prior to starting work. That includes psychiatrists, nurse practitioners, physician assistants, masters level mental health practitioners, and doctoral psychologists. The credentialing process will be in accordance with DDOC Policy C-01 and begins as soon CCS determines we will be making an offer of employment to the candidate. The CCS Risk Management Department will oversee credentialing activities.

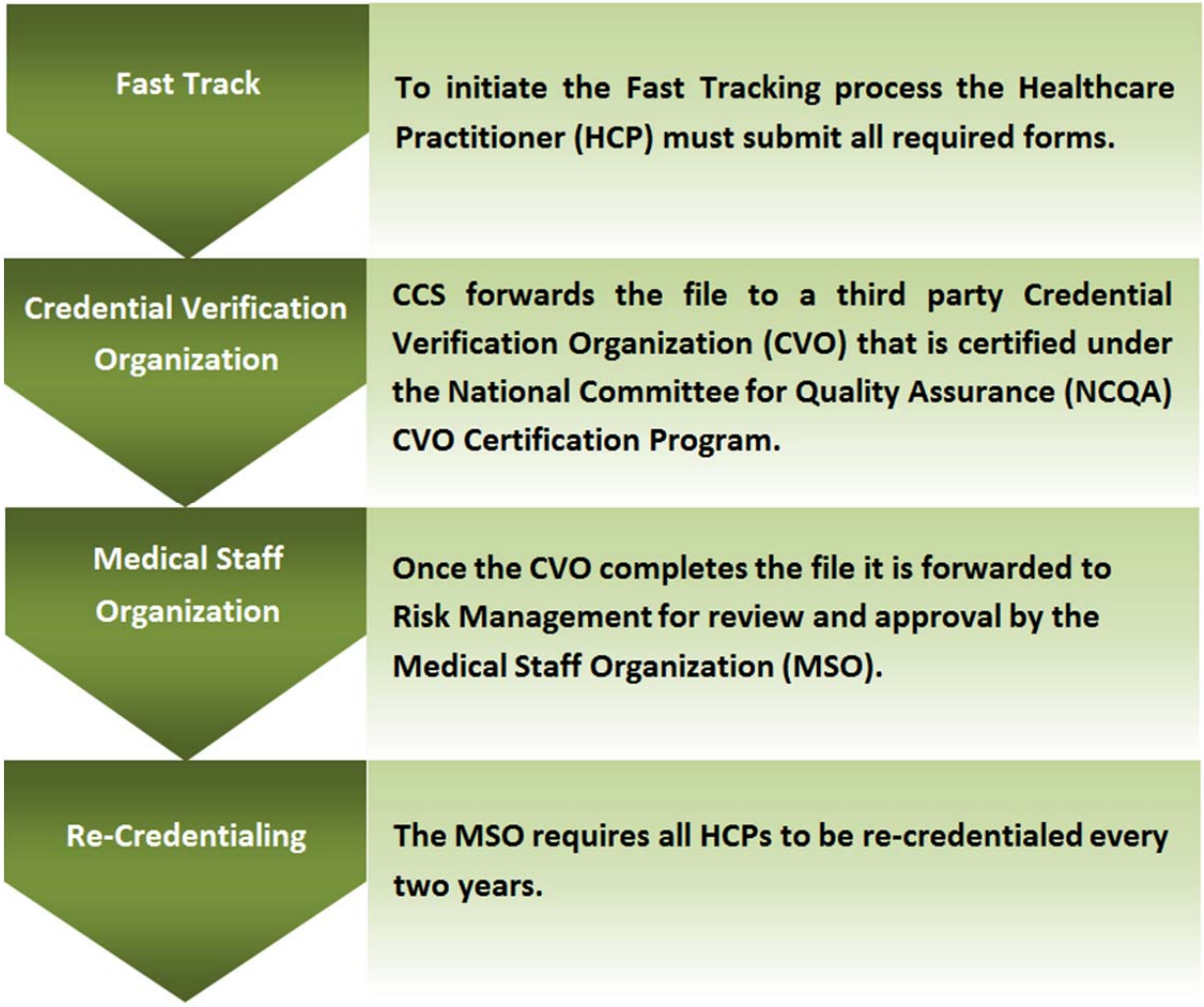


Figure 16: Components of the Licensure and Certification Process. *CCS uses this process to ensure that all CCS Clinicians are properly licensed and credentialed.*

Interim Privileges (Fast Track)	CCS refers to the process of granting interim privileges as Fast Tracking. To initiate the Fast Tracking process the Health Care Practitioner (HCP) must submit the following: • Completed credential application • Copy of license (verified) • Copy of current malpractice certificate of insurance (Subcontractors must list CCS as an additional insured if providing own coverage) • Copy of DEA certificate • Copy of Medical School Diploma/Graduate School Diploma • Copy of certifications (if applicable) • Copy of CPR certification • Completed malpractice application The Medical Staff Organization (MSO) then grants the HCP privileges as appropriate.
Credential Verification Organization (CVO)	CCS forwards the file to a third party CVO that is certified under the NCQA Certification Verification Certification Program for the following verifications: • Application Processing • Education and Training • DEA Certification • License to Practice • Malpractice Claims History • Medicare/Medicaid Sanctions • Ongoing Monitoring of Sanctions • Medical Board Sanctions • Work History
Medical Staff Organization (MSO)	Once the file is completed by the CVO, it is forwarded to Risk Management for review and approval by the MSO.
Re-credential Process	The MSO requires all HCPs be re-credentialed every two years.

2.6.5 Work Hours Required On-Site

CCS agrees to the language and directives in the RFP regarding work hours and staffing. We will provide full and adequate on-site staffing in all our mental health care services endeavors at DDOC. Any modifications to the staffing plan will be subject to agreement between CCS and

DDOC/BCHS. CCS acknowledges that training time per individual must not exceed 40 hours annually. CCS will account for training time in staffing and pricing materials. Off-site meetings will not be applied to DDOC working time, unless prior approval is received from the Bureau Chief.

2.6.6 Offender Grievances and Inquiries/Complaints Regarding Offender Care

CCS recognizes that our first responsibility is to our patients, to allow them access to care and treatment sufficient to meet their mental health needs. We expect our staff to operate efficiently and to respect those needs. Our excellent litigation history and our record of reduced grievances are indicative of the exemplary care CCS team members provide.

The CCS grievance process will be consistent with NCCHC and ACA standards P-A-11, J-A-11, 1-HC-3A-01 and DDOC policies A-11, and A-11.01. CCS informs all offenders of the grievance procedures during intake. CCS responds to offender grievances, complaints, and inquiries in a formal manner as soon as is practical. CCS will respond within seven (7) days of receipt of each grievance and within twenty-four (24) hours for any grievance deemed urgent or emergent. CCS defines urgent grievances as those complaints that involve an immediate need on the part of the offender for healthcare services.
CCS will use DACS to initiate grievances and for all follow-up communication. Internally, CCS has established a mechanism to report on the volume of grievances received, the nature of the grievances, the resolution status and corresponding time frames, and whether or not the grievance is substantiated. CCS maintains a daily log of all grievances. CCS logs the name of the person filing the grievance and the date and nature of the complaint. If the grievance process substantiates a grievance, thena corrective action plan is developed and implemented for that grievance.

CCS categorizes complaints and grievances and reports specifics as a part of the monthly health services report. CCS will submit the monthly report identifying offender grievances to the DDOC. This report will contain a description of the grievance or complaint, an explanation of the circumstances surrounding the grievance, and all actions taken to investigate and resolve the grievance. CCS resolves concerns and grievances in collaboration with the HSA and mental health services, dental, pharmacy, or other appropriate service providers.

The CCS training program includes grievance resolution. CCS trains health care personnel to address an offender's concern at the point of contact prior to the offender initiating a written grievance.

The appropriate designee will work with DDOC personnel in the investigation, follow-up, and resolution of complaints in accordance with DDOC policies. When necessary, CCS will conduct a face-to-face interview with the offender. Our CCS QI/MAC Committee will review and categorize grievances to identify potential issues and determine if patterns exist or develop.

2.6.7 Policies, Procedures, and Guidelines/Protocols

The CCS policies and procedures will be used at every step to guide the health care program. Policies and procedures regarding mental health services will be tailored site-specific for each

facility, address the standards of ACA, NCCHC, and applicable federal, state and local laws, and will be provided to the DDOC for approval within 90 days of contract award. These policies and procedures will be developed in concert with DDOC and/or facilities' policies and procedures for service delivery, in accordance with DDOC guidelines and available in a manual that is updated on an annual basis. These policies will be reviewed annuallyand will be provided to the Bureau Chief and DDOC Medical Director for approval. CCS will obtain concurrence from the DDOC before developing or revising policies and procedures.

2.6.8 Continuous Quality Improvement

In accordance with DDOC Policies 11-A-06, A-06.1 and A-06.2, NCCHC Standards P-A-06 and J-A-06 and ACA Standards 4-4410, 4-4402 and 4-9423, CCS has an established Delaware Continuous Quality Improvement Program (CQIP) falling under the authority of Dean Rieger, M.D., our Chief Medical Officer. The goals of the CQIP are to improve the quality of care provided to patients by intervening where opportunities for improvement exist and to ensure that systems and programs work effectively to make certain that quality health care services are provided to patients, as medically indicated.

It is the position of CCS that CQI is a fundamental activity in healthcare. By studying our essential functions on a routine basis, areas for improvement can be identified and addressed proactively. This allows for streamlined management of processes to promote efficiencies and accuracy, and close examination of outcomes to determine effectiveness of interventions. It is also very important to include front-line staff in CQI activities, as this promotes buy-in to corrective action plans and increases the investment of the staff in providing quality services that also meet accreditation standards. CCS accomplishes this through inclusion of staff in the following types of CQI activities:

- Training and orientation on CQI core principles and activities
- Completion of CQI studies
- Staff meetings where results of studies are discussed
- Highlighting areas of excellence
- Corrective action planning

The CCS CQIP is defined by written policy and defined procedures in accordance with the DDOC QAM.

Under the direction of the Delaware Regional Mental Health CQI Coordinator, routine CQI studies will be collaborative with our Medical team and examine areas where overlap or hand-off occurs, as well as other problem-prone, high frequency/volume, and risk management processes such as: Informed Consent, Screening and Evaluations, Special Needs, Segregation, Treatment Planning, Suicide Prevention, Discharge Planning, and Medication Administration. The CCS CQI Program consists of the following:

CQIP Manual	Under the authority of Dean Rieger, M.D., M.P.H., our Chief Medical Officer, CCS operates an established CQIP. The goal of the CQIP is to ensure that systems and programs work effectively to guarantee that our patients receive quality healthcare services. The CCS CQIP is defined by written policy and defined procedures. CCS will use our CQIP and DDOC QAM to establish a Mental Health services QI Plan for the DDOC. The CQI Plan will address services provided for quality, appropriateness, and continuity. The plan will review and define the scope of care provided within the system with a goal of improved offender outcomes.
CQIP Compliance	The CCS CQIP complies with NCCHC standards and includes, but is not limited to, audit and medical chart review procedures. The CCS program will base the site-specific CQIP for the DDOC on the scope of care provided. A multidisciplinary committee will direct quality improvement (QI) activities. The on-site CCS Medical Director is the designated QIC chairperson. Generally, the multi-disciplinary committee will meet at least once per month and consist of the Medical Director, mental health representative, dentist, H.S.A., D.O.N., CQI Coordinator, contract administrator and an appropriate DDOC representative or representatives. The committee will review significant issues and changes and provide feedback for the purpose of correcting any deficiencies or improving processes. CCS will mark all CQIP activity records CONFIDENTIAL. Discussions, data collection, meeting minutes, problem monitoring, peer reviews, and information collected as a result of the CQIP are not for duplication or outside review.
Scope of CQIP	CCS will be responsible for monitoring relevant areas for quality improvement not previously mentioned in the sections above, as requested by the Bureau Chief or designee. Monthly reporting will be provided to the Bureau Chief.

High Risk Items

The CCS CQIP addresses many forms of risk management, including clinical and environmental risk management tools that work to identify and reduce variability, as well as reducing liability when adverse events occur. The QIC will address the following areas for risk management purposes at QIC meetings:

Critical Clinical Event (CCE) and Emergency Drill Reviews
The QIC will monitor, review, and report on the CCS staff's response to critical incidents and drills. The committee will use the root cause analysis problem solving methodology to review the CCE.

Resolution Tracking
The QIC will track deficiencies identified through resolution.

Grievances
The CCS grievance process will be consistent with national standards and DDOC internal policies. The QIC will review and categorize grievances to identify potential issues and determine if patterns exist or develop.

Pharmacy Reports
CCS will use pharmacy reports to identify outliers and trends. CCS will evaluate and address all outliers. The CCS Chief of Psychiatry will also electronically review pharmacy utilization data on a regular basis.

Peer Review
CCS requires annual peer review of its physicians, psychiatrists, dentists, psychologists, physician assistants, and advanced practice nurses. The purpose of the peer review is to evaluate the clinical practice of the practitioner. Site CQI committees are, along with the HSA for medical and Director of Mental Health for mental health, responsible for insuring that peer reviews are carried out. The peer review process includes review of representative health records, an interview with the Supervisor regarding the practitioner's performance, an interview with the practitioner regarding his/her perception of his/her performance, and an exit interview during which the reviewer discusses the findings with the practitioner. When areas in need of improvement are identified, the reviewer works with the practitioner and the Supervisor to establish an improvement plan process.

Performance Indicators

The CCS Continuous Quality Improvement (CQI) Program will be further developed specific to the needs of the DDOC.

The overall goal of the CQI Program is to continuously improve the quality of care to offenders receiving mental health services by:

- Monitoring clinical activity
- Identifying opportunities to improve clinical outcomes
- Identifying educational needs of staff
- Managing utilization of resources to promote accuracy and efficiency in the provision of services

Improvement of care is accomplished through an ongoing examination of processes, procedures and data by a multidisciplinary team of staff at each institution. This is guided by CQI activity and may include monitoring of a specific activity such as mental health screening on a daily basis to ensure policy, procedure and contract compliance via a review of service delivery logs and offender records; or the monitoring of a process such as sick call to ensure compliance, effectiveness and outcomes. Individual incidents and any service delivery issues are reviewed to identify areas for improvement, development of necessary changes and outcome assessment. The CQI Program measures the quality and relevance of the mental health services provided and will systematically monitor current practices and documentation to ensure compliance with policies, procedures and specific contract requirements. In addition the Program evaluates whether resources are being utilized in a cost effective and clinically appropriate manner and in order to achieve desired outcomes.

The following general quality indicators will be evaluated on an ongoing basis utilizing CQI tools and via spot check review.

Access to Care – How easily an offender is able to obtain needed services.

Timeliness – The care or intervention is provided to the offender at the most beneficial or necessary time.

Effectiveness – Intervention results in the desired outcome.

Appropriateness – Care or intervention provided is relevant to clinical needs and community standards of care.

Continuity – Care or interventions are coordinated among practitioners, between vendors, between institutions and across time.

Quality – The degree of offender involvement in his/her own care decisions and the degree of sensitivity shown by service providers.

Peer Review

CCS will conduct quarterly peer review of its Mental Health Clinicians (Psychiatrists, Nurse Practitioners, Psychologists and Master's Level Mental Health Professionals). The purpose of the peer review is to assure the clinical practice of the practitioner is competent and is congruent

with the practice guidelines set forth by CCS and the DDOC. The review also creates an opportunity for the practitioner to receive feedback regarding his/her performance from another practitioner with an understanding of the clinical practice being reviewed in the hope that such feedback will lead to an improvement in the quality and/or efficiency of that clinical practice. Peer review is highly confidential and is not open to distribution or discovery; in most instances, courts have zealously guarded this confidentiality.

CCS clinical staff will participate in the peer review program administered by BCHS. The CCS Director of Mental Health Services will manage the process for peer reviews. CQI committees are, along with the CCS Regional Director of Mental Health Services, responsible for insuring that required peer reviews are carried out. The CCS Peer Review program is in compliance with NCCHC and ACA standards, and will be conducted in accordance with the requirements outlined in DDOC Policy C-02.

Several accrediting agencies require that peer review be completed annually. These agencies, including NCCHC and ACA, do not need to see the actual peer review, but they do need to see evidence that it has been carried out. At each site of practice, CCS maintains peer review signature sheets assuring the completion of the peer review and discussion of findings with the practitioner.

The peer review process includes review of representative health records (types of records reviewed depends upon the nature of the practice), an interview with the HSA and/or Mental Health Director regarding the practitioner's performance, an interview with the practitioner regarding his/her perception of his/her performance, and an exit interview during which the reviewer discusses the findings with the practitioner.
When significant opportunities for improvement are identified, the CCS Peer Reviewer will work with the practitioner and the Supervisor to develop a Performance Improvement Plan. The peer review will then be scheduled for follow-up at a date that is reflective of the magnitude of improvements to be made by the practitioner.

Reviewer	Professional Reviewed
Dr. Lawrence Reccoppa, Director of Psychiatric Services	Chief Psychiatrist
Chief Psychiatrist	Psychiatrists
Charlene Donovan, Ph.D., VP of Behavioral Health	Psychologists, Mental Health Professionals
Psychiatrist (from a different Facility)	Psychiatric Nurse Practitioner

Table 2: S Peer Reviewer Responsibilities. *Peer reviews are conducted by another practitioner with an understanding of the clinical practice being reviewed.*

Utilization Management and Utilization Review

The CCS Care Management Program is built upon evidenced-based practice and managed care concepts, balanced by the CCS belief that we always ask ourselves: "What if this was my family member?" While we understand the responsibility to not deny health care, we understand our role as stewards of resources in the appropriate delivery of specific health services.

Clinically developed and overseen by the CCS Chief Medical Officer, Dr. Dean Rieger, the Care Management program works cooperatively with the Quality Improvement Department. The

shared goal of these departments is the management of mental health services to ensure the care delivered to our patients is medically necessary, timely, of acceptable quality, and delivered in the most effective and cost efficient manner available.

CCS bases medical necessity determinations upon InterQual® Behavioral Health criteria. The InterQual standardized decision paths provide CCS mental health providers with the information they need make consistent, objective decisions.

The Care Management Processes include:

Prospective Review *(Prior Authorization)*	CCS requires prior review and authorization of all non-urgent or non-emergent off-site care provided to our patients. CCS clinicians utilize NCCHC standards and correctional guidelines to review and approve services. CCS will initiate a second review if standards are not clearly met.
Concurrent Review	The care manager assigned to the DDOC will manage all offsite care on a daily basis. The care manager will achieve this through daily contact with the off-site hospital. CCS requires fax notification of inpatient admissions at the time of admission. CCS clinicians utilize NCCHC standards and correctional guidelines to review inpatient services daily. CCS will initiate a second review if standards are not clearly met.
Retrospective Review	The Care Management department and site leadership will retrospectively review all emergency care. CCS engages a retrospective review process to resolve claims issues, to determine appropriateness of care post care delivery, and perform focused reviews. Additionally, CCS will perform focused reviews at the request of the provider.
Discharge Planning	CCS engages in an active and constant discharge planning process which begins at inpatient admission.
Chronic Care/Special Needs Management	CCS enrolls patients into chronic care programs which are designed to ensure the healthiest outcome for individual patients based on their health status.

2.6.9 Morbidity and Mortality Review

As the current medical vendor for the DDOC, CCS provides clinical participation in the DDOC Morbidity and Mortality Review Committee meetings per DDOC Policy A-10.1. In addition to medical participation in the meetings, as the Mental Health Services provider, CCS will participate in Morbidity and Mortality Review Committee meetings for completed and attempted suicides.

CCS utilizes a comprehensive review program that is a part of our overall suicide prevention program. Any event classified a suicide attempt is considered a Critical Clinical Event (CCE), with notification to the BHCS and key Home Office personnel occurring as soon as is practicable after the event. In accordance with DDOC Policy A-10.1, the treatment team at the site then completes a review of the event, employing a structured template that guides information gathering and process/procedure review. The review is completed and submitted to Home Office for analysis by the Vice President of Behavioral Health Services and the Continuous Quality Improvement (CQI) Program Manager, under the auspices of the Continuous Quality Improvement program. The report will be provided to the BHCS Chief, site Medical Director, DOC Medical Director, Quality Assurance Administrator and Compliance Director within twenty-four (24) hours. The goal of such an extensive effort at reviewing suicide attempts is to identify any trends or practices that will be of benefit to the CCS suicide prevention program across the company.

CCS agrees that in cases of completed suicides or serious attempts, a formal mortality review process will occur within 30 days in accordance with the DDOC Morbity and Mortality Review Policy and that this process will be chaired by the Psychiatrist who most recently treated the client. This review will be coordinated with the BHCS. CCS requires completion of a Psychological Autopsy as part of our Mortality Review process in the case of a completed suicide. This document also yields recommendations for improvement in cases where opportunities for improvement are noted.

2.6.10 Post-Critical Incident Review

In the event of a serious suicide attempt or completed suicide, CCS Mental Health staff will provide critical incident debriefing to all correctional and healthcare staff as well as offenders affected by the incident within twenty-four (24) to seventy-two (72) hours. Mental Health staff will work closely with the facility's designated debriefing team to ensure that information is made available to staff regarding accessing the designated employee assistance entity. For offenders in need of additional psychological services, Mental Health staff will provide a mental health evaluation and, when clinically indicated, develop a treatment plan to provide psychological and psychiatric services necessary to prevent psychological decompensation and promote optimal functioning of the offender.

CCS will participate in post critical incident review process in accordance with DDOC and CCS policies. In addition to participating in the DDOC critical incident review process, CCS will also conduct internal reviews of Critical Incidents.

CCS defines a Critical Clinical Events CCE as one of the following:

1. An occurrence involving death or serious physical or psychological injury, or risk thereof – traditionally known as a SENTINEL EVENT
2. A clinical event with significant implications for our clients; and/or
3. Clinical events that CCS has deemed high risk, and monitors for purposes of developing best practices. CCE reviews are carried out in order to review negative outcomes and identify opportunities to improve quality of care; this procedure describes how that is accomplished. Material from the CCE review is used solely to improve future

performance. Material from a CCE review is not available for use in employee disciplinary activities.

CCE reviews are initiated when a CCE e-mail is sent. Upon receipt of this e-mail, a review committee at the CCS Home Office to include representatives from Operations and Clinical, and a member of the Legal Affairs department will determine the level of review necessary. After this collaboration, the review committee will assign a lead investigator. Although the Regional Mental Health Director will generally serve as a point of contact, the lead investigator will typically be the site Psychiatrist, Charge Nurse, or designated Mid-Level Provider or other Health Care Practitioner. The CCE review is considered locally in the CQI process, but is also reviewed at Regional and Home Office levels.

The CCE review process is kept strictly confidential. However, CCEs are facility events and the review process should, whenever possible, include gathering information from representatives from the local facility administration. Any such information gathered, if documented, should be factual only. Statements that include evaluation, subjective opinion, and recommendations for improvement should be reserved for the CCE review forms only. CCEs vary in importance. Some are adequately addressed after simple review, while others may require in depth and detailed analysis. This procedure and the associated Policy Directive are written in a manner that calls for different levels of detail for different events.

The following events are considered CCEs and will almost always require a comprehensive review or completion of the appropriate QI screen:

- High risk conditions/events identified by CCS Mental Health Director
    - Suicide Attempts
    - Use of therapeutic restraint
    - Use of involuntary psychotropic medication
- Mortalities, including death in custody or death immediately following release from custody (if known):
    - Expected deaths
    - Unexpected deaths, non-suicides
    - Completed suicides
- Medication errors resulting in negative clinical outcome or death (classified as Category F, G, H and I; Category E medication errors must be reported and an ad hoc determination will be made regarding the need for a clinical sentinel event review)
- Hospitalizations resulting from delayed care or inappropriate treatment
- High risk conditions/events identified by Office of Chief Medical Officer (OCMO)
    - Off-Site Transport for Alcohol Withdrawals resulting in Delirium Tremens
    - Hospital readmission for the same diagnosis or secondary diagnosis within a 30 day period
    - Hospital admission within 24 hours of medical Intake
    - A significant variance from expected clinical norms at a facility.

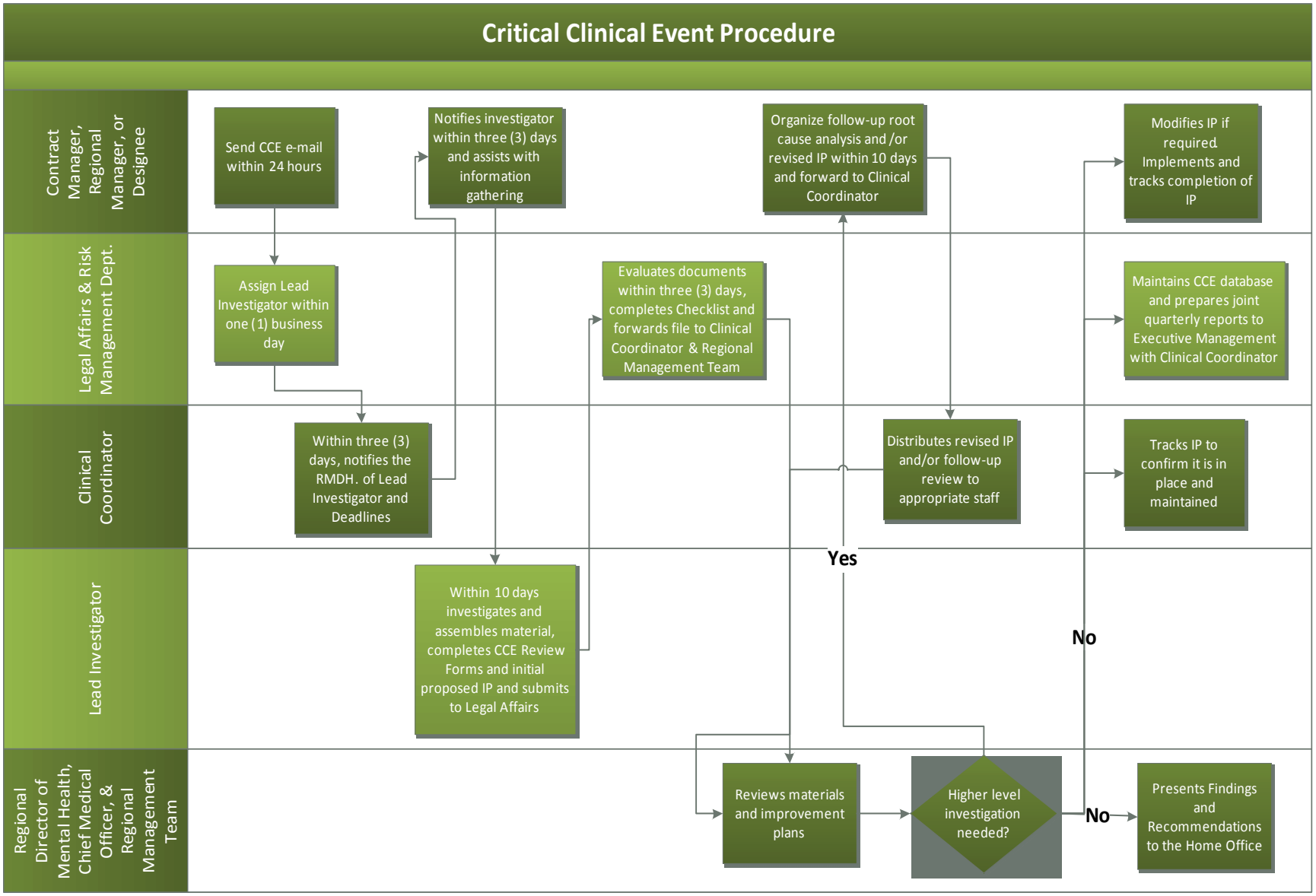


Figure 17: The CCS CCE Procedure. *CCS will initiate the CCE Procedure whenever an event occurs.*

2.6.11 Risk Management

Safety is an integrated element of the CCS corporate philosophy and values, and evident from the management level down to the grassroots operations at each facility. CCS agrees to abide by all DDOC rules, regulations, policies, and procedures regarding risk management. CCS also agrees to work with all other healthcare contractors to ensure the safety of patients, contractors, and DDOC personnel.

CCS agrees to work with the DDOC BCHS to develop and supply reports containing data from CQI activities, morbidity and mortality reviews, and post-incident reviews. These reports will be used to analyze and determine trends in order to find opportunities for improvement.

Patient Safety Program

As a part of the Risk Management Program, CCS has a comprehensive patient safety program. This program is a best practice program that requires reporting of:

- All deaths (expected, unexpected, and suicides),
- Suicide attempts,
- Medication errors resulting in negative clinical outcome,
- Hospitalizations resulting from delayed care or inappropriate treatment,
- Offender on offender sexual assault,
- Hospital readmission for the same diagnosis or secondary diagnosis with a 3 day period,
- Hunger strikes that last more than 72 hours,
- Use of therapeutic restraints on a patient,
- Involuntary administration of psychotropic medication, and
- Any significant variance from expected clinical norms at the facility.

CCS will request a root cause analysis of the event if deemed necessary by a multi-disciplinary committee within CCS. These reviews are confidential and hold attorney client privilege, but will result in corrective action plans that are working documents at the site, and available for review and input from DDOC.

Injury and Illness Prevention Program

As part of our CCS ongoing commitment to our employees' well-being, we established an Injury and Illness Prevention Program to implant and nurture a culture of safety consciousness, sustain our high level of safety at our all of our client facilities, and to ultimately help ensure the safest possible workplace for our employees, patients and clients.

The Injury and Illness Prevention Program consists of the following elements:

- Responsibility
- Compliance
- Communications
- Hazard Assessment
- Accident/Exposure Investigation
- Hazard Correction
- Training and Instruction
- Recordkeeping

All employees currently receive comprehensive safety, health, and environmental training in accordance with our orientation and continuing education. Safety is integral to all functional area training programs to ensure employee awareness of safe work procedures, thereby helping to promote their personal safety and wellbeing. Examples of the CCS monthly safety news flash is included in **tabbed attachment E**.

Security is an essential part of risk management in the correctional environment. All new employees and subcontractors receive security training.

Our Regional Director of Mental Health Services will be responsible for ensuring that safety/risk management training is adapted to each facility's requirements as well as any applicable directives, regulations and policies of the DDOC.

Throughout the contract, CCS will evaluate performance and assess training requirements to ensure our program is responsive to changing regulatory and operational requirements, as well as to trends in the provision of care.

2.6.12 Informed Consent/Right to Refuse Treatment

For the DDOC system, CCS will implement the use of DDOC forms to document informed consent for proposed treatments and examinations as well as a general description, alternatives and any risks involved. CCS will also document in writing any refusals of examination, treatment or medication. CCS will seek informed consent and refusal documentation in accordance with DDOC and CCS policy.

2.6.13 Records and Reports

CCS will provide a full array of periodic reports generated through the DACS and ERMA platforms, which will be available no later than the 10th of each month for the preceding month. Please see **Section 2.6.16** for a full description of CCS reporting capabilities.

2.6.14 Response Team

CCS will participate, in all roles awarded under this contract, in the DDOC response team.

2.6.15 Cooperative Interaction with Other Offender Heath Services Vendors

CCS is the current Medical Services provider for the DDOC. For almost two (2) years CCS has consistently demonstrated its effectiveness in cooperating with multiple health services vendors (e.g. dental, pharmacy, mental health). CCS will continue to cooperate fully with DDOC health care service partners to ensure quality of care, access to care, and continuity of care for all offenders in the DDOC system.

2.6.16 Reporting Requirements

CCS understands that the DDOC will implement performance measures in conjunction with the State's performance based budgeting. Therefore, CCS will collect and report data as requested by the DDOC in order to verify performance of specific tasks.

Data Entry
As the current Medical Services provider, CCS is familiar with DACS. CCS will continue to enter information into DACS as required. Additionally, CCS will continue to implement ERMA and use the EMAR in conjunction with Correct Rx.

Other Reporting
CCS agrees to submit any information and reports requested by the DDOC substance abuse treatment services administrator. CCS will use DDOC specified forms for any such reports and shall submit them within requested time periods.

Offender Tracking System
CCS will use ERMA to track all offender follow-up care services for offenders in community residential centers or agencies.

Progress Reports
CCS will provide the DDOC staff period progress reports on offenders as requested. CCS shall also provide special reports to parole boards as requested.

Treatment Compliance
CCS will assist the DDOC in maintaining compliance with State of Delaware laws applying to substance abuse treatment. This includes providing written reports and explanations, developing treatment plans, maintaining rosters of offenders, and providing discharge summaries.

2.6.17 Monthly Reports
CCS will continue to provide monthly statistical reports to the Bureau Chief no later than the 10th calendar day of each month. These reports will be expanded to include Mental Health and Sex Offender Treatment, Substance Abuse Services and DUI Programming, will include agency and provider contact information, ancillary services, and data that reflect the previous month's activity at the facility. CCS maintains an extensive logging system for collecting data and statistics to assist the State in analyzing trends in the utilization of health care services. The statistical data we provide to our clients on a monthly basis is discussed during both the MAC and quarterly CQI meetings.

CCS will provide the DDOC with monthly and quarterly statistical reports regarding financials and the operation of the Mental Health Services, Substance Abuse Treatment, DUI Program and Sex Offender Treatment contract, in accordance with the contract, requests by the DOC and national and local standards.

In addition, CCS has the ability to provide the DDOC with reports that demonstrate staffing fill rates, and compliance with the contracted staffing plan, as well as financial reports to aid the State in future budgeting. CCS will provide response to any reporting questions within two (2) working days.

2.6.18 Weekly Reports

In addition to the monthly reports listed previously, CCS will provide the DDOC with a weekly report that includes the following information:

- The average daily beds occupied in each program
- The daily average of vacant beds in each program
- The daily average of staff vacancies in each program
- The number of offenders on Key, Crest, or Aftercare waiting list
- Staffing Vacancies
- Other data as requested by the DDOC

2.6.19 Continuing Education

The CCS continuing education and training program builds on the foundation established in the orientation process and is in accordance with professional and legal standards. The CCS training department establishes self-study continuing education and training programs on a monthly basis. CCS maintains a continuing education provider license that provides personnel with continuing education credits, as an employee benefit. CCS distributes the self-study training programs electronically, and participants who successfully complete the program receive a certificate of completion. Following is sample list of CCS Continuing Education topics for self-study. Continuing professional development serves to improve the quality of service and helps reduce risk and grievances for the DDOC

Sample List of Continuing Education Topics	
Title	Credit
Prison Rape Elimination	1.0
EPS Training	1.0
The Process of Recovery in Depression: From the Initial Treatment to a Successful Outcome	1.0
OSHA Update 2012	1.0
Annual Suicide Training	2.0

Figure 18: *Sample Self-Study Continuing Education Topics.*

Correct Care Solutions is committed to the development of our team members. As part of this commitment, CCS has also arranged for its members to have access and receive Continuing Education Credit (CNE credits) from Medscape. Medscape is an on-line resource depository of clinical information and education. It includes medical articles, recaps from conferences, research links and CNEs.

While it is the responsibility of each CCS staff member to secure her/his own development, CCS provides tools to further the success of its team members.

Additionally, on-site CCS healthcare personnel will complete inservice training and education programs on topics and issues specific to issues at the DDOC. CCS identifies new topics on an

on-going basis through the Quality Improvement Program. CCS maintains a video library and other reference materials that sites can use to facilitate their site-specific training programs. CCS also utilizes community resources when available and appropriate. The CCS Training Department provides technical assistance.

Additionally, all healthcare staff will maintain current CPR/AED certification and attend appropriate workshops to maintain their licensure. The CCS HSA maintains documentation of completed training in an individualized training record for each employee.

On-Site Reference Library/Educational Resources

CCS will provide an up-to-date medical reference library at the DDOC accessible at all times by Mental Health personnel. Reference materials shall include basic reference texts related to diagnosis and treatment. CCS also allows access to **UpToDate,** our on-line reference materials.

UpToDate® Online Clinical Knowledge Base and Tools

*In one study, 90% of **UpToDate** users reported that **the Knowledge Base Tools** make them a better doctor.*

Always seeking avenues to provide our staff with the best and most current evidence-based resources required to provide the best quality care, CCS has recently incorporated *UpToDate*®, with online clinical information on over 7,700 topics, into our employee website. *UpToDate* is a third-party product that CCS has licensed and provides to each of our sites. It includes current information on Drug Interactions, Medical Calculators, Current Specialty Information, and Patient Information on more than 400 topics that a provider can reference, print and share with a patient. All CCS medical providers, including the entire nursing staff, are now able to access *UpToDate* materials through internet access.

UpToDate covers more than 7,700 topics in 14 medical specialties and includes more than 80,000 pages of text, graphics, links to Medline abstracts, more than 260,000 references, and a drug database. Content is reviewed and edited continuously with an updated version of *UpToDate* being released every four months.

UpToDate includes treatment recommendations based on the best medical evidence. Recommendations are kept current as new studies are released and practices change.

UpToDate is evidence-based and uses a literature-driven updating system; more than 430 journals are monitored by editors and authors, and anytime something of importance is published, it is incorporated into the program. The key word here is “incorporated.” *UpToDate* is not a journal watch. New studies are not simply added, but rather they are placed in the context of what has already been published in that field.

This instant availability of continuously updated, evidence-based healthcare information, accessible from inside the patient record, will aid medical staff in providing the highest quality of care. In one study, 90% of *UpToDate* users reported that *UpToDate* makes them a better doctor.

2.6.20 Work Schedule

CCS will work closely with the DDOC regarding the schedule for mental health service provision that best fits the needs of each facility, to include on-call schedules that cover all facilities seven (7) days per week, 24 hours per day, including state observed holidays. CCS understands that mental health services are needed at times outside of the regular business day and business week, and our staffing matrix at each facility will reflect recognition of those needs. Please refer to the CCS Staffing Plan in **Section 2.7** for detailed staffing information for each facility.

2.7 Mental Health Staffing Plan

In addition to the staffing plans developed for the Substance Abuse and DUI programming components of the RFP located in **Section 2.2.22**, CCS has established separate staffing plans for the Mental Health and Sex Offender Treatment Services in order to clearly outline the designated staff for the various components of our comprehensive program. Staffing plans for the Sex Offender Treament Component can be located in **Section 2.3.5**. As your current Medical Services Provider, we feel we have a thorough understanding of the needs of the DDOC and the uniqueness of each facility. We have designed our staffing plans to ensure the needs of each facility are met and so that timely and effective care can be provided to our patients. Our plans were developed in consideration of the staffing recommendations outlined in Appendix E, the needs of each individual facility and from information gathered in discussion with some potential CCS Mental Health leadership individuals.

In addition, we have collaborated with partners who have the extensive knowledge and experience to provide what we believe to be a thorough and innovative approach that will provide reliable, high quality and cost effective services for the DDOC.

We welcome the opportunity to further discuss any questions that you may have regarding our plans.

In addition to the Regional Staff reflected in our plan, the DDOC, individual facilities and the Delaware Regional Office will have support from a variety of departments in our Nashville corporate office including:

- A designated human resources recruiter
- A designated payroll technician
- A designated accounts payable manager
- Nashville Chief Psychiatry and VP of Mental Health support
- Legal counsel
- Risk Management
- Case management
- IT and Network Development Support

The Staffing designated for Mental Health Services (not inclusive of Substance Abuse, DUI Programming or Sex Offender Treatment) follows:

2.7.1 CCS Combined Mental Health Staffing

State of Delaware DOC								
Position	**Shift**	**Regional Office**	**Sussex, SCC & SVOP**	**James T. Vaughn, Morris & CVOP**	**Howard R. Young**	**Baylor, WWRC, Webb & Plummer**	**State Total FTE**	**State Total Hours**
DAY SHIFT								
Regional MH Director	Day	1.00					1.00	40.00
Psych Director	Day	1.00					1.00	40.00
CQI Coordinator	Day	1.00					1.00	40.00
Admin Assistant/Secretary	Day	1.00	1.00	1.00	1.00	1.00	5.00	200.00
Psychiatrist*	Day		0.50	2.00	0.50	0.50	3.50	140.00
Psychologist	Day		0.00	1.00	0.60	0.40	2.00	80.00
NP Psychiatric*	Day		1.00	1.50	1.00	0.75	4.25	170.00
Mental Health Director	Day		1.00	1.00	1.00	1.00	4.00	160.00
Mental Health Supervisor	Day		1.00	2.00	1.00	1.00	5.00	200.00
Mental Health Professional	Day		4.50	7.50	4.50	2.50	19.00	760.00
Activity Aide (Rec. Tech)	Day		0.00	3.00	0.00	0.00	3.00	120.00
Clerk - MH Clerk	Day		1.00	2.00	1.00	1.00	5.00	200.00
MH Observer	Day		2.00	2.00	2.00	2.00	8.00	320.00
Mental Health Professional	WE Day		0.40	0.40	0.40	0.40	1.60	64.00
MH Observer	WE Day		0.80	0.80	0.80	0.80	3.20	128.00
TOTAL FTEs - Day		***4.000***	***13.200***	***24.200***	***13.800***	***11.350***	***66.550***	***2,662.00***
EVENING SHIFT								
Mental Health Professional	Evening		0.50	0.50	0.50	0.50	2.00	80.00
MH Observer	Evening		2.00	2.00	2.00	2.00	8.00	320.00
Mental Health Professional	WE Evening		0.00	0.00	0.00	0.00	0.00	0.00
MH Observer	WE Evening		0.80	0.80	0.80	0.80	3.20	128.00
TOTAL FTEs - Evening		***0.000***	***3.300***	***3.300***	***3.300***	***3.300***	***13.200***	***528.000***
NIGHT SHIFT								
MH Observer	Night		2.00	2.00	2.00	2.00	8.00	320.00
MH Observer	WE Night		0.80	0.80	0.80	0.80	3.20	128.00
TOTAL FTEs - Night		***0.000***	***2.800***	***2.800***	***2.800***	***2.800***	***11.200***	***448.000***
TOTAL FTEs Per Week		***4.000***	***19.300***	***30.300***	***19.900***	***17.450***	***90.950***	***3,638.00***

**May substitute (1) hour of Psychiatrist time for (2) hours of mid-level practitioner time, as necessary and with DDOC approval.*

2.7.2 Regional Office

Correct Care Solutions									
State of Delaware DOC Mental Health - Regional									
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Total FTE**
DAY SHIFT									
Regional MH Director	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Psych Director	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
CQI Coordinator	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Admin Assistant/Secretary	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
TOTAL FTEs - Day								***160.00***	***4.00***
EVENING SHIFT									
TOTAL FTEs - Evening								***0.00***	***0.00***
NIGHT SHIFT									
TOTAL FTEs - Night								***0.00***	***0.00***
TOTAL FTEs Per Week								***160.00***	***4.00***

2.7.3 Sussex, SCCC & SVOP

Correct Care Solutions									
Sussex, SCCC & SVOP								**ADP**	**1670**
								Mental Health	**311**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Admin Assistant/Secretary	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Psychiatrist*	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
Psychologist	PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
NP Psychiatric*	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Director	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Supervisor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Professional	36.00	36.00	36.00	36.00	36.00	8.00	8.00	196.00	4.90
Clerk - MH Clerk	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Day								***528.00***	***13.20***
EVENING SHIFT									
Mental Health Professional	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Evening								***132.00***	***3.30***
NIGHT SHIFT									
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Night								***112.00***	***2.80***
TOTAL FTEs Per Week								***772.00***	***19.30***

**May substitute (1) hour of Psychiatrist time for (2) hours of mid-level practitioner time, as necessary and with DDOC approval.*

2.7.4 James T. Vaugh, Morris and CVOP

Correct Care Solutions									
James T. Vaugh, Morris and CVOP								**ADP**	**2550**
								Mental Health	**508**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Admin Assistant/Secretary	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Psychiatrist*	16.00	16.00	16.00	16.00	16.00	0.00	0.00	80.00	2.00
Psychologist	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
NP Psychiatric*	12.00	12.00	12.00	12.00	12.00	0.00	0.00	60.00	1.50
Mental Health Director	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Supervisor	16.00	16.00	16.00	16.00	16.00	0.00	0.00	80.00	2.00
Mental Health Professional	60.00	60.00	60.00	60.00	60.00	8.00	8.00	316.00	7.90
Activity Aide (Rec. Tech)	24.00	24.00	24.00	24.00	24.00	0.00	0.00	120.00	3.00
Clerk - MH Clerk	16.00	16.00	16.00	16.00	16.00	0.00	0.00	80.00	2.00
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Day								***968.00***	***24.20***
EVENING SHIFT									
Mental Health Professional	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Evening								***132.00***	***3.30***
NIGHT SHIFT									
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Night								***112.00***	***2.80***
TOTAL FTEs Per Week								***1,212.00***	***30.30***

**May substitute (1) hour of Psychiatrist time for (2) hours of mid-level practitioner time, as necessary and with DDOC approval.*

2.7.5 Howard R. Young

Correct Care Solutions									
Howard R. Young								**ADP**	**1650**
								Mental Health	**249**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Admin Assistant/Secretary	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Psychiatrist*	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
Psychologist	8.00	0.00	8.00	0.00	8.00	0.00	0.00	24.00	0.60
NP Psychiatric*	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Director	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Supervisor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Professional	36.00	36.00	36.00	36.00	36.00	8.00	8.00	196.00	4.90
Clerk - MH Clerk	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Day								***552.00***	***13.80***
EVENING SHIFT									
Mental Health Professional	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Evening								***132.00***	***3.30***
NIGHT SHIFT									
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Night								***112.00***	***2.80***
TOTAL FTEs Per Week								***796.00***	***19.90***

**May substitute (1) hour of Psychiatrist time for (2) hours of mid-level practitioner time, as necessary and with DDOC approval.*

2.7.6 Baylor & WWRC, Webb, and Plummer

Correct Care Solutions									
Baylor & WWRC, Webb, and Plummer								**ADP**	**450**
								Mental Health	**198**
Position	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Hrs/Wk**	**Site Total FTE**
DAY SHIFT									
Admin Assistant/Secretary	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Psychiatrist*	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
Psychologist	0.00	8.00	0.00	8.00	0.00	0.00	0.00	16.00	0.40
NP Psychiatric*	6.00	6.00	6.00	6.00	6.00	0.00	0.00	30.00	0.75
Mental Health Director	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Supervisor	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
Mental Health Professional	20.00	20.00	20.00	20.00	20.00	8.00	8.00	116.00	2.90
Clerk - MH Clerk	8.00	8.00	8.00	8.00	8.00	0.00	0.00	40.00	1.00
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Day								***454.00***	***11.35***
EVENING SHIFT									
Mental Health Professional	4.00	4.00	4.00	4.00	4.00	0.00	0.00	20.00	0.50
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Evening								***132.00***	***3.30***
NIGHT SHIFT									
MH Observer	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	2.80
TOTAL FTEs - Night								***112.00***	***2.80***
TOTAL FTEs Per Week								***698.00***	***17.45***

**May substitute (1) hour of Psychiatrist time for (2) hours of mid-level practitioner time, as necessary and with DDOC approval.*

2.7.7 On-Call Telepsychiatry Staffing

In addition to the on-site staffing and the local on-call services, CCS has reached agreement with two Psychiatrists to provide on-call telepsychiatry services as needed for initial evaluations, for routine follow-up care, for emergency services, and for provider consults. If CCS is awarded this contract, we will work with these providers to ensure each is properly licensed to practice psychiatry in Delaware. We will also add additional telepsychiatry providers to provide on-call services as necessary.

Following are the letters of intent from Dr. Johnson and from Dr. Spells to provide these services for CCS in Delaware.

9 April 2012

Benjamin Sohr
Vice President, Specialized Services
Correct Care Solutions
1283 Murfreesboro Rd
Suite #500
Nashville TN 37217

Dear Mr. Sohr

I am aware that Correct Care Solutions (CCS) is submitting a proposal in response to the Delaware Department of Correction Professional Services Request for Proposal to provide Correctional Mental Health Services (Contract No. DOC-1202Mental). I am extremely interested in working with CCS to provide Telepsychiatry services in support of this contract.

I am currently working in Telepsychiatry and have been for approximately four years. My responsibilities include initial evaluations and routine follow up care, emergency services for consults to manage difficult psychiatric patients, on call duties after hours and safety check and determine if the inmates are able to return to the general population. I have fellowship training in Geriatric Psychiatric and I am very comfortable working with the elderly prison population as well.

This letter of intent (LOI) confirms my willingness to work with CCS as a Telepsychiatry provider. In the event that CCS is awarded a contract in Delaware, I agree to provide CCS with Telepsychiatry services as directed. I agree that I must obtain a license to practice psychiatry in the State of Delaware and undergo the CCS credentialing process before providing services in Delaware.

Sincerely

William Johnson MD

William Johnson MD

Psychiatrist

Medical Consultants INC

3746 Old Coopertown Raod

Springfield TN 37172

Benjamin Sohr
Vice President, Specialized Services
Correct Care Solutions
1283 Murfreesboro Rd
Suite #500
Nashville TN 37217

Dear Mr. Sohr,

I am aware that Correct Care Solutions (CCS) is submitting a proposal in response to the Delaware Department of Correction Professional Services Request for Proposal to provide Correctional Mental Health Services (Contract No. DOC-1202Mental). I am extremely interested in working with CCS to provide Telepsychiatry services in support of this contract.

I provided on site Psychiatry services for two years at the Forsyth County Detention Center. I have provided Telepsychiatry services for two sites in Charlotte, North Carolina and one in Bolivia, North Carolina as a CCS contractor. In addition, I have telemedicine experience in my private practice. I have attached a copy of my curriculum vitae outlining my extensive Psychiatry experience and qualifications.

This letter of intent (LOI) confirms my willingness to work with CCS as a Telepsychiatry provider. In the event that CCS is awarded a contract in Delaware, I agree to provide CCS with Telepsychiatry services as directed. I agree that I must obtain a license to practice psychiatry in the State of Delaware and undergo the CCS credentialing process before providing services in Delaware.

Sincerely

Lori Spells, MD
Diplomate, American Board of Psychiatry and Neurology

3 Pricing

The Correct Care Solutions (CCS) proposal is complete and covers all required labor and materials necessary to provide the delivery system required to meet and/or exceed the scope of work required. In developing this cost proposal, CCS has attempted to provide the level of detail, clarity, and transparency of costs requested in the RFP.

CCS believes a fixed price scenario provides the DDOC with the most efficient method of managing the total costs for all required services while also providing a level of assurance in maintaining funding limits. A fixed price contract also provides CCS with the flexibility to work with the DDOC to place available resources in the areas of highest need. CCS is very familiar with the environment of economic pressures and budgetary constraints facing entities such as the DDOC.

CCS has a history of partnering with our clients to meet their needs in managing costs and developing solutions to operational and financial issues. We look forward to partnering and working with the DDOC to provide all required services.

3.1 Substance Abuse Treatment Program Pricing

The CCS cost proposal includes subcontracted pricing from Community Education Centers (CEC) for all services related to the substance abuse treatment program for the DDOC.

The following chart identifies the initial year cost and the cost per offender per day for the substance abuse treatment program.

Total Annual Cost	Cost Per Offender Per Day (Based on an ADP of 7,000)
$5,091,206.00	$1.99

Based upon the RFP information and subsequent addenda, this price represents what we believe to be the most cost-efficient, full-service model of substance abuse treatment for the DDOC.

3.2 Sex Offender Treatment Program Pricing

The CCS cost proposal includes subcontracted pricing from The Counseling & Psychotherapy Center, Inc. (CPC) for all services related to the sex offender treatment program for the DDOC.

The following chart identifies the initial year cost and the cost per offender per day for the sex offender treatment program.

Total Annual Cost	Cost Per Offender Per Day (Based on an ADP of 7,000)
$759, 684.00	$0.30

Based upon the RFP information and subsequent addenda, this price represents what we believe to be the most cost-efficient, full-service model of sex offender treatment for the DDOC.

3.3 Mental Health Program Pricing

The CCS cost proposal includes CCS directly providing all required mental health program services other than the subcontracted substance abuse services provided by CEC and the subcontracted sex offender services provided by CPC.

The following chart identifies the initial year cost and the cost per offender per day for the mental health program services to be provided directly by CCS.

Total Annual Cost	Cost Per Offender Per Day (Based on an ADP of 7,000)
$8,937,292.00	$3.50

Based upon the RFP information and subsequent addenda, this price represents what we believe to be the most cost-efficient, full-service mental health services model for the DDOC.

3.4 Performance Bond

CCS has included the required performance bond in its pricing. CCS already provides a performance bond for DDOC medical services. The CCS price will be reduced by $60,000 if the DDOC elects to waive the requirement for an additional mental health performance bond.

3.5 Pricing Form (RFP Appendix C)

CCS has combined all direct and subcontracted costs for comprehensive mental health services on the required DDOC pricing form. The total year one cost for these services is $14,788,182.00.

DDOC, BCHS RFP

Vendor Name: ***Correct Care Solutions***

Mental Health AND Substance Abuse

Based on 7,000 Average Daily Population (ADP)

Fixed Costs *(should not include mark-up percent)*	
Dr./PA/CRNP (Mid-level Practitioners and above) Salaried Employees	$1,920,604
Dr./PA/CRNP (Mid-level Practitioners and above) Subcontractors	$264,556
Line Staff (Salaried Employees)	$4,185,171
Line Staff (Subcontractors)	$4,876,970
Performance Bond	$50,750
Professional Liability/Malpractice Insurance	$162,720
Subtotal	*$11,460,771*
Management Costs *(should not include mark-up percent)*	
Senior Management	$575,675
Administrative Overhead	$705,886
Office Space	$0
Indirect Costs	$326,981
Subtotal	*$1,608,542*
Variable Costs *(should not include mark-up percent)*	
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies & Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Worker's Comp. Insurance	$959,199
Subtotal	*$959,199*
Mark-up	
Service Fee	5.14%
Management Fee	*$720,670*
Profit Over Costs	$0
Annual Base Total	*$14,749,182*
Year 1 Performance Incentive Potential*	*$39,000*
Potential Year 1 Not to Exceed Total	**$14,788,182**

Cost Price Inflation Not to Exceed Total	
*Year 2***	*$ 15,231,827*
*Year 3***	*$ 15,688,782*
*Year 4***	*$ 16,159,446*

Cost per offender/day $ 5.79

*Performance Incentives to begin in month 7.

3.6 Inflation Factors

CCS has included a maximum annual inflation factor of 3%. CCS will work with the DDOC to determine the best actual method of annual inflation calculation.

3.7 Performance Incentives

CCS has included at-risk dollars for performance incentive purposes. CCS proposes to utilize each of the sixty-five (65) mental health quality assurance categories identified in RFP Appendix B as measurement for these performance incentives. Each of these sixty-five (65) categories includes a mental health indicator and a clear compliance goal.

CCS proposes the DDOC reimburse CCS $100 per month for each of these sixty-five (65) compliance goals that are achieved. CCS is confident in its ability to achieve these goals and is willing to place $78,000 per year (approximately 10%, of its annual management fee) at risk to ensure goal alignment. CCS will use the performance incentive dollars to reward its DE Mental Health staff with performance bonuses.

CCS expects six (6) months to enact its policies and procedures prior to these compliance goals being formally tracked. As a result, the CCS at-risk performance incentive potential in year one is actually $39,000 (50% of the $78,000 possible per year).

3.8 CCS Staffing Costs

The chart below represents staffing costs by position for the 90.95 positions being directly provided by CCS. Complete staffing plans are included in the staffing section of this proposal.

Correct Care Solutions Pricing For Mental Health Services for the Delaware DOC Mental Health Staffing Cost Analysis for All Positions Directly Provided By Correct Care Solutions*				
Position Type	FTEs	Hourly Rate	Annual Salaries	Total Annual Cost
Regional MH Director	1.00	$53.00	$134,553	$134,553
Psych Director	1.00	$132.50	$336,384	$336,384
CQI Coordinator	1.00	$25.50	$64,738	$64,738
Admin Assistant/Secretary	5.00	$14.00	$35,542	$177,712
Psychiatrist	3.00	$117.00	$389,069	$1,167,206
Psychiatrist (CONTRACTED)	0.50	$128.70	$275,727	$137,863
Psychologist	2.00	$50.00	$139,261	$278,522
NP Psychiatric	4.25	$52.00	$144,832	$615,535
Mental Health Director	4.00	$34.00	$94,698	$378,790
Mental Health Supervisor	5.00	$26.00	$72,416	$362,079
Mental Health Professional	22.60	$24.00	$71,159	$1,608,193
Activity Aide (Rec. Tech)	3.00	$18.00	$50,134	$150,402
Clerk - MH Clerk	5.00	$14.00	$35,542	$177,712
MH Observer	33.60	$11.00	$41,880	$1,407,184

**Excludes subcontracted positions for Substance Abuse, DUI Programming, and Sex Offender Treatment provided through CEC and CPC.*

3.9 CEC Staffing Costs

The chart below represents staffing costs by position for the 97.5 positions being subcontracted for substance abuse services by CEC. Complete staffing plans are included in the staffing section of this proposal.

CEC Staff Costs for Substance Abuse Services				
	FTEs	Annual Salaries	With Fringe	Total Annual Cost
Statewide Director	0.5	$ 90,000.00	$ 119,970.00	$ 59,985.00
Deputy State Director	1	$ 60,000.00	$ 79,980.00	$ 79,980.00
Case Flow Manager	1	$ 36,000.00	$ 47,988.00	$ 47,988.00
State Office Manager	1	$ 37,000.00	$ 49,321.00	$ 49,321.00
Program Director	7	$ 54,000.00	$ 71,982.00	$ 503,874.00
Clinical Supervisors	10	$ 44,000.00	$ 58,652.00	$ 586,520.00
Counselors	69	$ 30,000.00	$ 39,990.00	$ 2,759,310.00
Admin Assistants	8	$ 29,000.00	$ 38,657.00	$ 309,256.00

3.10 CPC Staffing Costs

The chart below represents staffing costs by position for the 6.0 positions being subcontracted for sex offender treatment services by CPC. Complete staffing plans are included in the staffing section of this proposal.

CPC Staff Costs for Sex Offender Treatment Services					
	FTEs	Hourly Rate	Annual Salaries	With Fringe	Total Annual Cost
Dr./PA/CRNP (Mid-level Practitioners and above)	2.5	$ 43.12	$ 89,680	$105,822	$264,556
Line Staff	3.5	$ 35.00	$ 72,802	$ 85,907	$300,674

4 References

4.1.1 Kansas Department of Corrections

Customer Name	Kansas Department of Corrections		
Address	900 Jackson, Suite 900- Landon State Office Building - Topeka, KS 66612		
Contact Name	Viola Riggin, Director of Health Services		
Phone	785-296-0045	**Fax**	785-296-0304
Contact E-mail	violar@kdoc.dc.state.ks.us		
Period of Performance	October 2003 – Present		
Accreditation	NCCHC		
ADP	9,000 inmates — 10 prison facilities		

Summary of Services Provided:

CCS is responsible for the Mental Health care of the 9,000 inmates in the custody of the KDOC, including intensive services for the severely mentally ill at Larned Mental Health Facility and the Treatment and Reintegration Unit at Lansing Correctional Facility. Across the state all Mental Health Coordinators and Clinical Supervisors are Certified Correctional Health Professionals.

CCS is also responsible for Medical and Dental care of the inmates at the KDOC. CCS provides over 360 FTEs inclusive of Mental Health, Medical, and Dental. CCS is responsible for all utilization management functions and strives to continue to find ways to save our client dollars by bringing additional services on-site.

★★★★★★★★★★

"Your company has managed to master the art of providing healthcare in the correctional environment while assisting the KDOC in keeping our costs for healthcare at a reasonable level."

"Our inmate grievances and lawsuits have reduced dramatically since CCS took over the contract. The rate of inmate overall satisfaction is the highest KDOC has ever experienced since contracted services began in 1988."

Viola Riggin, Senior Contract Manager
Kansas Department of Corrections

★★★★★★★★★★

Significant Achievements and Successes:

CCS has had tremendous success in Kansas, including:

- Launched, in conjunction with other Kansas organizations, one of the nation's most proactive discharge planning programs to assist with decreasing recidivism.
- The Mental Health Teams at Larned Mental Health Facility and at the Treatment and Reintegration Unit at Lansing Correctional Facility work with community agencies to put on annual talent shows for staff to showcase the music and art abilities of the inmates.
- Bringing oncology services on-site for the first time and creating a center of excellence for our cancer patients.
- Decreasing grievances and litigation while increasing inmate satisfaction.
- Significantly improved relations with community providers which ultimately led to greater savings and more on-site services being provided.

- Greatly improved staff morale and client relations.
- Created a state wide pharmacy program that has created significant savings for County jails throughout Kansas.
- CCS has successfully passed NCCHC accreditation audits at all facilities.
- The CCS Kansas DOC Hospice program has been recognized by the National Hospice and Palliative Care Organization (NHPCO).

4.1.2 Vermont Department of Corrections

Customer Name	State of Vermont Department of Corrections
Address	103 South Main Street Waterbury, VT 05671
Contact Name	Trudee Ettlinger, Director of Health Services and Chief Nursing Officer
Phone	802-241-2371
Contact E-mail	Trudee.ettlinger@ahs.state.vt.us
Period of Performance	February 2010 – Present
Accreditation	NCCHC
ADP	1600 Inmates, $16.1M

Summary of Services Provided:
CCS is responsible for the comprehensive medical, mental health, and dental needs of the 1,600 inmates in the custody of the VTDOC. The VT system is all inclusive of both jails and sentenced inmates (prisons). CCS provides over 200 dedicated staff members to administer medical care inclusive of mental health and dental care across the state. CCS is responsible for all utilization management functions and thrives to continue to find ways to save our client dollars by bringing additional services on-site.

Significant Achievements and Successes:
In Vermont, CCS took over the Mental Health program from the same provider that currently provides services in Delaware. After transitioning the contract, the CCS Mental Health Department in Vermont has made vast improvements in communication between medical and mental health staff, mental health and the Vermont Department of Corrections, and among mental health and administration at each facility.

CCS has worked closely with the VT DOC to streamline services from a formerly fragmented system with mental health and medical provided by separate providers to a consolidated model. Considering the size of Vermont, CCS was thrilled to be selected to provide both mental health and medical services. CCS accomplishments include a dramatic decrease in agency nurses, a significant decrease in lawsuits and grievances, as well as improved relations with community advocacy groups.

On the next page, we have included a letter of reference from the VT DOC.

STATE OF VERMONT
Department of Corrections
[phone] 802-241-2442
Agency of Human Services

February 9, 2012

Jerry Boyle
President and CEO
Correct Care Solutions
3343 Perimeter Hill Drive, Suite 300
Nashville, TN 37211

Dear Jerry,

I am delighted to write this letter of recommendation for Correct Care Solutions (CCS) on behalf of the Vermont Department of Corrections.

CCS assumed responsibility for the Medical and Mental Health Services for the Vermont inmate population on February 1, 2010. Our previous providers were both well known in the field of correctional health and mental health services.

Since having been awarded the contract for provision of comprehensive health services in Vermont CCS has worked with our Vermont Health Services Division and Security teams to improve the quality of care and communication on all levels. CCS has worked to implement a plan that is committed to a solutions oriented approach to the unique challenges in Vermont and has demonstrated the ability to execute quality services to address the medical and mental health needs of our population.

We are confident that CCS continually strives to meet our mutual goals and has developed a true partnership with the Vermont DOC and our community providers.

We endorse CCS as a Medical and Mental Health Services provider!

Sincerely,

Delores Burroughs-Biron, RN, MSN, MD
Health Services Director Vermont DOC

VERMONT

4.1.3 Nebraska Department of Corrections

Customer Name	Tecumseh State Correctional Institution		
Address	Folsom and W. Prospector Place, Building 1 Lincoln, NE 68509-4461		
Contact Name	Robert Houston, Director		
Phone	402-335-5142	**Fax**	402-335-5123
Contact E-mail	rhouston@dcs.state.ne.us		
Period of Performance	September 1, 2005 – Present		
Accreditation	ACA		
ADP	950		

Summary of Services Provided:
CCS is responsible for the comprehensive medical, mental health, and dental needs of the inmates at Tecumseh State Correctional Institution. CCS is also responsible for all utilization management functions and strives to continue to find ways to save our client dollars by bringing additional services on-site.

Significant Achievements and Successes:
In 2011 Tecumseh State Correctional Institution received the state Multi-disciplinary Team Award for the collaborative efforts of custody, housing, medical, mental health, and psychiatry staff in the treatment and care of inmates with special mental health and medical needs. CCS provides the psychiatric services at Tecumseh and the Psychiatrist plays an instrumental role on the Team.

4.1.4 Davidson County, Tennessee

Customer Name	Davidson County Sheriff's Office
Address	506 2nd Avenue North Nashville, TN 37201
Contact Name	John Ford, Chief
Phone	615-862-8955
Contact E-mail	jford@dcso.nashville.org
Period of Performance	October 2005 to Present
Accreditation	ACA
ADP	2,800

Summary of Services Provided:
CCS is responsible for the comprehensive healthcare needs of the up to 2,800 inmates in the custody of the Davidson County Sheriff's Office, which are housed in five (5) separate facilities. CCS provides 24-hour day coverage inclusive of medical, mental health, and dental. CCS is responsible for all utilization management functions and strives to continue to find ways to save our client dollars by bringing additional services on-site.

★★★★★★★★★★

"While I have been extremely impressed with CCS' responsiveness, I have been even more impressed with the level of excitement and enthusiasm which has been instilled in your line staff. This is refreshing! It gives me great comfort to know that your staff respects your organization and its commitment to quality."

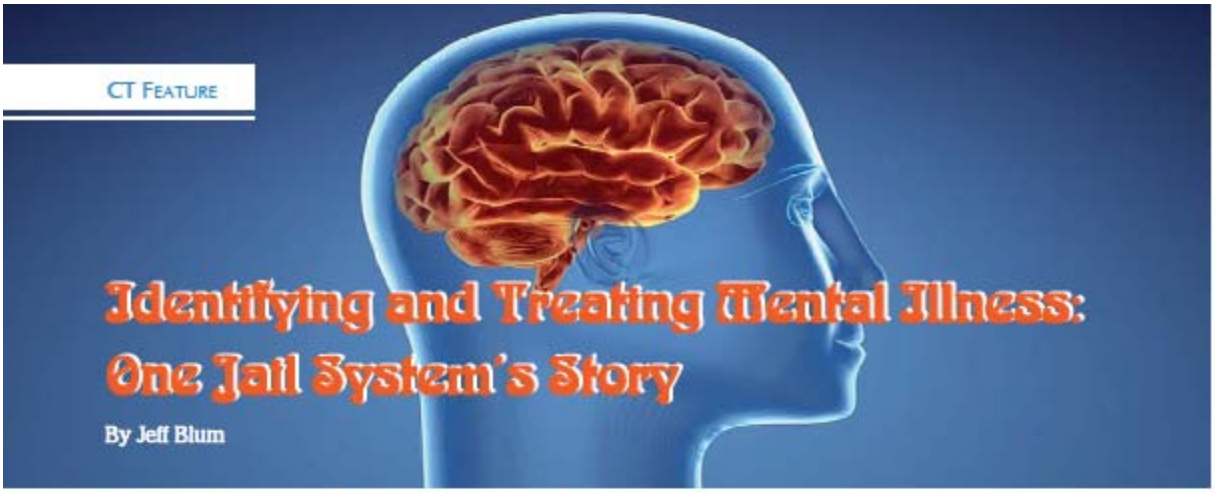
Sheriff Daron Hall
Current ACA President
Davidson County, TN

★★★★★★★★★★

Significant Achievements and Successes:

The CCS impact on Davidson County has been phenomenal since taking over this account from Corizon (formerly PHS) in 2005. CCS has reduced off-site trips from 214 per month to fewer than 100 per month even though the population has increased by 30+%. Grievances are lower than prior to CCS and overall care has improved. CCS was able to negotiate a 30% discount at local Vanderbilt hospital when the previous provider never received a discount. This discount alone yields more than $300,000 in annual savings for the County. CCS also partnered with a local mental health provider to provide a unique means to connecting care between the jail and the community. CCS worked closely with command staff as the largest of the five facilities went through a complete remodeling, including the booking area. CCS implemented numerous initiatives that improved efficiencies and eliminated backlog issues at Intake, which were a problem prior to CCS starting. CCS was responsible for implementing a "flag" system to identify chronic care patients and mental health patients at Intake, querying community mental health databases at Intake, implementing an CCS implemented a full Electronic Medical Records system that interfaces with the Jail Management System, community mental health system, pharmacy and lab vendors.

In Davidson County, CCS runs a collaborative Mental Health Care program which has been recognized for its success reorganizing the treatment approach and treatment philosophy of mental health issues within the jail. The following article was published in the *Corrections Today Magazine* (August 2007 issue), a publication of ACA.



CT Feature

Identifying and Treating Mental Illness: One Jail System's Story

By Jeff Blum

Some day, modern medicine may allow the exact diagnosis and treatment of brain disorders with the same level of certainty that exists for physical maladies such as diabetes or cancer. Currently, however, there is a great deal of subjectivity inherent in the process of diagnosing and treating what is commonly referred to as mental illness. For correctional facilities, this process can be particularly daunting because the lines between what is recognized as severe and persistent mental illness, personality disorders, trauma, addiction, and just plain meanness is often blurred.

Female Offenders and Mental Health

Diagnosis and treatment of mental illness in the female offender population has presented a challenge for the Davidson County Sheriff's Office in Nashville, Tenn. As in most correctional facilities, the female population has doubled in the past 15 years. All female pretrial detainees, convicted misdemeanants and convicted felons at the sheriff's office with up to a six-year sentence were under the care of a private prison provider between 1994 and 2004. The private provider had total responsibility for the detention and incarceration of the offenders in addition to the diagnosis and treatment of mental illness.

In 2004, the sheriff's office constructed a stand-alone women's facility and began the process of transitioning the 400-plus female inmates from the private provider to the Correctional Development Center-Female. The sheriff's office decided to keep all medicated inmates on the same medication for a period of six weeks after the transition. At the time of the transition, almost 70 percent of the women were diagnosed as having a mental illness and were receiving psychotropic medication.

As the offenders acclimated to the new facility and the sheriff's office mental health care provider had an opportunity to review files, there was concern that many of the offenders were being unnecessarily medicated. When the period of transition was complete, some medications were changed and others discontinued entirely if the mental health provider determined that the diagnosis of mental illness was inaccurate. As new female inmates cycled through the system and a more careful medication policy was instituted, the percentage of women on psychotropic medications was reduced by about 25 percent to an average of 45 percent.

A Change in Mental Health Care

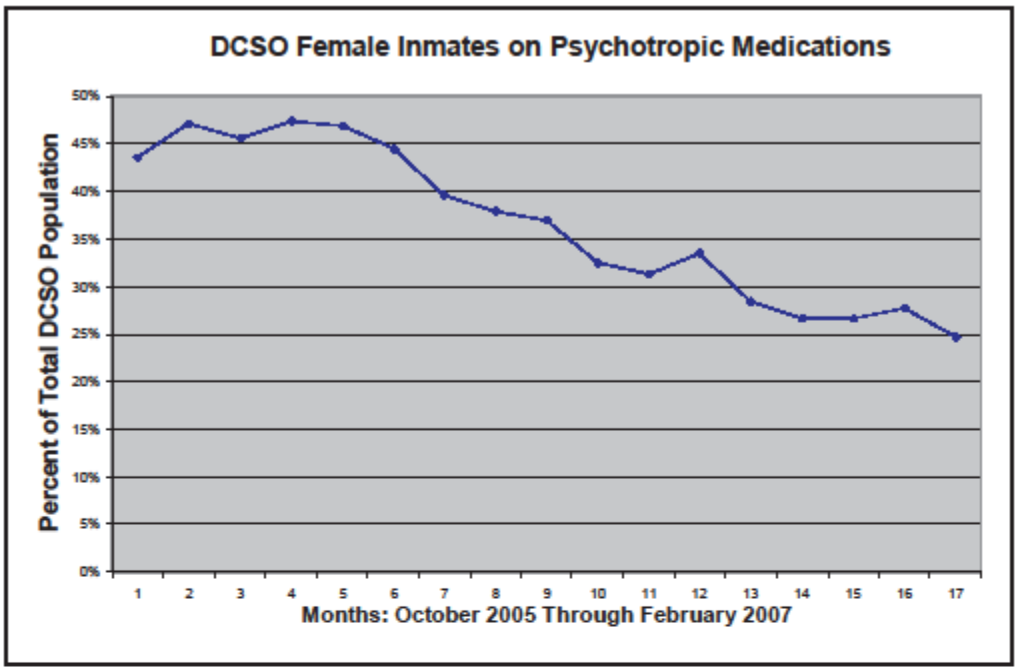
In October 2005, the sheriff's office awarded the contract for medical services to Correct Care Solutions, which had subcontracted with the Mental Health Cooperative (MHC) as the provider of mental health services. MHC came into the contract with extensive knowledge of the sheriff's office's client base and the criminal justice system.

As the largest provider of case-management services and the only provider of crisis services in Davidson County, MHC had been a primary player in the development of an extensive network of community and institutional mental health services focused on the criminal justice system. MHC also brought to the process a database containing information on more than 60,000 individuals encountered during its 10 years of case-management and crisis services. The information in this extensive database was critical to the changes in mental health care that would come later to the county's female offender population.

A History of Collaboration

Collaborative efforts between MHC and other mental health care providers in the criminal justice system started in 1994. The Criminal Justice and Mental Health Task Force was established through a modest grant from the Tennessee Bar Association, and — for the first time in Tennessee — the mental health community and criminal justice professionals sat at the same table and discussed common issues and clients.

It quickly became obvious that a core group of individuals with mental health and (in many instances) substance abuse issues were cycling through mental hospitals, community agencies and the jail. Despite a heavy investment of time and resources in these individuals by each agency, there was no sharing of information — or even the knowledge that these clients were receiving additional services.



Each agency was "reinventing the wheel" regarding these individuals, without the benefit of critical information from the other care providers. The rapid but confidential sharing of information became the primary goal of the task force.

The current collaborative effort depends on the sheriff's office admissions list, which is distributed daily by e-mail to all the community mental health centers in Davidson County. Since arrests are public information, the distribution of this list in no way breaches confidentiality. In order to permit the reciprocation of confidential information from community providers, mental health consumers who come under the care of any Davidson County community mental health centers sign releases that allow for contact with the sheriff's office regarding diagnosis, medication and mental health history if the client is arrested. Each morning, the providers compare the e-mailed admissions list with their client roster and contact the sheriff's office with critical information, making it possible to expedite diagnosis and medication.

The information provided by the community mental health centers is also entered into the "case notes" module of the sheriff's office jail management system, where offenders' names are flagged with a special-needs symbol that allows for quick identification, statistical analysis and the development of comprehensive reports.

The sheriff's jail docket report, containing vital information, such as diagnosis and community mental health provider, is printed daily and used by a sheriff's office mental health case manager, who serves as a liaison to the courts on issues of mental health. The mental health case manager has been instrumental in diverting a significant number of defendants with mental illness out of the criminal justice system and back to the community.

A comprehensive jail management system report, providing individual biographical, diagnostic, release and treatment information, is used in weekly case-review meetings attended by the sheriff's office mental health staff, clinicians from community mental health centers and sheriff's office representatives from classification, security, administration, case management, discharge planning and medical care. The information contained in the report, plus information from the broad spectrum of professionals attending the meeting, allows for careful monitoring of offenders during incarceration and interdisciplinary collaboration at the time of discharge.

A New Protocol

It was during the weekly case-review meetings that information from the comprehensive report brought into question the sheriff's office's longstanding policy of uncritically accepting diagnoses from past incarcerations and community providers. Over a period of six months of these weekly reviews (during which the arrest, incarceration and release of chronic offenders were charted), a pattern was recognized.

Many of the female offenders were initially diagnosed either by a private medical care provider or during a previous incarceration at the private facility when 70 percent of the population was being medicated. Although medicated while in custody and provided with a discharge plan that referred them to a community mental health center upon release, a majority of these offenders did not pursue treatment or medication in the community, returning to prostitution or other drug-related activities. Upon rearrest, offenders would request their previously prescribed medication even though they were not taking the medication in

the community. And, because of the aggressive medication policy of the sheriff's office, the medication was being provided based on the offenders' past history.

It was clinicians from the community mental health centers who began questioning many of the diagnoses and the prescribed medications. The sheriff's office policy of providing medication based on previous history, and this particular population's use of crack while in the community, resulted in their being under chemical influence for years at a time. Therefore, a protocol was instituted that allowed for a 30-day period of detoxification for any offender entering the system whose profile included a questionable diagnosis, substance abuse and a pattern of medication compliance only while incarcerated. During this 30-day period, offenders were closely monitored for any negative effects from the detoxification process and medicated if they developed clear symptoms of a psychotic disorder.

The results were startling. The percentage of women on psychotropic medication was cut by more than one-third, from 48 percent to 30 percent in six months — and the percentage has remained stable at 25 percent to 28 percent for the past five months. More important, however, many of the women learned through the detoxification protocol and substance abuse treatment that they can cope well without legal or illegal drugs.

In a sense, while trying to be part of the cure, the previous medication policy of the sheriff's office had been encouraging the very dependence upon chemicals that its treatment programs were trying to eliminate. Proper diagnosis allowed these offenders to confront and deal with the issues that had locked them into a cycle of chemical dependence and criminality.

The Opposition

As the new policy was implemented, and the amount of medication being distributed among the inmate population decreased, opposition arose from two distinct groups: inmates and correctional officers.

For many inmates, a mental health diagnosis had become an excuse for their criminal behavior — and the medication a substitute for the chemicals they abused on the street. Taking away the diagnosis and the medication forced them to come to grips with the true circumstances of their behavior and experience thought and emotion unaffected by chemicals.

For correctional officers, medication had become a chemical restraint. Under previous mental health care providers, powerful medications were administered for "sleep disorders," and many inmates literally slept through their period of incarceration. With the discontinuation of these medications, officers complained that the inmates were "too active" and "weren't sleeping all day," which made their jobs more difficult.

A Healthy Debate

Some mental health professionals may take issue with sheriff's office medication policies. They may credit the drop in the percentage of inmates on psychotropic medication as a function of under-diagnosis than careful screening, observation and medication management.

Recent headlines generated by the Bureau of Justice Statistics special report *Mental Health Problems of Prison and Jail Inmates* indicate that more than 55 percent of male inmates and 73 percent of female inmates are mentally ill. It is only by delving deeper into the substance of the report that one learns that, "The surveys did not assess the severity or duration of the symptoms, and no exclusions were made for symptoms due to medical illness, bereavement or substance use." In other words, if in the past year an individual experienced psychosis while high on cocaine, according to the BJS study, he or she had a "mental problem" rather than a substance abuse problem. If while incarcerated an offender learns of the death of his or her mother and that offender felt sad, it was counted as a "mental health problem" rather than a normal and healthy expression of grief.

By using the subjective label "mental problem," based on symptoms that may not be the result of the more clinical and objective finding of a severe and persistent mental illness, BJS may have furthered the negative public perception that inmates are "crazy" and, therefore, unpredictable and dangerous. Painting with such a broad brush inexorably links mental illness with criminality. It also exacerbates the existing stigma for individuals with a true severe and persistent mental illness who never encounter the criminal justice system, as well as for those discharged with mental illness who have been stabilized during incarceration and present no imminent danger to the community.

A More Humane Treatment Philosophy

Recent changes in treatment and medication policies in the Davidson County Sheriff's Office can be seen as an admission of a past error in judgment; it equated a liberal diagnosis and medication policy with humane treatment of the offender population. As an institution, the sheriff's office had bought into the hype that pervades American culture and is prevalent in the offender population — that every problem can be solved with a label and a pill.

With guidance from professionals at MHC, the administrators in the sheriff's office have come to the realization that the most humane treatment is the least intrusive intervention, free from stigmatizing labels, false promises and excuses for behavior. This is not an institutional excuse for minimizing services; rather, it is a mandate to expend the necessary resources to ensure accurate diagnosis and appropriate treatment. With this focus on proper diagnosis, the Davidson County Sheriff's Office reaps the benefits of a reduction in unnecessary and possibly harmful medication, while addressing the real issues that lock many inmates into an almost endless cycle of addiction, crime and incarceration.

Jeff Blum is the mental health coordinator for the Davidson County Sheriff's Office in Nashville, Tenn.

4.1.5 Mecklenburg County, North Carolina

Customer Name	Mecklenburg County Sheriff's Office		
Address	*801 East Fourth Street* *Charlotte, NC 28202*		
Contact Name	*Rachel Vanhoy, Business Manager*		
Phone	*704-336-2543*	***Fax***	*704-336-8585*
Contact E-mail	*Rachel.vanhoy@mecklenburgcountync.gov*		
Period of Performance	*October 1, 2008 – Present*		
Accreditation	*NCCHC*		
ADP	*2,800*		

Summary of Services Provided:
CCS is responsible for the comprehensive healthcare needs of the inmates in the custody of the Mecklenburg County Sheriff's Department. CCS provides 24 hour per day coverage inclusive of Medical, Mental Health, and Dental. CCS is responsible for all utilization management functions and strives to continue to find ways to save our client dollars by bringing additional services on-site.

Significant Achievements and Successes:
CCS revised the expectation of clinical licensure at the site and added Discharge Planning at the inception of the contact in 2008. Mental Health staff work closely with the VA and DFS to get services set up in the jail prior to release. Mecklenburg County Jail is also one of the leaders in Telepsychiatry for CCS.

4.1.6 Shelby County, Tennessee

Customer Name	Shelby County Division of Corrections
Address	*1045 Mullins Station Road Memphis, TN 38134*
Contact Name	*James Coleman, Director*
Phone	*901-377-4502*
Contact E-mail	*james.coleman@shelby-sheriff.org*
Period of Performance	*July 2006 – Present*
Accreditation	*NCCHC, ACA, CALEA (Jails), ACA (Prison)*
ADP	*6,000*

Summary of Services Provided:
CCS is responsible for the comprehensive healthcare needs of the inmates in the custody of both the Jail and DOC facilities in Memphis, TN. CCS provides 24-hour per day coverage inclusive of medical, mental health, and dental. CCS is responsible for all utilization management functions and continues to find ways to save our client dollars by bringing additional services on-site.

Significant Achievements and Successes:
Under its previous healthcare provider, the Shelby County facilities had been under a Department of (DOJ) Justice consent decree for over 12 years. Within eighteen months with CCS providing medical services, the decree was lifted. CCS added a proactive, therapeutic

special needs program for our seriously mentally ill inmates and juveniles and focused on significantly improving communication within the Mental Health Department and between Mental Health and Medical Services. Additionally, CCS transitioned the DOC from paper records and charts to our electronic medical records program, ERMA. When CCS took over the contract, we doubled the number of annual physicals being conducted each year, absorbed the significant volume increase in both Intakes and sick calls, and significantly reduced litigation and grievances from inmate population. Since contract inception, CCS has been under or at budget every year and was recently awarded a new contract through the competitive bid process.

With our oversight and commitment to standards and quality of care, the Shelby County is now ACA, CALEA and NCCHC accredited and the DOC is on track to be accredited by 2013.

4.1.7 Norfolk City, Virginia

Customer Name	Norfolk City Jail		
Address	*811 E. City Hall Avenue* *Norfolk, VA 23510*		
Contact Name	*Robert McCabe, Sheriff*		
Phone	*757-664-4951*	***Fax***	*757-441-2531*
Contact E-mail	*Robert.mccabe@norfolk.gov*		
Period of Performance	*July 1, 2004 – Present*		
Accreditation	*NCCHC*		
ADP	*1,800*		

Summary of Services Provided:

Norfolk City Jail was the first CCS jail client. CCS is responsible for the comprehensive healthcare needs of the inmates in the custody of the City of Norfolk's Sheriff Department. CCS is responsible for all utilization management functions and strives to continue to find ways to save our client dollars by bringing additional services on-site. CCS works closely with the Jail's command staff to deal with an overcrowded jail with significant physical challenges due to age, location, and layout.

★★★★★★★★★★

*"Though you have experienced some growth during the past year, you have remained true to your **commitment of being accessible**….as a client I feel valued and this sets CCS apart from your competitors."*

Sheriff Robert McCabe
Norfolk, VA
(Previously with CMS and PHS)

★★★★★★★★★★

Significant Achievements and Successes:

CCS has made tremendous improvements in the Norfolk program since transitioning this account from PHS (now part of Corizon). We have worked hard to stabilize staff, improve communication with command staff, and control costs. We have had a tremendous financial impact for the City by reducing off-site trips, decreasing pharmacy costs, and maximizing the

regional jail where the City is able to house 296 of its most needy population. In the first two years after taking over the contract, CCS refunded Cap dollars to Norfolk City. The previous provided had historically exceeded the Cap. CCS has successfully passed NCCHC accreditation, state of VA DOC audits, and Norfolk's internal PRIDE audits.

Since taking over the contact in 2005, the Mental Health team has participated in weekly pre-court team meetings to discuss active participants, those sanctioned to community service or jail terms, implementation of unique interventions, and discharge planning for those offenders who are currently incarcerated. In 2008 the Mental Health team helped in the development and implementation of the Post-Booking Mental Health Jail Diversion Service and in 2010 the Mental Health Coordinator was recognized as Outstanding Community Partner by Norfolk Probation and Parole. The Mental Health team most recently helped develop the Norfolk Mental Health Docket specifically designed for misdemeanants.

5 Proposal Summary

Thank you for the opportunity to respond to this RFP. CCS is proud to present its response to provide comprehensive Mental Health services, Substance Abuse treatment, DUI programming and Sex Offender treatment for the State of Delaware Department of Correction and we hope it demonstrates how we can continue to successfully build upon our existing partnership with the DDOC.

Why CCS Is The Right Partner for the DDOC Correctional Comprehensive Mental Health Services Program:

1. A proven track record of successfully managing Medical Services in the DDOC
2. A 100% success record in accreditation endeavors for the DDOC and all of our clients
3. CCS has developed a "Dream Team" in our partnership with Community Education Centers for Substance Abuse and DUI programming and the Counseling and Psychotherapy Center to manage Sex Offender Treatment
4. CCS has experience successfully integrating medical, mental health and substance abuse services
5. CCS believes in a proactive approach to treatment planning
6. CCS has a proven track record in the DDOC in the area of grievance reduction
7. CCS believes in developing community linkage programs with area Mental Health Agencies to provide the best continuity of care for its patient populations
8. Demonstrated internal recruiting excellence using full-time CCS staff
9. CCS has a focused approach to provider, staff and leadership training
10. The transition from your current provider to CCS would be seamless
11. We want your business, and we know you want the very best!

Our experience demonstrates that CCS and the DDOC share similar core values and we greatly value the partnership that has been developed. We believe CCS would be an excellent partner to provide comprehensive Mental Health services to the Delaware Department of Corrections. We look forward to enhancing our program in Delaware and our partnership with the DDOC and with continuing to demonstrate our abilities.

- We listen
- We understand
- We commit to the solution
- We partner for your success

Respectfully,

Patrick Cummiskey
EVP, Chief Development Officer
1283 Murfreesboro Road, Suite 500
Nashville, Tennessee 37217
615-324-5777 (direct)
615-324-5731 (fax)
pcummiskey@ccsks.com

LICENSE NO. 2010102630 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

LN: 12 50050 18

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 3LM2 5MN6#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
300 W WATER ST
DOVER DE 19904-6743

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 003

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

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FedEx 797941149880

INTERNET SITE

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LICENSE NO. 2010103165 DORM

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

LN: 12 50050 10

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 ALM2 5MN0#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
1201 COLLEGE PARK DR STE 101
DOVER DE 19904-8702

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 010

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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LICENSE NO. 2010102629 DORBL

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STATE OF DELAWARE
DIVISION OF REVENUE

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01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 19

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 2LM2 5MN8#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
23207 DUPONT BLVD
GEORGETOWN DE 19947-2664

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 002

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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REPLACEMENT LICENSES

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LICENSE NO. 2010102632 DDRBL

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STATE OF DELAWARE
DIVISION OF REVENUE

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ILN: 12 50050 15

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

2012

VALIDATED

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 5LM2 5MN1#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
620 BAYLOR BLVD
NEW CASTLE DE 19720-1140

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 005

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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REPLACEMENT LICENSES

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LICENSE NO. 2010102946 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

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BLN: 12 50050 14

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 9LM2 5MN3#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
660 BAYLOR BLVD
NEW CASTLE DE 19720-1140

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 009

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102818 DORSL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

TIN: 12 50050 17

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 7LM2 5MN7#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
875 SMYRNA LANDING RD
SMYRNA DE 19977-9653

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 007

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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REPLACEMENT LICENSES

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INTERNET SITE

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LICENSE NO. 2010102444 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 16

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 75.00

MAILING ADDRESS

BUSINESS LICENSE

BUSINESS LOCATION

#BWNKHPS
#15AK P0D0 1LM2 5MN0#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

CORRECT CARE SOLUTIONS LLC
1181 PADDOCK RD
SMYRNA DE 19977-9679

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 001

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102634 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 12

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 6LM2 5MN9#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
1301 E 12TH ST
WILMINGTON DE 19802-5315

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 006

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

Most licensees are also required to pay either gross receipts or excise taxes in addition to the license fee. You can file these taxes online or obtain a paper form from our website at www.revenue.delaware.gov. You must submit all business tax returns filed with the Division of Revenue under the same identification number. If you are a sole-proprietor, and have a federal employer identification number, use the employer identification number, not your social security number. Only sole proprietors with no employees are allowed to file under their social security number. Inquiries regarding your coupon booklets to pay withholding, corporate tentative, and Sub Chapter "S" estimated taxes, or to make changes to your name, address, or identification number, should be directed to the Business Master File Unit at (302) 577-8778.

1/12/12 - Sent to Site
FedEx 7979 4135 8802

INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102945 DDRBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 13

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 8LM2 5MN5#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
200 GREENBANK RD
WILMINGTON DE 19808-4760

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 008

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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FedEX 793110823345

INTERNET SITE

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LICENSE NO. 2010102631 DDRBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

BIN: 12 50050 11

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 4LM2 5MN4#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
38 TODDS LN
WILMINGTON DE 19802-3210

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 004

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

Davidson County Sheriff's Office
Davidson County Sheriff's Office Jail Facility
Nashville, Tennessee

March 21-23, 2011

VISITING COMMITTEE MEMBERS

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A. Introduction

The audit of the Davidson County Sheriff's Jails, Nashville, Tennessee was conducted on March 21-23, 2011, by the following team: Pat Keohane, Chairperson; William Seery, Member, Allan Westmoreland, Member; Melanie Gregory, Member.

B. Facility Demographics

Rated Capacity: (5 buildings in the jail complex)

Criminal Justice Center (CJC) Rated Capacity: 804

Hill Detention Center (HDC) Rated Capacity: 535

Correctional Development Center (CDC, male) Rated Capacity: 768

Correctional Development Center (CDC, female) Rated Capacity: 508

Offender Re-Entry Center (ORC, male and females), Capacity 300
(Note: ORC closed due to budget issues)

Total Capacity of the Davidson County Sheriff's jail: 2, 915

Actual Population: 2,436

Average Daily Population for the last 12 months:

CJC	HDC	CDC	Male	CDC, Female	ORC, male and females
641	508	608	411	268	

Total average offender population 2,436

Average Length of stay, Sentenced offenders: 15.9 months

Average Length of short-term stay at the jail: 20 days.

Security/Custody Levels:

Maximum	221
Medium	945
Minimum	996

Age Range of Offenders: Males 15-81 years of age
Females 16-76 years of age

Gender: Males and Females

Full-Time Staff: Administrative 5; Support 394; 443 Security:

C. Facility Description

The Davidson County Sheriff's Jail, Nashville, Tennessee is a large complex of buildings that house large numbers of both pre-trial and short sentenced offenders. The main facility is the Criminal Justice Center (CJC). It's located downtown close to the courts buildings. It is where all new offenders are processed into the jail, classified and moved to appropriate housing while in custody. It also houses the most difficult offenders or those who are most likely to cause security concerns while they are in custody. It's the oldest building with the most secure housing or Special Management housing areas. Most of the cells are located in this building.

The other downtown jail building is called Hill Detention Center (HDC). It is a converted warehouse into a jail. It is a medium or minimum classified area. It's mostly dormitory style housing and a portion of the facility is occupied by youthful offenders after the juvenile detention facility was damaged last year by the floods that occurred in the Nashville area.

This temporary arrangement pending repair of the juvenile building which is within sight of happening and moving the juveniles back to the building that is undergoing repair. Juvenile officers supervise the youthful offenders and all of them are separated from the adult offenders. The present count of juveniles is 15 and the area they occupy ties up 80 beds that are needed to manage the adult offenders. This is a contributing factor to the high count of adult offenders who are housed in the gym at (CJC).

About 5 miles away is the CDC-male unit. It is the third jail building and usually has about the same amount of offenders as the CJC downtown building. It is an all dormitory style housing facility and is newer than the two previous mentioned buildings.

The CDC-female unit is located adjacent to the male CDC facility. Most of the female building is double bunked cells and it has a Special Housing Unit.

All four buildings that make up the Davidson County Sheriff's jails require security checks of those entering into each building. Each front entrance requires walking through a metal detector and searches of one's person or what they are carrying into the buildings.

Surveillance cameras are mounted in most areas and are monitored in Central Control in each building. There is no armory or firearms stored in any of these buildings. Firearms and chemical agents are stored in the Davidson County Training academy Armory. Chemical agents issued by the department are carried by most officers.

Offender counts are all double counts. Inmates are required to be on their bunks during a routine count. All offenders have picture IDs and are required to carry them at all times.

Keys and tools are inventoried and all were in order and meet the standards.

D. Pre-Audit Meeting

The team met on Sunday, March 20, 2011 in Nashville, Tennessee, to discuss the information provided by the Association staff and the officials from Davidson County Sheriff's Office.

The chairperson divided standards into the following groups:

Standards # 4-ALDF-1A-01 to 4-ALDF-4B-09: Pat Keohane, Chairperson
Standards # 4-ALDF 5A-01 to 4-ALDF-5C-26: William Seery, Member
Standards # 4-ALDF-4C-01 to 4-ALDF-4D-28: Allen Westmoreland, Member
Standards # 4-ALDF-6A-01 to 4-ALDF-7F-07: Melanie Gregory, Member

E. The Audit Process

1. Transportation

The two audit team members, Mr. Keohane and Mr. Seery, were picked up at the airport and were escorted to the facility by two members of the Standards and Accountability Division; Mark Hadley and Kerry Hall of the Davidson County Sheriff's Office. The other two audit team members, Mr. Westmoreland and Ms. Gregory, were later picked up by Joey Friedman and Lynn Norris staff of the Division of the Sheriff's Office.

Those from the Sheriff's Office who provided transportation; Kim Perry, Kerry Hall, Mark Hadley, Joey Friedman and Darlene Holley.

2. Entrance Interview

The audit team proceeded to the office of Daron Hall, Sheriff. The team expressed the appreciation of the Association for the opportunity to be involved with Davidson County Sheriff's Jail, Nashville, Tennessee in the accreditation process.

Sheriff Daron Hall, Kim Perry, Compliance Officer escorted the team to conference room where the formal entry meeting was held.

<u>The following persons were in attendance</u>:

Daron Hall, Sheriff
John L. Ford III, Chief Deputy
John Hudson, Chief of Administration
Tony M Wilkes, Chief of Corrections
John Taylor, Chief Warrant Officer
Kim Perry, Chief of Standards Division
Mark Holley, Standards Division

Kerry Hall, Standards Division
Joey Friedman, Standards Division
Lynn Norris, Standards Division
Darlene Holley, Standards Division
Dan Weikal, Administrator of CJC
Pamela Hale, Administrator of HDC
Austin Bodie, Administrator of CDCM
Marasha Travis, Administrator of CDCF
Lawanda Page, Administrator of ORC

It was explained that the goal of the visiting team was to be as helpful and non-intrusive as possible during the conduct of the audit. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time.

3. Facility Tour

The team toured the entire facility from 8:15 a.m. to 5:30 p.m.

The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

Criminal Justice Center:

Dan Weikal, Administrator
Jamie Johnson, Chief of Security
Granvisse Earl-Young, Director of Programs
Kevin Tevis, Lieutenant
Jeremy McCraw, CCS
Kerry Hall, Standards Officer
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Administrative Assistant

Hill Detention Center:

Pamela Hale, Administrator
Kevin Cox, Chief of Security
Pam Butler, Administrative Assistant
Kim Peery, Director of Standards
Joshua Bone, Lieutenant
Robert Demoss, Lieutenant
Henry Lehman, Lieutenant
Jeremy McCraw, CCS
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Lieutenant

Correctional Development Males:

Austin Bodie, Administrator
Harold Taylor, Chief of Security
Shreeti Bickett, Programs Director
Jeremy McCraw, CCS
Lynn Norris, Standards Officer
Lieutenant Williams
Lieutenant Rutledge
Kim Peery, Director of Standards
Maria Toro, Immigration Services Coordinator
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Administrative Assistant

Correctional Development Females:

Marsha Travis, Administrator

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security

Although this complex is huge in size and located in four different buildings it functions as one agency and operates in a secure and organized fashion. Each building has an Administrator who is directly in-charge of managing their assigned building. The administration of the complex falls directly under the authority of the Sheriff Daron Hall and his Chief Deputy John L. Ford. It also has a number of Division Chiefs who oversee operations of a various number areas of responsibility within the jail operation.

The offender population covers a wide variety of custody and security needs. It also involves both male and female offenders. Staff were alert and professional. The communications between the offenders and Staff were very positive and the auditors observed operations at all areas of all four functioning areas of the jail complex.

We started our tour through the largest building Correctional Justice Center building (CJC); it is a five story building with the top of the building being two large recreation areas. These areas are fenced and very secure with direct staff supervisor and surveillance camera to aid it supervising these areas. There is also four smaller fenced areas for recreating those who require more security.

The CJC building is the most secure facility in the complex. It houses the processing and receiving area for all the jail operations. It has stronger and more individual cells that contain mostly double bunks. This building also houses those who require greater supervision and control. Each floor has a sergeant and officers to give direct supervision. The Gymnasium to the CJC building was full of offenders and the jail was forced to use it temporarily. The juvenile facility for the county which is not part of the jail was under repair during our tour and expected to renew operations next month. The flood last year had seriously damaged the juvenile facility at which time the Sheriff took a section of his jails and converted it for juveniles pending repair. This situation tied up a large section of one of his building and forced him to use the Gymnasium.

Key and Locks were checked and all were in accordance to the standards. Many staff and inmates alike were interviewed and all were complementary with the operations. There were a few comments about the food but we checked trays during our auditing and they appeared satisfactory.

Metal detectors were in place at the entrance to the CJC and security guards checked all those we entered the facility and anything they were carrying into the facility. Most of the Detention Officers carry small canisters of chemical agents. All were trained and knew the policy regarding their use.

Another area that was observed by the auditors was the booking area where the offender is first bought to the facility. This complex operation is where all offenders are processed into the system, screened (personal and medically), interviewed, searched and initially classified to an appropriate housing unit or building. This area was very busy and it is open 24 hours per day, 7 days per week. During various times during the audit including 3:00 a.m. on a Tuesday morning it was crowded with DWIs, domestic disturbance, assaults, vagrants, and cases waiting processing into the jails facilities. Staff were very professional and handled each case in commendable fashion.

The auditors than went to the Hill Detention Center which is the second building in the downtown area. It is dormitory style housing and the offenders housed in this building are both medium and minimum. The building had similar security at their entrance with metal detectors and screening all persons who enter. This building was originally a warehouse and has since been completely renovated to house those who did not require the same level of security as the CJC building. It is secure; the locking and key control was checked and met the standards. The auditors walked through each dormitory and talked to both the offenders and staff. We were again impressed with the communications between staff and offender. Surveillance cameras are monitored in the central control area. Most of the security is the building itself.

The auditors left the downtown buildings and went to the three building complex where two of the three are operational. We started at the Correctional Development Center (Males) This building houses medium custody offenders and Immigration, Customs and Enforcement (ICE) cases in dormitory settings. The ICE cases are separate from the county prisoners. Each dormitory houses less than fifty offenders. Detention Officers are assigned directly adjacent to each pod and routinely walk through them for security checks. All counts were double counts and all staff were alert; they knew policy and procedures.

Auditors walked through each pod and talked to both staff and offenders. The building was very secure and had outside exercise areas for those in the pods to get some fresh air. All the pods had a large multi-purpose room where the offenders could take their meals, watch TV, play cards, or write letters.

The last building toured where offenders were housed was the Correctional Development Center (Females). This building is located adjacent to the male facility. It is about seventy-five yards way and shares some of the services such as food service kitchen as well as medical or dental follow up. The female facility is mostly secure cell type housing. It was found to be clean and well managed. Staff and inmates were interviewed. The auditors were impressed with the communications between staff and offenders.

We toured the Warehouse facility that houses the Laundry facilities and storage for support of materials for the complex operations. It also is the area where the maintenance shops are located which includes most the tools that are needed to keep the buildings in good working order. The auditors were very impressed with the organization, accountability, operation and sanitation of this whole building.

Environmental Conditions

In all housing buildings of the Sheriff's complex the conditions and quality of life for the offenders were within the standards. The facility was cool during our initial days because of hot weather but, turned cold during the last part of our audit. Throughout the entire time it was comfortable and we did not receive any significant complaints from the offender population.

Sanitation

All buildings were clean and well organized. Documentation was in the record to substantiate frequent inspections of all areas within all the various buildings. It was very apparent that sanitation had a high priority at the complex. The auditors did find two areas requiring additional sanitation attention in both the CJC kitchen area and the CDC (Male) Kitchen area. Both these areas were re-inspected after our initial tour and they corrected the problems noted.

Fire Safety

All the buildings of the Davidson County Sheriff's complex have sprinkler systems and fire alarms in the main control centers. They work with the Nashville Fire Department and receive frequent inspections of all areas from a fire marshal. There are many fire extinguishers in all areas of the complex. All the fire extinguishers the auditors checked were up to date and ready for emergency usage.

The fire alarm system in the CDC (Male) facility had recently developed problems and was in the process of being fixed; an emergency purchase order of nearly $28,000 was shown to the auditors. During this period a "fire watch/check" system had been placed in effect until the necessary repair could be accomplished. Documentation was checked by the auditors and was in order.

Food Service

Two primary kitchens prepare the meals for the complex. The downtown kitchen is located at the CJC and handles all meals going to their facility and the HDC. It was an older kitchen and there were some sanitation issues that required the auditors to re-inspect the following day. On our initial check all the freezers and coolers were at the proper temperatures. The dish machine was operational and tool control was in place with inventories found to be in order. The dry storage area needed some adjustment as boxes were stacked above the sprinkler system. These issues were resolved by the staff immediately.

The other kitchen at the CDC (Male) building also had some sanitation issues. It was re-inspected the following morning and all the issued had been corrected. All the other issues of temperatures in freezers, coolers, dish machine were in order. Tool control was checked and all utensils used in food preparation were controlled and properly inventoried.

Medical Care

Healthcare services at the Davidson County Sheriff's Office (DCSO) are delivered through a contract with Correct Care Solutions (CCS). The facility has recently extended the contract with CCS for an additional 5 years. Each of the four facilities comprising DCSO are staffed 24/7 by CCS employees. The staffing for each of the four facilities was reviewed. It was determined that there is an appropriate number of licensed professional staff; one full time physician, 2 mid level practitioners (ANP's), RNs/LVNs and administrative support personnel. In addition, the staffing pattern reflects a large number of available PRN staff for all categories of providers.

The provision of mental health services is accomplished through a contract company known as Mental Health Cooperative.

There is an adequate number of mental health staffing assigned to all four facilities with the majority of the staffing being assigned to the CJC based upon it's housing of the majority of maximum security offenders and also serving as the booking/ receiving facility. Dental services are provided through a contract with a full time Dentist. The provision of dental services for the population primarily occurs at CJC and CDC (Male). Female offenders assigned to CDC (Female) are transported to CDC (Male) for the provision of dental care. The dental staffing also consists of a full time Dental Assistant and an available PRN Dentist. As identified previously, each medical clinic in the four facilities is staffed 24/7 by licensed professional staff. In addition, the facility has a designated on call schedule for the medical providers as well as the mental health and dental staff. Emergencies that cannot be addressed at the facility level would be transported to Metro Nashville General Hospital by EMS personnel assigned to the various fire department locations. In addition, Metro General Hospital also provides the majority of the offsite specialty clinic consultations. The facility also has a large number of AEDs that are located primarily in the medical department and documentation reviewed identified that these have been used frequently to address emergencies. Laboratory specimens are collected my nursing personnel as ordered by the medical providers. CCS has an existing contract with Bio Reference for the collection and analysis of lab specimens. The specimens are collected from all four facilities and there is a 7 day schedule available for the transport of lab samples. The facility also has an existing contract with Centennial Hospital for the analysis of stat lab specimens. The results of the lab specimens are returned to the facility through entry into the electronic medical record or are telephoned to the facility in case of a stat sample. The facility also has an existing contract with a mobile X-ray service for the provision of onsite radiology examinations. The radiology examinations are completed in digital format and are transferred electronically for interpretation by a radiologist. Once again, the results of the radiology examinations are returned to the facility through entry into the electronic medical record or are telephoned to the facility within 24 hours. Medication orders by the providers are faxed to Diamond Pharmacy with corporate offices in Pennsylvania. The ordered medications are delivered to the facilities by commercial carrier and then are collected by designated nursing personnel. The packing invoice is compared to the medications to ensure that the correct medication and correct dose has been received. All medications at the four facilities are delivered to the housing areas. As much as possible, the facility attempts to utilize BID distribution of medications. The facility allows a limited number of keep on person items which is generally limited to inhalers and creams/ointments. The delivery of medications is documented on a medication administration record (MAR) During the course of the onsite audit of DCSO a random inventory of the control practices of medications and medical/dental instruments was conducted at the four facilities. Several minor recommendations were made to facility medical administration regarding the accountability of such items as injectables at CJC. However, overall it was determined that each facility has excellent accountability for medications and medical/dental instruments. Offender sick call is available to the offender population 5 days a week.

Offenders complete a sick call request and these are placed in designated containers that are generally taken into each housing area by correctional officers. Several recommendations were made to facility security administration regarding improving the consistency of the placement of sick call requests in the designated boxes. Sick call requests are collected by medical personnel on a daily basis and triaged 7 days a week. Emergencies are immediately brought to the medical department. DCSO does not have a designated medical infirmary. Therefore, offenders requiring medical care above that than can provided through the outpatient clinics are transported to Metro Nashville General Hospital. The facility does have 3 respiratory isolation beds available at CJC. In addition, there are 3 available respiratory isolation beds at CDC (Females), but these have not been certified at the time of the audit. Suicide observation facilities are available at CJD and CDC (Females). The suicide observation facilities at CJC are located on unit 2A while at CDC (Females) they are located on J unit. The suicide observation cells do not have camera capability and generally 15 minute checks are utilized by correctional officers to maintain the status of offenders placed on suicide observation. Recommendations were made to administrative representatives concerning a review of the suicide observation cells located at CJC. In particular, these recommendations regarded the lighting fixtures and the sprinkler heads located within these cells. There are a number of chronic care clinics available to the offender population. The clinics available at the time of the onsite audit include asthma, cardiology, COPD, seizures, hypertension, diabetes, hepatitis, and HIV. Generally, offenders are seen in chronic clinic a minimum of every 90 days but more frequently based upon the control of their chronic condition. The facility does use an individual treatment plan to track the medical care delivered to chronic care patients. The medical department uses only disposal medical instruments. However, there is an autoclave available in each dental department at CJC and CDC (Males) for the sterilization of dental instruments. The facilities are conducting the required spore testing and the results were reviewed during the onsite audit. In addition, CCS does have an existing contract with Steri Cycle for the collection and disposal of bio hazard waste. Generally, the contractor collects the medical waste on a weekly basis from each of the four facilities.

A review of the healthcare outcome measures for the preceding 12 months identified that there were 10,102 admissions to the facility. Of these 730 had a positive PPD with six of these actually diagnosed with active TB. In addition, there was one conversion to a positive skin test in the preceding 12 months. There was a total of 187 offenders identified as being positive for Hepatitis C and of 444 offenders identified as HIV positive with 341 being treated with highly active antiviral treatment. There were a total of 16 suicide attempts in the preceding 12 months with one of these resulting in the offender's death. Over the past three years there have been 3 incidents of offender suicides. There were no offender deaths due to homicide or as a result of injuries sustained. There were 4 medically unexpected deaths in the preceding 12 months.

In addition, 1060 offenders were transported off site for emergency care with 501 being admitted to the area hospitals. Based upon the status of the facility as an initial offender booking/receiving facility, this number is not exceptional based upon the population encountered during the receiving/screening process. There were a total of 230 offender grievances regarding access to healthcare services with 19 of these found in favor of the offender. There were a total of 20,000 individual sick call encounters in the preceding 12 months with a total of 4,489 offenders being seen by the physician and mid levels. There were a total of 3,284 individual dental plans initiated with a total of 1,753 offenders enrolled in hypertensive chronic clinic. The facility also had a total of 641 diabetic offenders enrolled in chronic clinic and the required diabetic testing is conducted on a routine basis for this population. The report also is identifying a total of 93 nursing medication administration errors in the preceding 12 months. Upon further discussion with the administrative staff of CCS it was determined that the majority of these are identified as documentation errors by nursing staff on recording the distribution of medication on the MAR. They did coincide with the issuance of the wrong medication or wrong dose. The report is also identifying a total of 5 staff with lapsed licensure and/or certification. Upon further discussion with the administrative staff of CCS it was identified that this related solely to employees who allowed their CPR certification to expire. All of these were corrected upon the identification of the lapsed certification.

Recreation

Recreation areas at the CJC are on the roof. At CDC (Male) and CDC (Female) there is a recreation yard for offender usage. All common areas of all four buildings have TVs and tables for board games.

Religious Programming

Religious programs are very active and the Davidson County Jails has over a thousand religious volunteers to assist offenders with their spiritual needs.

Offender Work Programs

Those offenders who are of medium and below custody are more likely to have jobs. The higher security offenders are less likely to hold down a job. Most of the offenders who were seen by the auditors were busy cleaning and polishing the facility. Work details at the CDC were seen reporting for work early in the morning for food service, Laundry and various janitorial jobs.

Academic and Vocational Education

The Davidson County Sheriff's Jails offers various programs to offenders. Most of the offender population is short term so many of the programs structured as short term opportunity for those offenders who are trying to self improve.

They do offer Adult Basic Education, GED, GED Prep, Creative writing, English as a second language (ESL), and Library books, magazines and news papers.

Social Services

Programs to assist offenders are also in place for those offenders who have less than 6 months until release. Other such programs such as Job readiness, interviews, filling out an application for employment are offered.

Mentoring programs to assist offenders to re-entry back into the community are also available.

Visitation

Offenders are allowed to visit with family or friends for one hour per week. Depending on the building is the determination as to if it is a contact or non-contact visit.

Library Services

Each building has a library program. During the auditors tours throughout all the buildings we witnessed many offenders reading books. Offenders who are in more secure areas of the facility have an opportunity to exchange reading materials. All offenders can request legal materials should they request such.

Laundry

The auditors inspected the Laundry and expressed in a very positive manner its operation and organization. Chemicals were checked and inventory was in line with the standards.

F. Examination of Records

Following the facility tour, the team proceeded to the conference room at CDC (Males) to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

Over the last three years, the facility had no consent decrees, class action lawsuits or adverse judgments.

2. Significant Incidents/Outcome Measures

The significant Incidents show three natural deaths, two suicides and one investigation as to what happened. One escape from the food service dock at CDC (Males). All other reports of significant Incidents or outcome measures was within our expectations for a facility of this size.

3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations: There is little turn over in the ranks of staff

Departments Visit	Staff Contacted
Checkpoint	Officer Woods
6th Floor – Recreation Supply Room and Maintenance Shop	Corporal Davis
5th Floor	Sergeant Stinson Corporal Howard Officers Craig Officers Howard
4th Floor	Sergeant Levy Officer Wilke
3rd Floor	Sergeant Crawley Sergeant Hindsly
2nd Floor	Officer Oliff Sergeant Cogdill
Pharmacy & Medical Records	Jeremy McGraw, CCS
Property Room	Granvisse Earl Young
Classification	Beth Gentry
Mini Master Control	Officer Hollins
Gym	Corporal Conrad
Chemical Storage	Lieutenant Kevin Tevis

Booking	Sergeant Pillow
Kitchen	Vernistene Dulin, ABL
Master Control	Officer Cahall
3rd Shift CJC Attendee:	Mark Hadley
Booking	Sgt. McLaurine Cpl. Howard Officer Clark Scott Carpenter Kamela Guerro
1st Floor	Officer Guth Officer Glandney Officer Eskinde Officer Howell Officer Azer
2nd Floor	Sgt. Lloyd Officer Gunter Officer Darby
3rd Floor	Sgt. Dotson Officer Bertram Officer Rice Officer Hardin Officer Henson Officer Brown Officer Hicks
4th Floor	Sgt. Davis Officer Finch Officer Themm Cpl. Pressley
5th Floor	Sgt. Bozarth Cpl. McCrady Cpl. Roberson Cpl. Johnson
6th Floor	Lt. Fletcher Lt. Russ Officer Clark Officer Cox

Officer Crutcher

Briefing Conference Room, Hill Detention Center Attendees:
Pamela Hale, HDC Administrator
Kevin Cox, Chief of Security
Pam Butler, HDC Administrative Assistant
Kim Peery, Director of Standards
Darlene Holley, Standards Support Staff
Lynn Norris, Standards Officer
Joey Friedmann, Standards Officer
Mark Hadley, Standards Officer
Kerry Hall, Standards Officer
Joshua Bone, HDC 1st Shift Lieutenant
Robert Demoss, HDC 1st Shift Lieutenant
Henry Lehman, HDC 1st Shift Lieutenant
Jeremy McCraw, CCS
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Administrative Assistant

Tour Attendees:
Pamela Hale, HDC Administrator
Kevin Cox, Chief of Security
Pam Butler, HDC Administrative Assistant
Kim Peery, Director of Standards
Joshua Bone, HDC 1st Shift Lieutenant
Robert Demoss, HDC 1st Shift Lieutenant
Henry Lehman, HDC 1st Shift Lieutenant
Jeremy McCraw, CCS
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Administrative Assistant

Areas Toured	Persons Interviewed
Master Control	
A&B Cells	Officer Stagg
Medical	Tyronica Manier Joei Dixon Jeremy McGraw
Program	
C&D Cells	
G&H Cells	
E&F Cells	Inmate Worker Cell
Law Library	

Chaplin Office	Bruce Helms
Areas Toured	Persons Interviewed
3rd Shift HDC Attendee:	Mark Hadley
	Lt. Miller
	H. McQuade CCS
	Officer Nowack
	Officer Dalton
	Officer Laird
	Officer Hill
	Officer Williams
	Officer Wyatt

Briefing Conference Room, Correctional Development Center
Attendees:
Austin Bodie, CDCM Administrator
Marsha Travis, CDCF Administrator
Harold Taylor, CDCM Chief of Security
Shreeti Bickett, CDCM Programs Director
Lawanda Page, ORC Administrator
Regina DeRiggi, CDCF Treatment Supervisor
Jeremy McGraw, CCS
Lt. Williams, CDCM
Lt. Rutledge, CDCF
Kim Peery, Director of Standards
Lynn Norris, Standards Officer
Kerry Hall, Standards Officer
Darlene Holley, Standards Support Staff
Joey Friedmann, Standards Officer
Rashon Cody, ABL
Mike Craft, ABL Operations
Mark Hadley, Standards Officer
Joyce Heard, SCC Property Supervisor
Panda Adkins, Work Release Director
Regina DeRiggi, Treatment Supervisor
Maria Toro, Immigration Services Coordinator
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Administrative Assistant

CDCM Tour Attendees:
Austin Bodie, CDCM Administrator
Harold Taylor , CDCM Chief of Security
Shreeti Bickett, CDCM Programs Director
Jeremy McGraw, CCS
Lynn Norris, Standards Officer

Lt. Williams, CDCM
Lt. Rutledge, CDCF
Kim Peery, Director of Standards
Maria Toro, Immigration Services Coordinator
Chris Dill, Rutherford County Lieutenant
Shelly Dye, Rutherford County Administrative Assistant

Areas Toured	Persons Interviewed
A – Unit	Officer Alford Classification Tami Jones Case Manager Thriane Lopez Case Manager Loretta Phillips
D – Unit	Officer Moulty Officer Shock
C – Unit	Officer Mitchell Lolita Johnson S.A.V.E.
E – Unit	Officer Anderson
Assessments	Cordell Johnson
Female Treatment	Rita Jones
Recreation Yard	Officer Ledbetter
Kitchen	Joshua Anderson, ABL
Chemicals	Austin Bodie Lt. Butler

Areas Toured	Persons Interviewed
3rd Shift CDCM Attendee:	Mark Hadley
	Lt. Wright Officer Hibbs Officer Person Officer Sykes Officer Lester Officer Stewart Officer Rodgers Officer Huff Officer Toney

	Officer Troup Officer Peterson

Correctional Development Center Females
CDCF Tour Attendees:
Marsha Travis, CDCF Administrator

Areas Toured	Persons Interviewed
Female Intake	Officer Gibson
I – Unit, Medium Custody J – Unit, Special Management	
K – Unit, Work Release	Officer Elswick
L – Unit, Inmate Work/Release	Officer Rogers Panda Adkins
M – Unit, Drug Alcohol Treatment N – Units, Special Needs	Officer Tankersley
P – Unit Minimum Custody Medical & Mental Health	
Building 1 Multi – purpose office	Officer Temple
Mail	J. Thomas

Areas Toured	Persons Interviewed
3rd Shift CDCF Attendee:	Mark Hadley Officer Fiser Officer Preville Officer Fajgenbaum Officer Hicks Officer Woodhouse Officer White Officer Burgess Officer Gaston Officer Kinacade Officer Joseph

All areas in CDJ
All areas in HDC
All areas in CMCM
All area in CMCF
All areas in the maintenance building, Laundry, warehouse

4. Shifts

a. Day Shift

The team was present at the facility during the day shift from 7:30 a.m. to 4:00 p.m.

All buildings were on 8 hour shifts except Hill Detention Center where the staff assigned there were on 12 hour shifts.

All the staff assigned to all 4 building were very positive about the Sheriff's Office and its operation. Many examples of staff recognition were evident in all four buildings. Photos of staff receiving recognition from the Sheriff and his Administration were in the lobbies of all the various buildings as well as on his web site that staff can access. Morale was high and all staff who the auditors spoke to were very positive about job satisfaction.

b. Evening Shift

The team was present at the facility during the evening shift from 4:00 p.m. to 6:00 p.m.

Staff morale was also high. Those staff we talked to were proud to work at the Sheriff's Office and expressed nothing but positive comments to the auditors.

c. Night Shift

The team was present at the facility during the night shift from 2:45 a.m. to 7:00 a.m.

One of the auditors was picked up at the hotel at 2:30 a.m. by Mark Hadley, Accreditation Officer and taken first to CJC. They toured and saw all staff on duty at that facility. From there they went to the Hill Detention Center and visited all staff on duty.

They then left downtown and went to the CDC (Male) and the CDC (Female) buildings where they were able to conclude visiting with all staff on duty at that time in the morning with the Sheriff's jail operation.

5. Status of Previously Non-compliant Standards/Plans of Action

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

Standard # 4-ALDF 1A-15: The older parts of the jail do not meet the standard for natural light in the rooms.

Standard # 4-ALDF 1A-16: The older jail buildings downtown do not meet this Standard.

G. Interviews

During the course of the audit, team members met with both staff and offenders to verify observations and/or to clarify questions concerning facility operations.

1. Offender Interviews

   The auditors spoke to over 300 offenders. There was no significant complaints and the offenders felt safe. The only area that we received any significant issue was the Gymnasium that was very overcrowded.

2. Staff Interviews

   The morale was very high and the auditors received nothing but supportive comments and good feelings about the Davidson County Sheriffs operation. The auditors talked to over 350 staff. All staff on the night shift we visited on their post and all was very positive.

H. Exit Discussion

The exit interview was held at 11:00 a.m. in a multi-purpose room in the Offender Release Center with the Sheriff Daron Hall and 75-100 staff in attendance.

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

AND THE

AMERICAN CORRECTIONAL ASSOCIATION

COMPLIANCE TALLY

Manual Type	*Adult Local Detention Facilities, 4th edition*
Supplement	*2010 Standards Supplement*
Facility/Program	Davidson County Sheriff's Jails, Nashville, Tennessee
Audit Dates	March 21-23, 2011
Auditor(s)	Pat Keohane, Chairperson; William Seery, Member; Allan Westmoreland, Member; Melanie Gregory, Member.

	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	60 mandatory standards	323 non-mandatory standards
Number Not Applicable	0	13
Number Applicable	60	310
Number Non-Compliance	0	4
Number in Compliance	60	306
Percentage (%) of Compliance	100 %	98.7 %

- Number of Standards minus Number of Not Applicable equals Number Applicable
- Number Applicable minus Number Non-Compliance equals Number Compliance
- Number Compliance divided by Number Applicable equals Percentage of Compliance

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Davidson County Sheriff's Office
Davidson County Sheriff's Office Jail Facility
Nashville, Tennessee

March 21-23, 2011

Visiting Committee Findings

Non-Mandatory Standards

Non-Compliance

Standard #4-ALDF-1A-11

EACH INMATE CONFINED IN A CELL/ROOM IS PROVIDED WITH THE FOLLOWING:

- A SLEEPING SURFACE AND MATTRESS THAT ALLOWS THE INMATE TO BE AT LEAST 12 INCHES OFF THE FLOOR
- ACCESS TO A WRITING SURFACE AND PROXIMATE AREA TO SIT
- A PLACE TO STORE CLOTHES AND PERSONAL BELONGINGS

FINDINGS:

The GYM area is not in compliance with the Standards. It has no writing surfaces or areas spaces for those offenders who are assigned to this area. The " boats" that are used to house offenders in this overcrowded area were of significant concern to the facility staff and the auditors.

AGENCY RESPONSE

AUDITOR'S RESPONSE

The auditor's response will be placed here. Please state whether or not the plan of action, waiver, or request for discretionary compliance is acceptable or not, and provide a few sentences as to why you support it or do not support it.

Standard #4-ALDF-1A-12

DAYROOMS WITH SPACE FOR VARIED INMATE ACTIVITIES ARE SITUATED IMMEDIATELY ADJACENT TO INMATE SLEEPING AREAS. DAYROOMS PROVIDE A MINIMUM OF 35 SQUARE FEET OF SPACE PER INMATE (EXCLUSIVE OF LAVATORIES, SHOWERS, AND TOILETS) FOR THE MAXIMUM NUMBER OF INMATES WHO USE THE DAYROOM AT ONE TIME.

NO DAYROOM ENCOMPASSES LESS THAN 100 SQUARE FEET OF SPACE, EXCLUSIVE OF LAVATORIES, SHOWERS, AND TOILETS.

FINDINGS:

The facility in many areas does not meet the standard that requires 35 square feet. of space per inmate.

AGENCY RESPONSE

AUDITOR'S RESPONSE

The auditor's response will be placed here. Please state whether or not the plan of action, waiver, or request for discretionary compliance is acceptable or not, and provide a few sentences as to why you support it or do not support it.

Standard #4-ALDF-1A-15 Revised August 2006.

ALL INMATE ROOMS/CELLS PROVIDE ACCESS TO NATURAL LIGHT. (EXISTING ONLY)
FINDINGS:

Not all areas of the jail have access to natural light.

Standard #4-ALDF-1A-16 Revised August 2006.

ALL INMATE ROOMS/CELLS PROVIDE THE OCCUPANTS WITH ACCESS TO NATURAL LIGHT BY MEANS OF AT LEAST THREE SQUARE FEET OF TRANSPARENT GLAZING, PLUS TWO ADDITIONAL SQUARE FEET OF TRANSPARENT GLAZING PER INMATE IN ROOMS/CELLS WITH THREE OR MORE INMATES. (RENOVATION, ADDITION, NEW CONSTRUCTION ONLY)

FINDINGS:

Some of the areas in the jail do not meet the standard for natural light.

AGENCY RESPONSE

AUDITOR'S RESPONSE

The auditor's response will be placed here. Please state whether or not the plan of action, waiver, or request for discretionary compliance is acceptable or not, and provide a few sentences as to why you support it or do not support it.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Davidson County Sheriff's Office
Davidson County Sheriff's Office Jail Facility
Nashville, Tennessee

March 21-23, 2011

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-ALDF-1A-09 Revised August 2008

SINGLE CELLS IN GENERAL POPULATION PROVIDE AT LEAST 35 SQUARE FEET OF UNENCUMBERED SPACE. AT LEAST 70 SQUARE FEET TOTAL FLOOR SPACE IS PROVIDED WHEN THE OCCUPANT IS CONFINED FOR MORE THAN 10 HOURS PER DAY.

FINDINGS:

This facility uses dormitory style housing or double cells.

Standard #4-ALDF-1A-18-1 Added August 2008 (No construction only)

NOISE LEVELS IN HOUSING AREAS (IN OTHER WORDS, DAYROOMS WITH ADJACENT CELLS OR DORMS) SHALL NOT EXCEED THE FOLLOWING:

- UNOCCUPIED – 45 DBA (A SCALE), BUILDING SERVICE SYSTEMS SHALL BE ON AND IN NORMAL OPERATING CONDITION. MID-FREQUENCY AVERAGE REVERBERATION TIME (T 60) MUST BE LESS THAN 1.0 SEC.
- OCCUPIED – 70 DBA (A SCALE) FOR A MINIMUM OF 15 SECONDS OF CONTINUOUS AVERAGE MEASUREMENT IN NORMAL OPERATING CONDITIONS.

ALL MONITORING SHALL BE CONDUCTED IN CLOSE PROXIMITY TO THE CORRECTIONAL OFFICER'S POST. IF A CORRECTIONAL OFFICER'S POST IS NOT IDENTIFIED THEN MONITORING SHALL BE CONDUCTED AT A LOCATION CONSIDERED BEST TO MONITOR HOUSING NOISE LEVELS. MEASUREMENTS SHALL BE CONDUCTED A MINIMUM OF ONCE PER ACCREDITATION CYCLE BY A QUALIFIED SOURCE.

FINDINGS:

This facility is of old construction.

Standard #4-ALDF-2C-02

WHEN A CANINE UNIT IS OPERATED BY THE FACILITY:

- THERE IS A MISSION STATEMENT, INCLUDING GOALS AND OBJECTIVES
- THE CIRCUMSTANCES IN WHICH CANINE UNITS MAY BE USED ARE CLEARLY DEFINED
- EMERGENCY PLANS ARE INTEGRATED INTO THE OVERALL EMERGENCY PLANS OF THE FACILITY
- THERE ARE CRITERIA FOR SELECTING, TRAINING AND CARING FOR ANIMALS
- THERE ARE CRITERIA FOR THE SELECTION, TRAINING, AND PHYSICAL FITNESS OF HANDLERS
- THERE IS AN APPROVED SANITATION PLAN THAT COVERS INSPECTION, HOUSING, TRANSPORTATION AND DAILY GROOMING FOR THE ANIMALS
- THERE ARE DAILY AND CURRENT RECORDS ON TRAINING, CARE OF DOGS AND SIGNIFICANT EVENTS.

FINDINGS:

No canine program.

Standard #4-ALDF-4A-14

WHEN REQUIRED BY STATUTE, FOOD PRODUCTS THAT ARE GROWN OR PRODUCED WITHIN THE SYSTEM ARE INSPECTED AND APPROVED BY THE APPROPRIATE GOVERNMENT AGENCY; THERE IS A DISTRIBUTION SYSTEM THAT ENSURES PROMPT DELIVERY OF FOODSTUFFS TO FACILITY KITCHENS.

FINDINGS:

The jail does not grow food stuffs.

Standard #4-ALDF-4C-09

IF INFIRMARY CARE IS PROVIDED ONSITE, IT INCLUDES, AT A MINIMUM, THE FOLLOWING:

- DEFINITION OF THE SCOPE OF INFIRMARY CARE SERVICES

AVAILABLE

- A PHYSICIAN ON CALL OR AVAILABLE 24 HOURS PER DAY
- HEALTH CARE PERSONNEL HAVE ACCESS TO A PHYSICIAN OR A REGISTERED NURSE AND ARE ON DUTY 24 HOURS PER DAY WHEN PATIENTS ARE PRESENT
- ALL INMATES/PATIENTS ARE WITHIN SIGHT OR SOUND OF A STAFF MEMBER
- AN INFIRMARY CARE MANUAL THAT INCLUDES NURSING CARE PROCEDURES
- AN INFIRMARY RECORD THAT IS A SEPARATE AND DISTINCT SECTION OF THE COMPLETE MEDICAL RECORD
- COMPLIANCE WITH APPLICABLE STATE STATUTES AND LOCAL LICENSING REQUIREMENTS

FINDINGS:

The Health care provider does not provide an onsite infirmary.

Standard #4-ALDF-4D-10

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION COMMENSURATE WITH THEIR LEVEL OF TRAINING. THERE IS A WRITTEN AGREEMENT BETWEEN THE FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS THE SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS OR INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

No Students, Interns or Residents are used to provide health care.

Standard #4-ALDF-5C-13

WHERE AN INDUSTRIES PROGRAM EXISTS, ITS ESTABLISHMENT IS AUTHORIZED AND AREAS OF AUTHORITY, RESPONSIBILITY, AND ACCOUNTABILITY ARE DELINEATED.

FINDINGS:

This jail does not have an industry program.

Standard #4-ALDF-5C-14

THE NUMBER OF INMATES ASSIGNED TO INDUSTRIES OPERATIONS MEETS THE REALISTIC WORKLOAD NEEDS OF EACH OPERATING UNIT.

FINDINGS:

No industry program.

Standard #4-ALDF-5C-15

THERE IS A COMPREHENSIVE QUALITY CONTROL PROCESS.

FINDINGS:

No industry program.

Standard #4-ALDF-5C-16

A COST ACCOUNTING SYSTEM FOR EACH INDUSTRIES UNIT IS DESIGNED, IMPLEMENTED, AND MAINTAINED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.

FINDINGS:

No industry program.

Standard #4-ALDF-5C-17

INMATES HAVE THE OPPORTUNITY TO PARTICIPATE IN PRACTICES OF THEIR RELIGIOUS FAITH THAT ARE DEEMED ESSENTIAL BY THE FAITH'S JUDICATORY, LIMITED ONLY BY DOCUMENTATION SHOWING THREAT TO THE SAFETY OF PERSONS INVOLVED IN SUCH ACTIVITY ITSELF OR DISRUPTION OF ORDER IN THE FACILITY.

FINDINGS:

No industry program.

Standard #4-ALDF-6B-06 Revised August 2008

UNLESS PROHIBITED BY STATE LAW, OFFENDERS (UNDER STAFF SUPERVISION) MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES INCLUDE:

- PEER SUPPORT AND EDUCATION

- HOSPICE ACTIVITIES
- ASSIST IMPAIRED OFFENDERS ON A ONE-ON-ONE BASIS WITH ACTIVITIES OF DAILY LIVING
- SUICIDE COMPANION OR BUDDY IF QUALIFIED AND TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF SUICIDE PREVENTION PLAN
- HANDLING DENTAL INSTRUMENTS FOR THE PURPOSE OF SANITIZING AND CLEANING, WHEN DIRECTLY SUPERVISED AND IN COMPLIANCE WITH APPLICABLE TOOL CONTROL POLICIES, WHILE IN A DENTAL ASSISTANTS TRAINING PROGRAM CERTIFIED BY THE STATE DEPARTMENT OF EDUCATION OR OTHER COMPARABLE APPROPRIATE AUTHORITY

OFFENDERS ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

- PERFORMING DIRECT PATIENT CARE SERVICES
- SCHEDULING HEALTH CARE APPOINTMENTS
- DETERMINING ACCESS OF OTHER OFFENDERS TO HEALTH CARE SERVICES
- HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS OR HEALTH RECORDS
- OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION (BY SPECIALLY TRAINED STAFF) IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

Offenders are not used in this status mentioned in the standard.

Standard #4-ALDF-7D-16

PROCEDURES GOVERN THE OPERATION OF ANY FUND ESTABLISHED FOR INMATES. ANY INTEREST EARNED ON MONIES OTHER THAN OPERATING FUNDS ACCRUES TO THE BENEFIT OF THE INMATES.

FINDINGS:

This facility does not use this concept. Offenders are short term. Their monies do not accumulate interest.

Standard #4-ALDF-7F-07

IF VOLUNTEERS ARE USED IN THE DELIVERY OF HEALTH CARE, THERE IS A DOCUMENTED SYSTEM FOR SELECTION, TRAINING, STAFF SUPERVISION, FACILITY ORIENTATION, AND A DEFINITION OF TASKS, RESPONSIBILITIES AND AUTHORITY THAT IS APPROVED BY THE HEALTH AUTHORITY.

VOLUNTEERS MAY ONLY PERFORM DUTIES CONSISTENT WITH THEIR CREDENTIALS AND TRAINING. VOLUNTEERS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

This facility does not use volunteers in delivery of health care.

Significant Incident Summary

This summary is required to be provided to the regional specialist at least two weeks prior to the arrival of your audit team. The information contained on this form will be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. It should contain data for the last 12 months; indicate those months in the boxes provided. Please type the data. If you have questions on how to complete the form, please contact your regional specialist.

Facility: Davidson County Sheriff's Office Jail Facility Year: March 2010 – February 2011

		Months											
Incidents		3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	01/11	02/11
Assault: Offenders/ Offenders*	Indicate types (sexual**, physical, etc.)	P S	P S	P S	P S	P S	P S	P S	P S	P S	P S	P S	P S
	# With Weapon	0 0	0 0	1 0	1 0	1 0	0 0	2 0	1 0	1 0	1 0	2 0	0 0
	# Without Weapon	23 0	21 1	20 0	21 0	23 0	25 0	21 0	5 0	20 0	28 0	19 0	17 0
Assault: Offender/ Staff	Indicate types (sexual**, physical, etc.)	P S	P S	P S	P S	P S	P S	P S	P S	P S	P S	P S	P S
	# With Weapon	0 0	1 0	0 0	0 0	0 0	0 0	0 0	0 0	1 0	0 0	0 0	0 0
	# Without Weapon	7 0	6 0	6 0	11 6 pending	9 0	7 0	8 0	8 0	9 0	2 0	13 0	2 0
Number of Forced Moves Used* **	(Cell extraction or other forced relocation of offenders)	12	17	20	21	25	16	21	24	18	25	9	16
Disturbances** **		0	3	0	2	1	0	2	4	0	0	2	2
Number of Times Chemical Agents Used		24	24	31	26	33	27	18	21	14	21	21	20
Number of Times Special Reaction Team Used		0	2	0	1	0	0	0	0	0	0	0	0
Four/Five Point Restraints	Number	0	0	0	2	0	0	2	4	1	1	3	1
	Indicate type (chair, bed, board, etc.)	N/A	N/A	N/A	C	N/A	N/A	C	C	C	C	C	C
Offender Medical Referrals as a Result of Injuries Sustained	#'s should reflect incidents on this form, not rec or other source	7	8	3	3	11	7	5	8	7	10	8	4
Escapes	# Attempted	0	0	0	0	0	0	0	0	0	0	0	0
	# Actual	0	0	0	0	0	0	0	0	0	0	0	0
Substantiated Grievances (resolved in favor of offender)	Reason (medical, food, religious, etc.)	5/8/0/33 M F R E	17/6/0/39 M F R E	16/20/2/42 M F R E	17/20/1/91 M F R E	28/7/3/88 M F R E	20/12/2/78 M F R E	23/50/1/87 M F R E	9/28/0/111 M F R E	4/42/1/81 M F R E	3/19/2/109 M F R E	8/10/01/79 M F R E	1/12/0/56 M F R E
	Number	46	62	80	129	126	112	161	148	128	133	98	69
Deaths	Reason (violent, illness, suicide, natural)	N/A	N/A	N/A	N/A	N/A	Natural	Natural, Suicid	N/A	N/A	N/A	pending	
	Number	0	0	0	0	0	1	2	0	0	0	2	

*Any physical contact that involves two or more offenders
**Oral, anal or vaginal copulation involving at least two parties
***Routine transportation of offenders is not considered "forced"
****Any incident that involves four or more offenders. Includes gang fights, organized multiple hunger strikes, work stoppages, hostage situations, major fires, or other large scale incidents

Facility Year

Measure Code	Total	Outcome Measure Text	Total
1A-1-Denominator	792	Average number of Full-Time Equivalent (FTE) staff positions in the last 12 months	0
1A-1-Numerator	105	Number of worker compensation claims filed for injuries that resulted from the physical environment / Injury on Duty in the past 12 months	
1A-2-Denominator	3004	Average Daily Population in the past 12 months	
1A-2(1)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Inmates ONLY)	0
1A-2(2)-Numerator	1	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Staff ONLY)	0
1A-2(3)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Volunteers ONLY)	0
1A-2(4)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Community ONLY)	0
1A-2(5)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Contractors ONLY)	0
1A-3-Denominator	10102	The number of admissions in the past 12 months	
1A-3(1)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Inmates ONLY)	0

1A-3(2)-Numerator	1	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Staff ONLY)	0
1A-3(3)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Volunteers ONLY)	0
1A-3(4)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Community ONLY)	0
1A-3(5)-Numerator	0	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months (Contractors ONLY)	0
1A-4-Denominator	3004	Average Daily Population in the past 12 months	
1A-4(1)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Inmates ONLY)	0
1A-4(2)-Numerator	35	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Staff ONLY)	0
1A-4(3)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Volunteers ONLY)	0
1A-4(4)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Community ONLY)	0

1A-4(5)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Contractors ONLY)	0
1A-5-Denominator	10102	The number of admissions in the past 12 months	
1A-5(1)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Inmates ONLY)	0
1A-5(2)-Numerator	31	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Staff ONLY)	0
1A-5(3)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Volunteers ONLY)	0
1A-5(4)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Community ONLY)	0
1A-5(5)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months (Contractors ONLY)	0
1A-6-Numerator	3	Number of sanitation or health code violations identified by external agencies in the past 12 months	
1A-6-Denominator	3004	Average Daily Population in the past 12 months	0
1A-7-Numerator	198	Number of health code violations corrected in the	

		past 12 months	
1A-7-Denominator	198	The number of health code violations identified in the past 12 months	1
1A-8-Numerator	24	Number of inmate grievances related to safety or sanitation found in favor of inmates in the past 12 months	
1A-8-Denominator	226	The number of inmate's grievances related to safety or sanitation in the past 12 months	0
1A-9-Numerator	2	Number of fire code violations corrected in the past 12 months	
1A-9-Denominator	2	The number of fire code violations cited by jurisdictional authority in the past 12 months	1
1A-10-Numerator	0	Number of inmate injuries resulting from fires requiring medical treatment in a 12-month period	
1A-10-Denominator	3004	Average Daily Population in the past 12 months	0
1A-11-Denominator		Average Daily Population of inmates in the past 12 months	
1A-11-Numerator	0	Number of inmate injuries (other than by fire) requiring medical treatment in the past 12 months	
1A-12-Numerator	0	Number of staff injuries resulting from fires requiring medical treatment in the past 12 months	
1A-12-Denominator	701	The Average Daily Population of staff in the past 12 months	0
1A-13-Numerator	56	Number of staff injuries (other than fire) requiring medical treatment in the past 12 months	
1A-13-Denominator	664	The Average Daily Population of staff in the past 12 months	0

1A-14-Numerator	0	Number of inmate lawsuits related to safety or sanitation found in favor of the inmate in the past 12 months	
1A-14-Denominator	0	The number of inmate lawsuits related to safety or sanitation in the past 12 months	0
1B-1-Numerator	0	Number of vehicle accidents resulting in property damage in the past 12 months	
1B-1-Denominator	3004	Average Daily Population in the past 12 months	0
1B-2-Numerator	0	Number of vehicle accidents resulting in injuries requiring medical treatment for any party in the past 12 months	
1B-2-Denominator	3004	Average Daily Population in the past 12 months	0
1B-3-Denominator	3004	Average Daily Population in the past 12 months	0
1B-3-Numerator	0	Amount ($) of damage from vehicle accidents in the past 12 months	
1C-1-Numerator	1	Number of emergencies, caused by forces external to the facility, that result in property damage in the past 12 months	
1C-1-Denominator	82	The number of emergencies	0
1C-2-Denominator	3004	Average Daily Population in the past 12 months	
1C-2(1)-Numerator	0	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months (Inmates ONLY)	0
1C-2(2)-Numerator	6	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months (Staff ONLY)	0

1C-2(3)-Numerator	0	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months (Volunteers ONLY)	0
1C-2(4)-Numerator	0	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months (Community ONLY)	0
1C-2(5)-Numerator	0	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months (Contractors ONLY)	0
1C-3-Numerator	6	Number of times that normal facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months	
1C-3-Denominator	3004	Average Daily Population in the past 12 months	0
1C-4-Denominator	6	The number of emergencies caused by forces external to the facility	23
1C-4-Numerator	137	Number of hours that facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months	
1C-5-Numerator	3	Number of emergencies that were not caused by forces external to the facility that resulted in property damage in the past 12 months	
1C-5-Denominator	3004	Average Daily Population in the past 12 months	0
1C-6-Numerator	281	Number of injuries requiring medical attention that result from emergencies that were not caused by forces external to the facility in the past 12	

months

1C-6-Denominator	3004	Average Daily Population in the past 12 months	0
1C-7-Numerator	60	Number of times that normal facility operations were suspended due to emergencies that were not cased by forces external to the facility in the past 12 months	
1C-7-Denominator	3004	Average Daily Population in the past 12 months	0
1C-8-Denominator	59	The number of emergencies	2
1C-8-Numerator	138	Number of hours that facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months	
1C-9-Denominator	3004	Average Daily Population in the past 12 months	
1C-9(1)-Numerator	0	Number of injuries resulting from fires requiring medical treatment in the past 12 months (Inmates ONLY)	0
1C-9(2)-Numerator	0	Number of injuries resulting from fires requiring medical treatment in the past 12 months (Staff ONLY)	0
1C-9(3)-Numerator	0	Number of injuries resulting from fires requiring medical treatment in the past 12 months (Volunteers ONLY)	0
1C-9(4)-Numerator	0	Number of injuries resulting from fires requiring medical treatment in the past 12 months (Community ONLY)	0
1C-9(5)-Numerator	0	Number of injuries resulting from fires requiring medical treatment in the past 12 months (Contractors ONLY)	0

1C-10-Numerator	1	Number of fires that resulted in property damage in the past 12 months	
1C-10-Denominator	3004	Average Daily Population in the past 12 months	0
1C-11-Numerator	0	Amount ($) of property damage from fire in the past 12 months	
1C-11-Denominator	3004	Average Daily Population in the past 12 months	0
1C-12-Denominator	3004	Average Daily Population in the past 12 months	0
1C-12-Numerator	38	Number of code violations cited in the past 12 months	
1C-13-Numerator	0	Number of incidents involving toxic or caustic materials in the past 12 months	
1C-13-Denominator	3004	Average Daily Population in the past 12 months	0
1C-14-Numerator	177	Number of incidents of inventory discrepancies in the past 12 months	
1C-14-Denominator	3004	Average Daily Population in the past 12 months	0
2A-1-Numerator	327	Number of incidents involving harm in the past 12 months	
2A-1-Denominator	3004	Average Daily Population in the past 12 months	0
2A-2-Numerator	327	Number of incidents involving harm in the past 12 months	
2A-2-Denominator	10102	The number of admissions in the past 12 months	0
2A-3-Denominator	3004	Average Daily Population in the past 12 months	
2A-3(1)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Inmates Only)	0
2A-3(2)-Numerator	8	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12	0

		months (Staff ONLY)	
2A-3(3)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Volunteers ONLY)	0
2A-3(4)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Community ONLY)	0
2A-3(5)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Contractors ONLY)	0
2A-4-Denominator	10102	The number of admissions in the past 12 months	
2A-4(1)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Inmates Only)	0
2A-4(2)-Numerator	7	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Staff ONLY)	0
2A-4(3)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Volunteers ONLY)	0
2A-4(4)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Community ONLY)	0
2A-4(5)-Numerator	0	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months (Contractors ONLY)	0

2A-5-Numerator	5	Number of unauthorized inmate absences from the facility in the past 12 months	
2A-5-Denominator	3004	Average Daily Population in the past 12 months	0
2A-6-Numerator	0	Number of instances of unauthorized access to the facility in the past 12 months	
2A-6-Denominator	3004	Average Daily Population in the past 12 months	0
2B-1-Denominator	3004	Average Daily Population in the past 12 months	0
2B-1-Numerator	479	Number of instances in which force was used in the past 12 months	
2B-2-Numerator	479	Number of instances in which force was used in the past 12 months	
2B-2-Denominator	10102	The number of admissions in the past 12 months	0
2B-3-Numerator	3	Number of times that staff uses of force were found to have been inappropriate in the past 12 months	
2B-3-Denominator	479	The number of instances in which force was used	0
2B-4-Numerator	32	Number of inmate grievances filed alleging inappropriate use of force in the past 12 months	
2B-4-Denominator	3004	Average Daily Population in the past 12 months	0
2B-5-Numerator	3	Number of grievances alleging inappropriate use of force decided in favor of inmate in the past 12 months	
2B-5-Denominator	32	The number of grievances alleging inappropriate use of force filed	0
2B-6-Denominator	3004	Average Daily Population in the past 12 months	
2B-6(1)-Numerator	25	Number of injuries requiring medical treatment resulting from staff use of force in the past 12 months (Staff ONLY)	0

2B-6(2)-Numerator	0	Number of injuries requiring medical treatment resulting from staff use of force in the past 12 months (Inmates ONLY)	0
2C-1-Numerator	550	Number of incidents involving contraband in the past 12 months	
2C-1-Denominator	3004	Average Daily Population in the past 12 months	0
2C-2-Numerator	550	Number of incidents involving contraband in the past 12 months	
2C-2-Denominator	10102	The number of admissions in the past 12 months	0
2C-3-Numerator	40	Number of weapons found in the facility in the past 12 months	
2C-3-Denominator	3004	Average Daily Population in the past 12 months	0
2C-4-Numerator	99	Number of controlled substances found in the facility in the past 12 months	
2C-4-Denominator	3004	Average Daily Population in the past 12 months	0
2C-5-Denominator	10102	The number of admissions in the last 12 months	0
2C-5-Numerator	99	Number of controlled substances found in the facility in the past 12 months	
2D-1-Numerator	204	Number of incidents involving keys in the past 12 months	
2D-1-Denominator	3004	Average Daily Population in the past 12 months	0
2D-2-Numerator	40	Number of incidents involving tools in the past 12 months	
2D-2-Denominator	3004	Average Daily Population in the past 12 months	0
2D-3-Numerator	4	Number of incidents involving culinary equipment in the past 12 months	
2D-3-Denominator	3004	Average Daily Population in the past 12 months	0

2D-4-Numerator	3	Number of incidents involving medical equipment and sharps in the past 12 months	
2D-4-Denominator	3004	Average Daily Population in the past 12 months	0
3A-1-Numerator	10932	Number of rule violations in the past 12 months	
3A-1-Denominator	3004	Average Daily Population in the past 12 months	4
3A-2-Denominator	3004	Average Daily Population in the past 12 months	0
3A-2-Numerator	282	Number of assaults - inmate against inmate, inmate against staff in the past 12 months	
4A-1-Denominator	3004	Average Daily Population in the past 12 months	0
4A-1-Numerator	0	Number of documented inmate illnesses attributed to food service operations in the past 12 months	
4A-2-Numerator	183	Number of inmate grievances about food service decided in favor of the inmate in the past 12 months	
4A-2-Denominator	1441	The number of inmate grievances about food service in the past 12 months	0
4A-3-Numerator	14	Number of violations cited by independent authorities for food service sanitation in the past 12 months (yearly total only)	
4B-1-Numerator	32	Inmate grievances regarding inmate access to personal hygiene decided in favor of the inmate in the past 12 months	
4B-1-Denominator	3004	Average Daily Population in the past 12 months	0
4B-2-Numerator	0	Number of inmate illnesses attributed to poor hygiene practices in the past 12 months	
4B-2-Denominator	3004	Average Daily Population in the past 12 months	0

4B-3-Numerator	171	Number of inmates diagnosed with hygiene-related conditions (scabies, lice, or fungal infections) in the past 12 months	
4B-3-Denominator	3004	Average Daily Population in the past 12 months	0
4B-4-Numerator	36	Number of inmate grievaces related to hygiene found in favor of the inmate in the past 12 months	
4B-4-Denominator	104	The number of inmate grievances related to hygiene in the past 12 months	0
4B-5-Denominator	0	The number of inmate lawsuits related to hygiene in the past 12 months	0
4B-5-Numerator	0	Number of inmate lawsuits related to hygiene found in favor of the inmate in the past 12 months	
4C-1-Numerator	730	Number of inmates with a positive tuberculin skin test on admission in the past 12 months	
4C-1-Denominator	10102	The number of admissions in the past 12 months	0
4C-2-Numerator	6	Number of inmates diagnosed with active tuberculosis in the past 12 months	
4C-2-Denominator	3004	Average Daily Population in the past 12 months	0
4C-3-Numerator	1	Number of conversions to a positive tuberculin skin test in the past 12 months	
4C-3-Denominator	31705	The number of tuberculin skin tests given in the past 12 months	0
4C-4-Numerator	0	Number of inmates with a positive tuberculin skin test who complete prophylaxis treatment for tuberculosis in the past 12 months	

4C-4-Denominator	7	The number of inmates with a positive tuberculin skin test on prophylaxis treatment for tuberculosis in the past 12 months	0
4C-5-Numerator	187	Number of Hepatitis C positive inmates in the past 12 months	
4C-5-Denominator	3004	Average Daily Population in the past 12 months	0
4C-6-Numerator	232	Number of HIV positive inmates in the past 12 months	
4C-6-Denominator	3004	Average Daily Population in the past 12 months	0
4C-7-Numerator	341	Number of HIV positive inmates who are being treated with highly active antiretroviral treatment in the past 12 months	
4C-7-Denominator	444	The number of known HIV positive inmates in the past 12 months	1
4C-8-Numerator	3493	Number of inmates diagnosed with an Axis I (excluding sole diagnosis of substance abuse) in the past 12 months	
4C-8-Denominator	3004	Average Daily Population in the past 12 months	1
4C-9-Numerator	16	Number of inmate suicide attempts in the past 12 months	
4C-9-Denominator	3004	Average Daily Population in the past 12 months	0
4C-10-Numerator	1	Number of inmate suicides in the past 12 months	
4C-10-Denominator	3004	Average Daily Population in the past 12 months	0
4C-11-Numerator	0	Number of inmate deaths due to homicide in the past 12 months	
4C-11-Denominator	3004	Average Daily Population in the past 12 months	0
4C-12-Denominator	3004	Average Daily Population in the past 12 months	0
4C-12-Numerator	0	Number of inmate deaths due to injuries in the past 12 months	

4C-13-Numerator	0	Number of medically expected deaths in the past 12 months	
4C-13-Denominator	3004	Average Daily Population in the past 12 months	0
4C-14-Numerator	4	Number of medically unexpected deaths in the past 12 months	
4C-14-Denominator	3004	Average Daily Population in the past 12 months	0
4C-15-Numerator	0	Number of inmate admissions to the infirmary (where available) in the past 12 months	
4C-15-Denominator	3004	Average Daily Population in the past 12 months	0
4C-16-Numerator	501	Number of inmate admissions to off-site hospitals in the past 12 months	
4C-16-Denominator	3004	Average Daily Population in the past 12 months	0
4C-17-Denominator	3004	Average Daily Population in the past 12 months	0
4C-17-Numerator	1060	Number of inmates transported off-site (via an ambulance or correctional vehicle) for treatment of emergency health conditions in the past 12 months	
4C-18-Numerator	1083	Number of inmate specialty consults completed in the past 12 months	
4C-18-Denominator	1452	The number of specialty consults (on-site or off-site) ordered by primary health care provider (MD, NP, PA) in the past 12 months	1
4C-19-Numerator	19	Number of inmate grievances about access to health care services found in favor of the inmate in the past 12 months	
4C-19-Denominator	230	The number of inmate grievances about access to health care services in the past 12 months	0

4C-20-Numerator	19	Number of inmate grievances related to the quality of health care found in favor of inmates in the past 12 months	
4C-20-Denominator	172	The number of inmate grievances related to the quality of health care in the past 12 months	0
4C-21-Numerator	0	Number of inmates' lawsuites about access to health care services found in favor of inmates in the past 12 months	
4C-21-Denominator	0	The number of inmates' lawsuits about access to health care services in the past 12 months	0
4C-22-Denominator	3004	Average Daily Population in the past 12 months	7
4C-22-Numerator	20027	Number of individual sick call encounters in the past 12 months	
4C-23-Numerator	4989	Number of physician visits in the past 12 months	
4C-23-Denominator	3004	Average Daily Population in the past 12 months	2
4C-24-Numerator	3284	Number of individualized dental treatment plans in the past 12 months	
4C-24-Denominator	3004	Average Daily Population in the past 12 months	1
4C-25-Numerator	1753	Number of hypertensive inmates enrolled in a a chronic care clinic in the past 12 months	
4C-25-Denominator	3004	Average Daily Population in the past 12 months	1
4C-26-Numerator	641	Number of diabetic inmates enrolled in a chronic care clinic in the past 12 months	
4C-26-Denominator	3004	Average Daily Population in the past 12 months	0
4C-27-Numerator	46	Number of incidents involving pharmaceuticals as contraband in the past 12 months	
4C-27-	3004	Average Daily Population in	0

Denominator		the past 12 months	
4C-28-Numerator	758	Number of cardiac diets received by inmates with cardiac disease in the past 12 months	
4C-28-Denominator	486	The number of cardiac diets prescribed in the past 12 months	2
4C-29-Numerator	12	Number of hypertensive diets received by inmates with hypertension in the past 12 months	
4C-29-Denominator	14	The number of hypertensive diets prescribed in the past 12 months	1
4C-30-Denominator	1387	Number of diabetic diets prescribed in the past 12 months	1
4C-30-Numerator	1737	Number of diabetic diets received by inmates with diabetes in the past 12 months	
4C-31-Numerator	38	Number of renal diets received by inmates with renal disease in the past 12 months	
4C-31-Denominator	30	The number of renal diets prescribed in the past 12 months	1
4C-32-Numerator	2	Number of needle-stick injuries in the past 12 months	
4C-32-Denominator	980	The number of employees in the past 12 months	0
4C-33-Numerator	10	Number of pharmacy dispensing errors in the past 12 months	
4C-33-Denominator	25039	The number of prescriptions dispensed by the pharmacy in the past 12 months	0
4C-34-Numerator	93	Number of nursing medication administration errors in the past 12 months	
4C-34-Denominator	26252	The number of medications administered in the past 12 months	0

4D-1-Numerator	5	Number of staff with lapsed licensure and/or certification in the past 12 months	
4D-1-Denominator	760	The number of licensed or certified staff in the past 12 months	0
4D-2-Numerator	51	Number of new employees in the past 12 months who completed orientation training prior to undertaking job assignments	
4D-2-Denominator	56	The number of new employees in the past 12 months	1
4D-3-Numerator	246	Number of employees who completed in-service training requirements in the past 12 months	
4D-3-Denominator	264	The number of employees eligible in the past 12 months	1
4D-4-Denominator	33	The number of authorized MD staff positions in the past 12 months	0
4D-4-Numerator	4	Number of MD staff who left employment in the past 12 months	
4D-5-Numerator	13	Number of RN staff who left employment in the past 12 months	
4D-5-Denominator	183	The number of authorized RN staff positions in the past 12 months	0
4D-6-Numerator	15	Number of LPN staff who left employment in the past 12 months	
4D-6-Denominator	535	The number of authorized LPN staff positions in the past 12 months	0
4D-7-Numerator	0	Number of medical records staff who left employment in the past 12 months	
4D-7-Denominator	12	The number of authorized medical records staff positions in the past 12 months	0
4D-8-Denominator	3004	Average Daily Population in the past 12 months	0

4D-8-Denominator		NONE	
4D-8-Numerator	14	Number of alleged sexual misconduct incidents between staff and detainees in the past 12 months	
4D-8 Numerator		NONE	
4D-9-Denominator	3004	Average Daily Population in the past 12 months	0
4D-9-Numerator	0	Number of alleged sexual misconduct incidents between volunteers and/or contract personnel and detainees during the past 12 months	
4D-10-Denominator	3004	Average Daily Population in the past 12 months	0
4D-10-Numerator	4	Number of confirmed sexual misconduct incidents between staff and detainees in the past 12 months	
4D-11-Denominator	3004	Average Daily Population in the past 12 months	0
4D-11-Numerator	0	Number of confirmed sexual misconduct incidents between volunteers and/or contract personnel and detainees during the past 12 months	
4D-12-Denominator	3004	Average Daily Population in the past 12 months	0
4D-12-Numerator	103	Number of detainees identified as high risk with a history of sexual assaultive behavior in the past 12 months	
4D-13-Numerator	50	Number of detainees identified as at risk for sexual victimization in the past 12 months	
4D-13-Denominator	3004	Average Daily Population in the past 12 months	0
5A-1-Denominator	4630	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months	0

5A-1-Numerator	96	Number of inmates who passed GED exams while confined in the past 12 months	
5A-2-Denominator	4630	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months	0
5A-2-Numerator	1058	Total number of grade levels advanced by inmates in the past 12 months	
5A-3-Numerator	631	Number of certificates of vocational competency awarded to inmates in the past 12 months	
5A-3-Denominator	4630	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months	0
5B-0-		NONE	
5C-0-		NONE	
6A-1-Denominator	3004	Average Daily Population in the past 12 months	0
6A-1-Numerator	400	Total number of inmate grievances in the past 12 months regarding: (a) access to court; (b) mail or correspondance; (c) sexual harassment; (d) discipline; (e) discrimination; (f) protection from harm	
6A-2-Numerator	123	Number of inmate grievances (see [a] through [e] above) decided in favor of inmates in the past 12 months	
6A-2-Denominator	8039	The total number of grievances filed in the past 12 months	0
6A-3-Denominator	3004	Average Daily Population in the past 12 months	0
6A-3-Numerator	12	Total number of inmate court suits alleging violation of inmate rights filed against the facility in the past 12 months	

6A-4-Numerator	0	Number of inmate court suits alleging violation of inmate rights decided in favor of inmates in the past 12 months	
6A-4-Denominator	21	The total number of inmate suits filed in the past 12 months	0
6B-1-Denominator	3004	Average Daily Population in the past 12 months	0
6B-1-Numerator	11	Number of inmate grievances regarding discrimination in the past 12 months	
6B-2-Denominator	12	The total number of inmate grievances filed regarding discrimination in the past 12 months	0
6B-2-Numerator	0	Number inmate grievances regarding discrimination resolved in favor of inmates in the past 12 months	
6B-3-Denominator	3004	Average Daily Population in the past 12 months	0
6B-3-Numerator	1179	Number of grievances resolved in favor of inmates in the past 12 months	
6B-4-Numerator	1172	Number of grievances resolved in favor of inmates in the past 12 months	
6B-4-Denominator	8039	The total number of grievances filed in the past 12 months	0
6B-5-Numerator	0	Number of court malpractice or torte liability cases found in favor of the inmate in the past 12 months	
6B-5-Denominator	9	The number of court malpractice or torte liability cases in the past 12 months	0
6C-1-Denominator	3004	Average Daily Population in the past 12 months	0
6C-1-Numerator	0	Number of disciplinary incidents resolved informally in the past 12 months	
6C-2-Denominator	3385	The total number of disciplinary decisions made in the psat 12 months	0

6C-2-Numerator	140	Number of formal inmate disciplinary decisions that were appealed in the past 12 months	
6C-3-Numerator	0	Number of appealed disciplinary decisions decided in favor of the inmate in the past 12 months	
6C-3-Denominator	3485	The total number of disciplinary decisions made in the past 12 months	0
6C-4-Numerator	57	Number of disciplinary appeals / grievances filed by inmates challenging disciplinary procedures in the past 12 months	
6C-4-Denominator	3004	Average Daily Population in the past 12 months	0
6C-5-Numerator	5	Number of disciplinary-related grievances resolved in favor of the inmate in the past 12 months	
6C-5-Denominator	44	The total number of disciplinary-related grievances filed in the past 12 months	0
6C-6-Denominator	3004	Average Daily Population in the past 12 months	0
6C-6-Numerator	0	Number of court suits filed against the facility regarding discipline in the past 12 months	
6C-7-Denominator	0	The total number of court decisions regarding discipline decided in the past 12 months	0
6C-7-Numerator	0	Number of court cases regarding discipline decided against the facility in the past 12 months	
6C-8-Denominator	3004	Average Daily Population in the past 12 months	4
6C-8-Numerator	10932	Number of rule violations in the past 12 months	
6C-9-Numerator	487	Number of inmates terminated from the facility due to rule violations in the past 12	

		months	
6C-9-Denominator	3004	Average Daily Population in the past 12 months	0
6D-1-Denominator	362	The number of inmates who had restitution obligations in the past 12 months	0
6D-1-Numerator	16	Number of inmates released in the past 12 months who made regular payments toward their restitution obligations	
6D-2-Numerator	0	Number of inmates who satisfy their court cost / fines obligations in the past 12 months	
6D-2-Denominator	362	The number of inmates who had court cost / fine obligations in the past 12 months	0
6D-3-Numerator	25240	Total amount of restitution paid by inmates in the past 12 months	
6D-3-Denominator	3004	Average Daily Population in the past 12 months	8
6D-4-Denominator	3004	Average Daily Population in the past 12 months	83
6D-4-Numerator	250704	Total number of hours of community service donated by inmates in the past 12 months	
6D-5-Numerator	92	Total number of inmates who participated in restitution in the past 12 months	
6D-5-Denominator	68088	The total number of inmates housed in the past 12 months	0
6D-6-Numerator	2628	Total number of inmates who participated in community service work in the past 12 months	
6D-6-Denominator	68750	The total number of inmates housed in the past 12 months	0
6D-7-Denominator	68750	The total number of inmates housed in the past 12 months	0

6D-7-Numerator	0	Total number of inmates who participated in victim awareness programs in the past 12 months	
6D-8-Denominator	68750	The total number of inmates housed in the past 12 months	0
6D-8-Numerator	25240	Total amount of restitution paid by inmates in the past 12 months	
6D-9-Denominator	68750	The total number of inmates housed in the past 12 months	3
6D-9-Numerator	201299	Total number of hours delivered by inmates who participated in community service work in the past 12 months	
7A-0-		NONE	
7B-1-Denominator	8950	The number of staff at the end of the last calendar year	0
7B-1-Numerator	830	Total number of years of staff members' education as of the end of the last calendar year	
7B-2-Numerator	72	Number of staff who left employment for any reason in the past 12 months	
7B-2-Denominator	9500	The number of full-time equivalent staff positions in the past 12 months	0
7B-3-Numerator	155	Total number of credit hours in courses relevant to their facility responsibilities earned by staff participating in higher education in the past 12 months	
7B-3-Denominator	9500	The number of full-time equivalent staff positions in the past 12 months	0
7B-4-Numerator	1078	Number of professional development events attended by staff in the past 12 months	
7B-4-Denominator	9500	The number of full-time equivalent staff positions in the past 12 months	0
7C-1-Denominator	9500	The number of full-time equivalent staff positions in the past 12 months	0

7C-1-Numerator	49	Number of incidents in which staff was found to have acted in violation of facility policy in the past 12 months	
7C-2-Numerator	13	Number of staff terminated for conduct violations in the past 12 months	
7C-2-Denominator	9500	The number of full-time equivalent staff positions in the past 12 months	0
7C-3-Denominator	61	The number of inmate grievances alleging improper staff conduct filed in the past 12 months	0
7C-3-Numerator	2	Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months	
7C-4-Denominator	3004	Average Daily Population in the past 12 months	0
7C-4-Numerator	0	Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months	
7C-5-Numerator	1	Where staff is tested, the number of staff substance abuse tests failed in the past 12 months	
7C-5-Denominator	250	The number of staff substance abuse tests administered in the past 12 months	0
7C-6-Numerator	0	Number of staff terminations for violation of drug-free work policy in the past 12 months	
7C-6-Denominator	52	The number of staff terminations / resignations in the past 12 months	0
7C-7-Denominator	33	The number of physician positions authorized in the past 12 months	0
7C-7-Numerator	3	The average number of physicians employed in the past 12 months	
7C-8-Denominator	675	The number of nurse positions authorized in the past 12	0

		months	
7C-8-Numerator	52	The average number of nurses employed in the past 12 months	
7C-9-Denominator	91	The number of mid-level health care practitioners positions authorized in the past 12 months	0
7C-9-Numerator	8	The average number of mid-level health care practitioners employed in the past 12 months	
7C-10-Denominator	98	The number of ancillary health care staff positions authorized in the past 12 months	0
7C-10-Numerator	8	The average number of ancillary health care staff employed in the past 12 months	
7D-1-Denominator	42803710	The budget for the past 12 months	0
7D-1-Numerator	0	Net amount of budget shortfalls or surplus at the end of the last fiscal year (budget less expenditures)	
7D-2-Numerator	0	Number of material audit findings by an independent financial auditor at the conclusion of the last audit. (yearly total only)	
7D-3-Numerator	61	Number of grievances filed by inmates regarding their records or property in the past 12 months	
7D-3-Denominator	3004	Average Daily Population in the past 12 months	0
7D-4-Denominator	63	The total number of inmate grievances (records / property) in the past 12 months	0
7D-4-Numerator	10	Number of inmate grievances (records / property) decided in favor of inmates in the past 12 months	

7D-5-Numerator	132	Number of objectives achieved in the past 12 months	
7D-5-Denominator	292	The number of objectives for the past 12 months	0
7D-6-Numerator	7	Number of program changes made in the past 12 months	
7D-6-Denominator	15	The number of program changes recommended in the past 12 months	0
7D-7-Denominator	4	The number of problems identified by internal health care review in the past 12 months	1
7D-7-Numerator	4	Number of problems identified by internal health care review that were corrected in the past 12 months	
7E-1-Denominator	9500	The number of full-time equivalent staff positions in the past 12 months	
7E-1(1)-Numerator	1	Number of grievances filed by staff in the past 12 months	0
7E-1(2)-Numerator	28	Number of grievances filed by staff in the past 12 months	0
7E-2-Denominator	0	The total number of staff grievances decided in favor of staff in the past 12 months	
7E-2(1)-Numerator	0	Number of staff grievances decided in favor of staff in the past 12 months	#DIV/0!
7E-2(2)-Numerator	9	Number of staff grievances decided in favor of staff in the past 12 months	#DIV/0!
7E-3-Denominator	9780	The number of staff at the end of the last calendar year (e.g. average number of years experience)	10
7E-3-Numerator	96132	Total number of years of staff members' experience in the field as of the end of the last calendar year	
7E-4-Denominator	32	The number of staff termination or demotion hearings requested in the past	1

		12 months	
7E-4-Numerator	25	Number of staff termination, suspension or demotion hearings in which the facility decision was upheld in the past 12 months	
7F-1-Numerator	8460	Total number of hours of volunteer service delivered by members of the community in the past 12 months	
7F-1-Denominator	3004	Average Daily Population in the past 12 months	3
7F-2-Denominator	3004	Average Daily Population in the past 12 months	
7F-2-Numerator		Total number of individual community members who provided voluntary service in the past 12 months	
7F-3-Denominator	3004	Average Daily Population in the past 12 months	0
7F-3-Numerator	1	Total number of complaints filed by media regarding access to information in the past 12 months	
7F-4-Numerator	2	Total number of positive statements made by media regarding the facility in the past 12 months	
7F-4-Denominator	3004	Average Daily Population in the past 12 months	0
7F-5-Numerator	12	Total number of complaints from the community in the past 12 months	
7F-5-Denominator	3004	Average Daily Population in the past 12 months	0
7F-6-Denominator	3004	Average Daily Population in the past 12 months	67
7F-6-Numerator	201299	Total number of hours of community service work delivered by inmates in the past 12 months	

A. Lexington County Detention Center, SC
B. November 18, 2011
1

1Lexington County Detention Center, SC
November 18, 2011

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On October 13-14, 2011 NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2008 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual.

There are 35 essential standards; 34 are applicable to this facility and 33 (97%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standard Not in Compliance

J-G-04	Basic Mental Health Services

Essential Standard Not Applicable

J-G-03	Infirmary Care

There are 32 important standards; 31 are applicable to this facility and 29 (94%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standards Not in Compliance

J-C-02	Clinical Performance Enhancement
J-F-03	Use of Tobacco

Important Standard Not Applicable

J-C-08	Health Care Liaison

Decision: On November 18, 2011, NCCHC's Accreditation Committee awarded the facility Continuing Accreditation with Verification (CAV), *contingent* upon receiving requested compliance verification by February 17, 2012.

I. Facility Profile

Type of Facility:	Jail
Total Admissions for 2010:	13,483
Design-rated capacity:	641
Average daily population:	893.1
Average daily intake:	36.9
Satellite:	none

Description of Facility

This southern east coast facility is next to the main sheriff's department complex. The main jail (maximum security) was built in 1975; an annex was added in 1991; and in 1999, a maximum and medium security facility was built as a means to accommodate the increasing demand for cell space. Since the last survey, the kitchen floor and heating and air conditioning units in the dormitories have been replaced.

The original housing units are three-story, each containing three linear-style housing units. There is a common day room outside the cells and an exercise yard. Another section follows the direct supervision style of management. Each housing unit consists of two floors with a large common day room, a multipurpose room, and an additional exercise area. Some housing units have half-walls with no doors, and other pods have doors on each cell. The third style is constructed with a large day space and rows of beds in cubicle-style configuration.

Adult male and female inmates for municipal, county, state, and federal law enforcement agencies are housed here, as are sentenced state and local inmate workers, who provide labor at the facility and other county government offices and departments.

A total of 110 correctional officers (COs) are scheduled on duty during two work shifts.

Inmate Population Characteristics

On the day of the survey, there were 759 inmates (658 men and 101 women).

Facility's Health Services

Health services have been provided by a correctional health care contractor since February 2008. Mental health services are provided by a separate contractor.

Staffing

Health staff are on site 24 hours a day, seven days a week. At the time of the survey, there were 17 full-time staff and several part-time staff; there were no vacancies.

II. Survey Method

The on-site survey consisted of touring the clinic area, inmate housing areas, and segregation. We reviewed 51 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and correctional officer (CO) training records. We interviewed the major, lieutenant (from support services), health services administrator (HSA), medical director, psychiatrist, psychologist, dentist, several nurses, medical records clerk, five correctional officers, and six randomly selected inmates.

III. Survey Findings and Comments

A.GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Inmates have access to health care. Patients are seen by a qualified clinician and receive care for their serious medical, mental health, and dental needs. Inmates are assessed $5.00 for self-initiated services and for new prescriptions. The following services are exempt from the policy: receiving screening, communicable disease testing, court ordered treatment, initial health assessment, food handlers' medical screening, health education, chronic care clinic visits, pregnancy care, major mental health illnesses, federal inmates' health care, and other services initiated by health staff. All inmates receive care regardless of ability to pay. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is a correctional health care contractor, whose on-site representative is the full-time HSA. Clinical judgments rest with the designated responsible physician. He is on site 32 hours a week. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding inmates' serious medical, dental, and mental health needs in the inmates' best interests. We noted excellent cooperation between custody and health staff. Administrative decisions (such as utilization review) are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. The standard is met.

J-A-04 Administrative Meetings and Reports (E). Custody administrators, the HSA, and other necessary health staff meet at least quarterly to discuss issues related to health services. Health service utilization statistical reports are distributed and discussed. Health staff (HSA, nursing staff, a mental health staff representative, and other invited guests) meet monthly to ensure information sharing, problem solve, receive ongoing education, and to discuss health services operations. Staff who are unable to attend review the meeting minutes. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy manual is site-specific. The RHA last reviewed it on June 21, 2011. The standard is met.

J-A-06 Continuous Quality Improvement Program (E). The comprehensive continuous quality improvement program (CQI) program monitors major aspects of health care through a multidisciplinary committee that meets monthly. The membership includes the HSA, medical director, captain, medical staff, and other designated staff as needed. Outcome quality improvement study topics included the effectiveness of the influenza vaccine and Hemoglobin A1C values in diabetic patients. Process quality improvement study topics included the flow of request slips to improve sick call process, reduction of needle stick injuries, and the identification of patients with chronic care needs. The CQI program is reviewed annually for its effectiveness. The responsible physician is involved in the program; he designs CQI monitoring activities and assists with identifying thresholds, interpreting data, problem solving, and

implementing corrective actions. The standard is met.

J-A-07 Emergency Response Plan (E). Mass disaster drills have been conducted annually; the scenarios involved a riot and hostage situation in a housing unit and weather-related (earthquake and tornado) events. Health staff responded quickly and triaged the casualties, providing appropriate care. Man-down drills were documented in 2009, 2010, and 2011. The mass disaster and man-down drills were critiqued and shared with all health staff. The standard is met.

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health staff with regard to inmates' special health needs occurs verbally and in writing. The standard is met.

J-A-09 Privacy of Care (I). Health care encounters and discussion of patient privacy occur in auditory and visual privacy. Staff are instructed in maintaining confidentiality during orientation and annually thereafter. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). Since the last survey, there has been one inmate death, due to suicide. The inmate jumped from the second floor housing tier. The death review was complete; the RHA wrote the clinical mortality review, administration filed a thorough investigative review, and a psychological autopsy was completed within 30 days. Treating staff were informed of the mortality review results. Mental health staff implemented updated logging methods to track at-risk patients. The standard is met.

J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is integrated with the formal grievance program. On average, five health-related grievances are filed per month. The standard is met.

B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Control Program (E). Infection control is addressed through a CQI subcommittee. Inmates with communicable diseases can be treated in the medical isolation rooms on site. Effective ectoparasite control procedures are used to treat infected inmates. The areas in which health services are provided are inspected monthly for environmental issues.
The standard is met.

J-B-02 Patient Safety (I). An error reporting system is in place for health staff to voluntarily report, in a nonpunitive environment, errors that affect patient safety. During orientation, health staff are trained to report unanticipated problems involving risk to patients. Each adverse or near-miss clinical event is analyzed and discussed with the individual. Examples of events that would be reviewed include medication errors, near suicides, hospitalization resulting from delayed care or inappropriate treatment, and potentially serious occurrences that were identified prior to an adverse patient outcome. The standard is met.

J-B-03 Staff Safety (I). The health services' designated safety officer provides monthly in-

service programs on safety issues during the health staff meetings. The RHA promotes the use of safety needles by the staff. Health staff appears to work under safe and sanitary conditions. The standard is met.

J-B-04 Federal Sexual Assault Reporting Regulations (I). The major described the facility as compliant with the 2003 Federal Prison Rape Elimination Act. The standard is met.

J-B-05 Procedure In The Event of a Sexual Assault (I). All allegations of sexual assaults are initially investigated by custody staff. Victims of sexual assault are referred to a community facility for treatment and evidence collection and are offered prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases. They are also offered an evaluation by the psychologist for crisis intervention counseling. The standard is met.

C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentialing (E). Health care personnel who provide services to inmates have current licenses and other appropriate credentials on file. The credentialing process includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank. Health staff must undergo the security clearance required by the Sheriff's Department. The standard is met.

J-C-02 Clinical Performance Enhancement (I). The performance of the responsible physician and dentist has been reviewed annually and shared with them. A PhD-level psychologist was licensed in March 2011; she has been at the site for five years although in a different position; she is not due for a review until March 2012.

The psychiatrist, who is employed by a separate contracted provider, has not had a clinical performance enhancement review. **The standard is not met.**

> Corrective action is required for Compliance Indicator #1 The clinical performance of the facility's primary care providers should be reviewed at least annually. Clinical performance enhancement review processes are designed to enhance competence and address areas in need of improvement. Ultimately, honing the practitioner's clinical skills positively impacts patient care. The following is acceptable documentation for compliance: a log or other written record providing the name and signature of the psychiatrist, the date of the most recent clinical performance enhancement review in accordance with the standard, and the signature of the reviewer clinician. Corrective action is required in order to meet this standard.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals have the required number of continuing education credits; all are current in cardiopulmonary resuscitation (CPR) training. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff have the required training in health-related topics and more than 75% are current in CPR training. The standard is

met.

J-C-05 Medication Administration Training (E). Nurses administer medications. Proper administration of medication in a correctional setting is a topic during the nurses' orientation, which is documented on a checklist and filed in the personnel record. The standard is met.

J-C-06 Inmate Workers (E). Inmate workers do not provide health services at this facility; they are employed in a janitorial capacity in the health services unit, after being trained by a nurse and under supervision of custody staff. The standard is met.

J-C-07 Staffing (I). Full-time equivalent health staff includes:

Health Services Administrator	1.0
Medical Director	0.85
Registered Nurse	1.4
Licensed Practical Nurse	11.8
Dentist	0.2
Dental Assistant	0.3
Medical Record Technician	1.0
Administrative Assistant	1.0

The medical and mental health services fall under separate authorities. The state Department of Mental Health, Jail and Correctional Services contracts with the Sheriff's Office to provide services.

Psychiatrist	(at the community mental health center)
Psychiatrist (on site)	0.20
Ph-D Psychologist	0.94
Mental Health Professional	0.94
Masters-level Psychologist (weekends)	0.25

At the time of the survey, there were no vacancies. The standard is met.

J-C-08 Health Care Liaison (I). Health staff are on site 24 hours a day, seven days a week. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff have undergone the appropriate orientation. The orientation lesson plan is reviewed every two years, or more frequently as necessary. Orientation documents are filed in personnel records. The standard is met.

D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). Pharmaceutical services, which are provided by a national company and local pharmacies, are sufficient to meet the needs of the inmates. Space

dedicated to the medication area is small but appears functional. The medications are well-organized, secured, and inventoried; we found no outdated, discontinued, or recalled medications and verified the accuracy of the sharps and controlled substance counts. A consultant pharmacist inspects the medication practices monthly. The standard is met.

J-D-02 Medication Services (E). The responsible physician determines the prescriptive practices at this facility. Inmates entering the facility on prescription medication continue to receive the medication (or acceptable alternate medication) in a timely fashion as prescribed. A keep-on-person (KOP) self-medication program is not in place. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area includes one examination room that is divided into two areas and an inmate waiting area, one-chair dental operatory, nurse's station, room in which to store medications and the medication preparation cart, and a curtained area for health records storage. Curtains are used to ensure patient privacy; the space is extremely tight but utilized appropriately. There are also two offices for administrative staff. Items subject to abuse are inventoried daily. Adequate supplies and equipment are available. The standard is met.

J-D-04 Diagnostic Services (I). The RHA contracts with a national laboratory. Results are returned in a timely fashion and are reviewed by the physician. The CLIA waiver is current. A mobile x-ray unit is brought to the facility at least once a week or as necessary. More complex studies are completed at the local hospital. On-site services include those for stool blood, finger-stick blood glucose, peak flow, multiple-test dipstick urinalysis, and pregnancy testing. The standard is met.

J-D-05 Hospital and Specialty Care (I). Arrangements with a hospital for inpatient medical and specialized medical outpatient care are documented by a contract. The standard is met.

E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). Upon arrival at this facility, inmates are given verbal and written information (in English and Spanish) that describes access to health care services, the fee-for-service policy, and the health-related grievance procedures. Inmates who have difficulty communicating due to disability or language can use a translation service for assistance. The standard is met.

J-E-02 Receiving Screening (E). New admissions arrive directly from the community or from other facilities. Qualified health care professionals complete the receiving screening as soon as possible; the process includes a disposition and addresses all the inquiries as described in the standard. The standard is met.

J-E-03 Transfer Screening (E). A qualified health professional screens transfers upon arrival (within two hours). The transfer process includes a review of any information forwarded from the sending facility. A medical summary sheet is required for all inter- and intra-system transfers in order to maintain continuity of care. The standard is met.

J-E-04 Initial Health Assessment (E). The RHA has implemented the full population health assessment at this facility; a trained RN completes the health assessment (including the hands-on portion of the examination) for all inmates within 14 days after their admission. The physician reviews all health assessments. The standard is met.

J-E-05 Mental Health Screening and Evaluation (I). A trained RN completes the mental health screening during the initial health assessment (within 14 days). The mental health screening includes all inquiries as described in the standard. Inmates who screen positive on the mental health screening are referred to qualified mental health professionals for further evaluation. The standard is met.

J-E-06 Oral Care (E). A trained RN completes the oral screening during the initial health assessment (within 14 days). The oral screening includes instruction on dental hygiene and preventive oral education. Oral care is timely and it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions. The dentist completes an oral examination within 12 months of an inmate's admission, supported by x-rays. The standard is met.

J-E-07 Nonemergency Health Care Requests and Services (E). Inmates submit a health request slip whenever necessary. Triage takes place at least once every 24 hours, daily; if triage requires a face-to-face assessment, the inmate is seen in sick call within 24 to 48 hours (72 hours on the weekends). When a provider visit (physician, midlevel, mental health, dental, or specialty staff) is necessary, clinical need dictates timing. The standard is met.

J-E-08 Emergency Services (E). The RHA provides 24-hour emergency medical, mental health, and dental services and maintains emergency drugs, supplies, and medical equipment. Emergency transportation to a local hospital can be arranged as necessary. The standard is met.

J-E-09 Segregated Inmates (I). Conditions of segregation at this facility (NCCHC's category 2b) require health rounds at least three days a week by medical or mental health staff, which is the practice. The rounds are documented on individual logs, and significant findings are documented in the health record. Upon notification that an inmate has been segregated, qualified health care professionals review the inmate's health record to determine whether there are any contraindications to segregation. The standard is met.

J-E-10 Patient Escort (I). Inmates are escorted to on- and off-site clinical appointments in a timely manner. The standard is met.

J-E-11 Nursing Assessment Protocols (I). Nursing assessment protocols (clinical pathways) are used. The responsible physician and nursing administrator last reviewed them on June 8, 2011. Annual reviews of skills are documented. The clinical pathways do not include prescription medication, except in cases of life-threatening situations where a subsequent physician's written or verbal order is required. The standard is met.

J-E-12 Continuity of Care During Incarceration (E). We confirmed that continuity of care is appropriate. Inmates receive treatment and diagnostic tests ordered by clinicians. When an inmate returns from the emergency room or hospitalization, protocols are followed in accordance with the standard. Individual treatment plans guide treatment for episodes of illness and include the appropriate elements. The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations. The physician reviews charts of sufficient frequency and number to assure that clinically appropriate care is ordered and implemented by attending health staff. The standard is met.

J-E-13 Discharge Planning (I). Upon notification of the pending discharge of an inmate with serious medical or mental health needs, health staff (with the patient's written consent) contact outside providers to arrange for a follow-up appointment, prepare a transfer of health summaries and relevant parts of the health record to community providers, and arrange for medication as appropriate. The standard is met.

F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

J-F-01 Healthy Lifestyle Promotion (I). A variety of health-related brochures and pamphlets are generally available to all inmates. Individual health instruction during clinical encounters is documented in the health record. Whenever possible, educational audio and videotapes are available to inmates as well. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 72 medical diets and 16 allergy-specific diets were being prepared for patients with specific dietary needs. Orders for medical diets include the type of diet and the duration for which it is to be provided, as well as special instructions. Inmate workers who prepare medical diets are trained in making appropriate substitutions and portion control. A registered dietitian reviews the medical diet menus at least every six months. The standard is met.

J-F-03 Use of Tobacco (I). Smoking is prohibited in all indoor areas. Pamphlets and other

educational material regarding the use of all tobacco products are available in the clinic area.

Nicotine replacement products are not available, however. **The standard is not met.**

> Corrective action is required for Compliance Indicator #2 At a minimum, the prevention and abatement program should include nicotine replacement products and written materials on prevention and abatement of tobacco use. Acceptable documentation includes evidence that nicotine replacement products (i.e., pharmaceutical support) are available to patients when the clinician decides that such treatment is clinically necessary. Corrective action is required in order to meet this standard.

G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Care as reflected in the health record appears in compliance with current community standards. The responsible physician establishes and annually approves clinical protocols consistent with national clinical practice guidelines. Health records documentation confirms that clinicians follow the chronic disease protocols and that the treatment plans contain the appropriate elements. Chronic illnesses are listed on the problem list and the RHA maintains a list of chronic care patients. The standard is met.

J-G-02 Patients With Special Health Needs (E). When required by the health condition(s) of the patient, treatment plans define the individual's care. Special needs include adolescence, developmental disability, the frail or elderly, physical disability, pregnancy, and others. Treatment plans include the frequency of follow-up, instructions, and diagnostic testing and therapeutic regimens. Special needs are listed on the problem list and the RHA has a list of special needs patients. The standard is met.

J-G-03 Infirmary Care (E). There is no infirmary, but there are several observation cells in the intake booking area. Observation beds are those designated for specific medical or mental health purposes, such as watching a patient's response to a change in medication regimen. Patients may also be placed in this area to prevent them from eating or drinking before a medical test. A qualified health care professional is available 24 hours a day to assist patients housed in the observation area. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). Mental health services at this facility are provided by the state Department of Mental Health, Jail and Correctional Services. These services include assessment and screening for inpatient admission, medication monitoring, and referral linkages to community services for repeat offenders charged with non-violent offenses. The licensed professional counselor meets with the patients and makes recommendations to the psychiatrist, who is on site eight hours a week.

Individual counseling, group counseling, psychosocial/psychoeducational programs are not provided, however. **The standard is not met.**

> Corrective action is required for Compliance Indicator #2d Regardless of a facility's type or size, basic on-site outpatient services should include individual counseling, group

counseling, and psychosocial/psychoeducational programs. Acceptable documentation includes verification that these basic services will be available to inmates who need such treatment. In order to receive accreditation, verification that this standard has been met is required.

J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans addressing suicidal ideation and its recurrence are developed. Patient follow-up occurs as clinically indicated by the licensed professional counselor. Actively suicidal inmates are placed on constant, one-on-one observation by custody staff. Potentially suicidal inmates are monitored on an irregular schedule not exceeding 15 minutes between checks. There has been one suicide since the last survey. On February 5, 2010, a 65-year-old man jumped from the second floor housing tier. He was a high profile inmate due to the nature of his crime. Following the death review, the mental health provider implemented a referral log. The standard is met.

J-G-06 Intoxication and Withdrawal (E). Individuals with mild to moderate symptoms of intoxication or withdrawal can be managed on site under protocols established and approved by the responsible physician. Staff monitor withdrawing inmates utilizing the Clinical Institute Withdrawal Assessment Review Sheet Alcohol revised (CIWA-Ar) tool, with appropriate medication, when the physician determines it is medically indicated. Inmates on methadone or similar substances receive appropriate treatment for methadone withdrawal syndrome. Patients with severe withdrawal are transferred to an inpatient facility. The standard is met.

J-G-07 Care of the Pregnant Inmate (E). Prenatal care, specialized obstetrical services when indicated, and postpartum care are available to pregnant inmates. Pregnant inmates on methadone or similar substances continue on the treatment. The RHA has a list of all pregnancies and their outcomes. The standard is met.

J-G-08 Inmates With Alcohol and Other Drug Problems (I). Self-help substance abuse programs are offered on site. The standard is met.

J-G-09 Pregnancy Counseling (I). Comprehensive counseling services, in accordance with the woman's expressed desire regarding their pregnancy, are available to pregnant inmates by the local women's care center. The standard is met.

J-G-10 Aids to Impairment (I). We observed inmates using aids to impairment during the tour. The standard is met.

J-G-11 Care For The Terminally Ill (I). Although it would be rare for a terminally ill inmate to be held at this facility, procedures are in place to make the appropriate accommodations before transferring them to other facilities. The standard is met.

H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Inmate medical, dental, and mental health

records are integrated in hard copy format; the health record includes a problem list, as well as all other critical elements. The standard is met.

J-H-02 Confidentiality of Health Records (E). Health records are maintained under secure conditions. Only qualified health staff that has a valid need can access the health records. Health staff have documented instruction in maintaining patient confidentiality. The standard is met.

J-H-03 Access To Custody Information (I). Qualified health care professionals have access to information in the inmate's custody record when such information may be relevant to the inmate's health and course of treatment. The standard is met.

J-H-04 Management of Health Records (I). During our review, we confirmed that the health record is available for each patient care encounter. When an inmate is transferred to another facility, a summary of the current health record is sent to the receiving facility. The jurisdiction's legal requirements regarding retention and retrieval of the health records are followed. The standard is met.

I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

J-I-01 Restraint and Seclusion (E). The least restrictive interventions possible are used when intervention is necessary. Should the physician determine that the inmate is at imminent risk to self or others, clinical restraints must be applied and removed by custody staff. Patients are released from therapeutic restraint or seclusion status as soon as it is clinically judged acceptable. A formal treatment plan is utilized for clinically ordered restraint or seclusion. When custody staff order restraints, they notify health staff to conduct health monitoring during the period of restraint. If concern arises about the inmate's mental health status, if vital signs deteriorate, or other obvious physical problems develop, health staff notify the facility commander and the physician so that appropriate orders can be given. The standard is met.

J-I-02 Emergency Psychotropic Medication (E). The psychiatrist determines the most appropriate course of action based on a personal evaluation. The inmate must be considered to be suffering from an acute mental illness and at least a threat to self-harm or deteriorating physical well-being with risk to life or long-term health before forced psychotropic medication is implemented. The standard is met.

J-I-03 Forensic Information (I). Health staff do not collect forensic information except when state laws require blood samples, the inmate consents, and it is for inmate-specific, court-ordered laboratory tests, examinations or radiology procedures. The standard is met.

J-I-04 End-of-life Decision Making (I). Inmates approaching the end of life are permitted to execute advance directives. These directives will be signed only after the inmate is counseled regarding the meaning and consequences of such decisions. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). Informed consents and refusals of care are documented and include the signatures of the patient and a health staff witness. Inmates are counseled as to possible adverse consequences to their health that may occur as a result of a refusal. The standard is met.

J-I-06 Medical and Other Research (I). No health-related research is conducted at this facility. The standard is met.

National Commission
on Correctional Health Care

ACCREDITATION REPORT OF THE HEALTH CARE SERVICES AT

Dane County Jail

Madison, Wisconsin

June 17, 2011

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(703) 880-1460

Dane County Jail, WI
June 17, 2011
UPDATE REPORT

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On January 26-28, 2011, NCCHC conducted its review for continuing accreditation of the Dane County Jail under the NCCHC *2008 Standards for Health Services in Jails*. On March 11, 2011, NCCHC granted continuing accreditation with verification (CAV). Subsequently, the RHA has submitted corrective action, which brought the facility into compliance with applicable essential standards. This report focuses primarily on issues that required corrective action for compliance with the standards and is most effective when read in conjunction with NCCHC's March 11, 2011 report.

There are 35 essential standards; 34 are applicable to this facility and 34 (100%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. *The Dane County Jail has now met this condition.*

Essential Standards Not in Compliance
None

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 32 important standards; 32 are applicable to this facility and 32 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. The Dane County Jail has met this condition.

Important Standard Not in Compliance
None

Important Standards Not Applicable
None

We commend the facility staff for their professional conduct in coming into compliance with NCCHC's *Standards for Health Services in Jails*. The Dane County Jail is awarded accreditation.

J-D-01 Pharmaceutical Operations (E). Pharmaceutical services, which are provided by national and local pharmacies, are sufficient to meet the needs of the inmates. A small locked pharmacy room is in each of the clinic areas. Nurses control the keys to the rooms and medication carts. A consulting pharmacist inspects these areas quarterly.

Since the last survey, inspections have occurred quarterly at the main facility, but not at the satellite, where there are medications on blister cards and in the refrigerator. The standard is not met.

> Corrective action is required for Compliance Indicator #10 When there is no staff pharmacist, a consulting pharmacist should be used to document inspections and consultations not less than quarterly. All off-site locations should be included in the inspection schedules. Acceptable documentation includes a copy of the consulting pharmacist's most recent on-site review of the pharmaceutical practices in the satellite. In order to receive accreditation, verification that this standard has been is required.

In June 2011, the RHA submitted a medication room inspection report from the satellite signed by the pharmacist. *The standard is now met.*

J-E-04 Initial Health Assessment (E). The RHA has implemented the full population health assessment. All inmates receive an initial health assessment within 14 calendar days of their admission. In the main facility, the registered nurse completes the hands-on assessment in the clinic exam room. In the satellite, a registered nurse or nurse practitioner completes the assessment in the nursing room. We verified the nurses have been trained to complete the health assessment.

However, the record review indicated that the physician does not review all physicals completed by the RN. The standard is not met.

> Corrective action is required for Compliance Indicator #2d ii The hands-on portion of the health assessment may be performed by an RN when the nurse completes appropriate training; however, all findings must be reviewed by a physician when the RN completes the physical. Documentation of corrective action is required in order to verify that a physician reviews all RN-generated health assessments. Acceptable documentation could include one of the following: (a) a copy of a CQI process study on physician review of all health assessments conducted by RNs; or (b) a 30-day log with key information of: inmate number, date of completed health assessment, initials of RN, and date of physician co-signature. In order to receive accreditation, verification that this standard has been met is required.

In June 2011, the RHA submitted a CQI study on initial health assessment review, as well as the revised medical history and physical assessment form, which includes space for the physician's co-signature. Health assessments completed by the RN were reviewed and signed by the physician in 100% of the records audited. The CQI study also assessed appropriate referrals, dental education, documentation of communicable disease testing, mental health assessment, and timeliness. *The standard is now met.*

J-E-06 Oral Care (E). Oral care is timely and includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions. The dentist performs an oral examination within 12 months of admission. The trained registered nurse completes the oral screening at the time of health assessment.

Instruction on dental hygiene and preventive oral education is generally provided, but the documentation in the health record is inconsistent (we noted it in just four of 12 records). The standard is not met.

> Corrective action is required for Compliance Indicator # 2 Instruction in oral hygiene and preventive oral education should be given within one month of admission. Oral hygiene instruction and preventive oral education should be given by dentists, dental hygienists, or dentally trained personnel, and consist of measures to assist the patient in caring for his or her own oral health. Acceptable documentation includes: (a) a plan that addresses how such education is being provided (e.g., handouts or other written materials or verbal instruction documented during the oral screening); or (b) a CQI process study assessing the process by which instruction in oral hygiene and preventive oral hygiene is provided and documented. In order to receive accreditation, verification that this standard has been met is required.

In June 2011, the RHA submitted a copy of the handout provided to inmates regarding proper brushing procedure, which is provided during the initial health assessment. Data from the CQI study reflected that the provision of dental education was provided in 100% of the audited charts. *The standard is now met.*

J-E-09 Segregated Inmates (I). Conditions of segregation at this facility (NCCHC's category 2b) require health rounds at least three times a week. In practice, the medication nurse makes daily rounds and logs them on the individual log sheet. If there are significant health findings, the nurse documents it in the inmate's health record. The mental health social worker will conduct a weekly evaluation during the period of segregation. When inmates are segregated, health staff are notified. Segregation housing is in the following areas: PSB intake/receiving, which has 20 cells, five for females and 15 for males; CCB, which has six beds for males, six beds for females and four for administrative confinement. The Ferris Center does not house segregated inmates. Inmates give sick call slips to the officers rather than placing them in the locked box. The standard is not met.

> Corrective action is required #1 Nonemergency requests are to be reviewed within 24 hours and the inmate seen by a qualified health care professional at sick call within the next 24 hours (72 hours on weekends). Confidentiality of health information may not be maintained when health care requests are being handed to correctional officers, and this process may be a factor in preventing timely triage of the health request and scheduling of sick call. Acceptable documentation includes a CQI process study on the submission and retrieval of health care requests and the timeliness of sick call. In order to receive accreditation, verification that this standard has been met is required.

In June 2011, the RHA submitted a CQI study on segregation rounds assessing completed records, frequency of assessment, arrangements with medication administration, and segregation

record placement in the inmate's medical chart. All inmates were seen and assessed a minimum of three days per week and is consistent with documentation. *The standard is now met.*

National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

June 30, 2010

Major P.E. Livengood
Johnson County Adult Detention Center
27745 W 159th St.
New Century, KS 66031

Dear Major Livengood:

The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC) met on June 25, 2010 to review the findings from a recent survey and to consider the accreditation status of the Johnson County Adult Detention Center. The Committee voted to continue the accreditation of your facility with the following qualification: that compliance be demonstrated with all of the Essential standards and at least 85% of the applicable Important standards. Compliance should be documented in a report and submitted to NCCHC by September 17. 2010. Enclosed is the accreditation report for your facility, listing cited standards and recommendations for achieving compliance.

The Committee acknowledged the facility's significant level of compliance with a number of NCCHC standards. However, in order to maintain your accreditation, it is important that you address the cited standards in a timely manner.

In addition, the 2010 Annual Maintenance Report (AMR) has not been received. Following receipt of verification of compliance and the 2010 AMR, a Certificate of Accreditation will be sent to you indicating your facility's accreditation status. The AMR is enclosed for your convenience. If we can be of any assistance to you, feel free to call us at any time.

Sincerely,

Jennifer E. Kistler, MPH, CCHP
Director of Accreditation

Enclosures

cc: Edward A. Harrison, NCCHC President
Mike Diviney, RN, Health Services Administrator

National Commission
on Correctional Health Care

ACCREDITATION REPORT OF
THE HEALTH CARE SERVICES AT

Johnson County Adult Detention Center

New Century, Kansas

June 25,2010

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(703) 880-1460

Johnson County Adult Detention Center, KS
June 25, 2010

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On March 3-4, 2010, NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2008 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual.

There are 35 essential standards; 33 are applicable to this facility and 31 (94%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standards Not in Compliance

J-E-07	Nonemergency Health Care Requests and Services
J-E-12	Continuity of Care During Incarceration

Essential Standards Not Applicable

J-E-03	Transfer Screening
J-G-03	Infirmary Care

There are 32 important standards; 31 are applicable to this facility and 31 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standards Not in Compliance
None

Important Standard Not Applicable

J-C-08	Health Care Liaison

Decision: On June 25, 2010, NCCHC's Accreditation Committee awarded the facility Continuing Accreditation with Verification (CAV), *contingent* upon receiving requested compliance verification by September 17, 2010.

I. Facility Profile

Type of Facility:	Jail
Total Admissions for 2009:	17,839
Design-rated capacity:	817
Average daily population:	804
Average daily intake:	49

Description of Facility

The Department of Correction (DOC) detention centers were established in 1988 and 1999, when the second unit was built adjacent to the original Criminal Justice Complex. This unit is referred to as the Adult Detention Center. In January 2010, the old jail closed and the expanded detention center was opened, with inmates and staff transitioning to one, three-story building.

Administrative offices and the medical area (including the medical module and mental health unit) are located on the first floor, along with booking and several of the housing units. Forty-eight segregation cells for men and women are arranged like the spokes of a wheel on the second floor. The third floor consists of eight-man cells. Supervision is either direct or pod.

A total of 198 correctional officers (COs) are scheduled on duty during three, eight-hour work shifts.

Inmate Population Characteristics

On the day of the survey, there were 804 adult inmates (688 males and 116 females).

Facility's Health Services

Health services have been provided by a national contractor since 2008. The mental health authority is a community services provider who employs a full-time mental health director. At the time of the survey, negotiations were underway for the health care provider to assume responsibility for the psychiatric services and nursing staff.

Staffing

Health staff are on site 24 hours a day, seven days a week. At the time of the survey, there were 31.2 full-time staff and no vacancies.

II. Survey Method

The on-site survey consisted of touring the clinic area, inmate housing areas, and segregation. Documents reviewed included 40 health records, three death records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. Interviews were conducted on a structured and confidential basis. Those interviewed included the captains, responsible physician, nurse practitioner, health services administrator (HSA), assistant HSA, director of nurses (DON), mental health director, psychiatrist, dentist, food services supervisor, medical records clerk, five nurses, three COs, and nine randomly selected inmates.

III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Inmates have access to health care. Patients are seen by a qualified clinician and receive care in a timely manner as ordered for their serious medical, mental health, and dental needs. Inmates are assessed $5.00 for self-initiated services and medications, and $10.00 for provider services. Mental health care, physical examinations, chronic care, and obstetrical care are exempt from the co-pay policy. All inmates are seen regardless of ability to pay. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is the contracted company, whose on-site representative is a nurse manager. He is on site five days a week. Clinical judgments rest with a designated responsible physician, who is on site 12 hours a week. The mental health authority is a community services provider who employs a full-time mental health director. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding inmates' serious medical, dental, and mental health needs in the inmates' best interests. We noted good cooperation between custody and medical staff Utilization review is conducted by the corporate office and there were no missed outside appointments. The standard is met.

J-A-04 Administrative Meetings and Reports (E). The security and health staff (including mental health staff) meet monthly to discuss administrative matters. Health staff (responsible physician, HSA, and nursing staff) meet monthly to discuss health services operations. Monthly statistics on health services utilization are maintained. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy manual is site-specific. The RHA and responsible physician last reviewed it on January 11, 2010. The standard is met.

J-A-06 Continuous Quality Improvement Program (E). A comprehensive CQI program is in place to monitor major aspects of health care through a multidisciplinary committee that meets monthly. The membership includes the nurse practitioner, HSA, assistant HSA, mental health representatives, DON, and infection control nurse. One outcome study examined hypertension in chronic care to see how well inmates were adhering to their medications and diet by measuring weight and vital signs over a six-month period. A second outcome study focused on STD testing and education. During the last quarter, 229 inmates agreed to be tested based on the educational program. Process studies included timely medication renewals and health assessments. The effectiveness of the CQI program was reviewed in 2009. The standard is met.

J-A-07 Emergency Response Plan (E). The scenario of one disaster drill was that of a mass influx of inmates due to the evacuation of another facility. A second drill (May 2009) involved an outbreak of pandemic flu affecting 80 inmates. Man-down drills have been documented as well. All the drills were critiqued and shared during staff meetings. The standard is met.

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health staff with regard to inmates' special health needs occurs in writing. The inmate management team (consisting of a sergeant, HSA, assistant HSA, psychiatric nurse, and case manager) meets biweekly to discuss inmates with special medical or mental health problems. The special management units are located in unit 11 for the women and unit 10A for the men. The standard is met.

J-A-09 Privacy of Care (I). Clinical encounters are conducted in auditory privacy. Nursing staff and deputies are instructed in maintaining confidentiality during their orientation. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). There have been three deaths (suicide) at this facility since the last survey. Death reviews (including psychological autopsies) were conducted in a timely manner. The standard is met.

J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is integrated with the formal grievance program. Inmates may file an informal grievance first, which must be answered within 48 hours. If a formal grievance is filed, a response is required within seven working days. Approximately 14 grievances are filed a month. The standard is met.

B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Control Program (E). Infection control matters are addressed in both administrative and CQI meetings. Inmates with communicable diseases are housed in one of the four negative pressure rooms. Air flow is regularly monitored. Sharps and biohazard waste are disposed of properly. Inmates are treated for lice upon clinical indications. Infection control reports are maintained as required by local, state, and federal laws. Patients with communicable diseases are referred to the health department upon discharge. A bloodborne pathogen program is in place. We found the infection control manual to very well written. The standard is met.

J-B-02 Patient Safety (I). Medication error forms and sentential event reporting systems are available. The standard is met.

J-B-03 Staff Safety (I). Health staff appear to work under safe and sanitary conditions. Monthly environmental and safety inspections of the entire facility are documented. The standard is met.

J-B-04 Federal Sexual Assault Reporting Regulations (I). The facility administrator described the facility as compliant with the 2003 Federal Prison Rape Elimination Act. Correctional and health staff have been trained regarding the Prisoner Rape Elimination Act. The standard is met.

J-B-05 Procedure In The Event of a Sexual Assault (I). Victims of sexual assault are referred to the emergency department and mental health services for treatment. There have been no allegations of sexual assault since the last survey. The standard is met.

C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentialing (E). Health care personnel who provide services to inmates have current licenses and other appropriate credentials on file. There are no sanctions against current employees. The credentialing process includes inquiry into the National Practitioner Data Bank. The standard is met.

J-C-02 Clinical Performance Enhancement (I). The clinical performances of the physician, dentist, psychiatrist, and mid-level provider were reviewed in 2009 and shared with the staff member under review. The standard is met.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals have the required number of continuing education credits; all are current in cardiopulmonary resuscitation (CPR) training. As the state's nursing license requirements consist of 30 hours every two years, compliance with NCCHC's standards was evident. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff have the required training in health-related topics and all are current in CPR training. The officers are trained in topics such as suicide prevention, bloodborne pathogens, PREA, and first aid. The standard is met.

J-C-05 Medication Administration Training (E). Licensed practical nurses administer medications. A medication module, "Preventing Medication Errors," is used for training. All staff acknowledge this training in writing. The standard is met.

J-C-06 Inmate Workers (E). Inmate workers provide janitorial services in the medical unit and only under correctional staff supervision. The standard is met.

J-C-07 Staffing (I). Full-time equivalent health staff includes:

Physician	0.6
Nurse Practitioner	0.8

Health Administrator	1.0
Assistant Health Administrator	1.0
DON	1.0
RN	5.0
LPN	14.6
Dentist	0.3
Dental Assistant	1.0
Records clerk	3.0
Mental Health Staff Director	1.0
Counselors	2.1
Psychiatric Nurse	2.0
Psychiatrist	0.4
Case Managers	2.0

At the time of the survey, there were no vacancies. The standard is met.

J-C-08 Health Care Liaison (I). Health staff are on site 24 hours a day. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff have received the appropriate orientation through the use of an orientation module and on-line program. New employees are assigned to work with a mentor for 40 hours. The standard is met.

D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). Pharmaceutical services, which are provided by national and local pharmacies, are sufficient to meet the needs of the inmates. We found no expired medications, and poison control antidotes were available. Quarterly consulting pharmacist reviews for 2009 and 2010 to date were available. The standard is met.

J-D-02 Medication Services (E). The physician determines the prescriptive practices at this facility. New inmates' medications are continued until they can be seen by a physician or psychiatrist. Eye drops, lotions, and inhalers are available as keep-on-person medications. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area includes two examination rooms and a two-chair dental operatory; medical records storage; medication room; offices for the mental health director, HSA, and medical records clerk; and a nursing station. A small waiting room is available for inmates awaiting medical appointments. Six triage rooms are available on the various floors. The standard is met.

J-D-04 Diagnostic Services (I). A national laboratory and a mobile x-ray firm have been contracted to provide diagnostic services. On-site services include materials for multiple-test

dipstick urinalysis, blood glucose testing, peak flow readings, stool blood testing, and pregnancy tests. The CLIA waiver was to expire on September 4, 2011. The standard is met.

J-D-05 Hospital and Specialty Care (I). We verified that according to state statues, all hospitals must accept inmates and only charge Medicaid rates. The standard is met.

E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). There are a number of means to ensure inmates are aware of health service access: upon arrival, inmates are given a handbook (available in English and Spanish) that describes the co-pay policy and access to care procedures. A sign written in English and Spanish is posted in the intake unit as well. Inmates are also verbally instructed on these matters during the receiving screening. The orientation also addresses access to health care services. The standard is met.

J-E-02 Receiving Screening (E). New admissions arrive directly from the community. The RN stationed in the booking area at all times completes the receiving screenings within two hours. The form addresses all elements required by the standard. Inmates with potentially communicable disease are housed in one of the negative pressure rooms. The standard is met.

J-E-03 Transfer Screening (E). This is not a transfer facility; inmates arrive here from other county jails and then a new receiving screening is performed. The standard is not applicable.

J-E-04 Initial Health Assessment (E). The RHA has implemented the full population health assessment. A trained RN conducts the health assessments, which are reviewed and co-signed by a physician. Our chart review indicated that health assessments are usually completed within seven days. Testing for tuberculosis is completed during the health assessment. The standard is met.

J-E-05 Mental Health Screening and Evaluation (I). Nurses complete the mental health screening during the intake screening. A suicide screening is part of that process. If inmates have current or prior mental health issues, they are referred to a mental health provider. The standard is met.

J-E-06 Oral Care (E). Dental care is not limited to extractions. The nurse completes the oral screening during the health assessment and provides instructions on oral hygiene at this time. The dentist completes annual examinations for inmates who have been incarcerated for over a year. Inmates with emergent or painful conditions have timely access to dental care. An oral surgeon has been contracted to provide services when necessary. Infection control procedures are followed and weekly spore counts are performed. The standard is met.

J-E-07 Nonemergency Health Care Requests and Services (E). Nursing staff pick up sick call requests three times a day. The requests are triaged; if the inmate has an urgent request, the deputy will notify the health care staff. Inmates are seen in sick call by a nurse within 16 hours, by a physician within seven days, and by dental staff within two to three weeks (except for urgent conditions).

Mental health requests are forwarded to the psychiatric nurses and mental health director for triage. Inmates seeking routine mental health care typically wait for six weeks, or longer, to be seen. We verified this delay through chart review and interviews with the mental health director and psychiatric nurses. The psychiatrists are on site eight hours a week. They will see two new patients and four follow-up patients only on each visit; priority is given to the most severely mentally ill. **The standard is not met.**

Corrective action is required for Compliance Indicators: #1 and #4

> Corrective action is required Nonemergency requests are to be reviewed within 24 hours and the inmate seen by a qualified health care professional at sick call within the next 24 hours (72 hours on weekends). The frequency and duration of sick call should be sufficient to meet the health needs of the inmate population. Acceptable documentation includes a CQI process study on the timeliness and frequency of mental health sick call and whether it is sufficiently staffed. In order to receive accreditation, verification that this standard has been met is required.

J-E-08 Emergency Services (E). The RHA provides 24-hour emergency medical, mental health, and dental services. The RHA and responsible physician are on call 24 hours a day. Emergency supplies and kits are checked weekly. A hospital is located within 15 minutes of the jail. The standard is met.

J-E-09 Segregated Inmates (I). There are 48 segregation cells. Conditions of segregation at this facility (NCCHC's category 2b or limited contact) require health rounds at least three times a week, which is the practice at this facility. Rounds are documented on an individual log. The health staff review the medical record for contraindications prior to an inmate's placement in segregation. The standard is met.

J-E-10 Patient Escort (I). Inmates are escorted to on- and off-site medical appointments in a timely manner. Patient confidentiality is maintained during transport as health records are placed in a sealed envelope. The standard is met.

J-E-11 Nursing Assessment Protocols (I). Nursing pathways are utilized. The pathways do not contain prescription medication except for emergency situations, e.g., acute cardiac pain or anaphylaxis. The physician last reviewed and signed the protocols on February 1, 2010. The standard is met.

J-E-12 Continuity of Care During Incarceration (E). Our chart review indicated that there is often a problem getting the results of emergency room visits and discharge summaries. **The standard is not met.**

Corrective action is required for Compliance Indicators # 2 and 3 When an inmate returns from hospitalization or an emergency room visit, the physician should see the patient, review the discharge orders, and issue follow-up orders as clinically indicated. If the physician is not on site, designated staff should immediately review the hospital's discharge instructions or ER findings and contact the facility physician for orders as needed. Acceptable documentation includes: a CQI process study on the continuity of care for patients returning from hospitalization or ER visits. In order to receive accreditation, verification that this standard has been met is required.

J-E-13 Discharge Planning (I). In cases of planned discharges, the health staff provide a discharge form that includes the health department, shelters, and community resources for the uninsured. Mental health staff refer the inmates to community mental health programs. Mental health case managers work with soon-to-be released inmates; mental health staff will also call a 30-day prescription into the pharmacy for a discharging inmate. By state law, no prescription is required for insulin. The standard is met.

F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

J-F-01 Healthy Lifestyle Promotion (I). A variety of health-related brochures and pamphlets are available in the clinic and the examination rooms. Individual patient education is documented in the chart during clinical encounters. A variety of counseling programs are offered on site, such as Alcoholics and Narcotics Anonymous and coping skills. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 30 medical diets were being prepared for patients with specific dietary needs. The medical diets were last reviewed in March 2010. The standard is met.

J-F-03 Use of Tobacco (I). Smoking is prohibited in all indoor areas. Pamphlets on smoking cessation are available. The standard is met.

G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Chronic care patients are seen every three months. The treatment plans are very comprehensive. The corporate medical director has designed the

chronic care forms so that providers are aware of each diagnostic test that is to be ordered to be compliant with the guidelines. The standard is met.

J-G-02 Patients With Special Health Needs (E). A list of special needs inmates is maintained and special needs are noted on the problem lists. The standard is met.

J-G-03 Infirmary Care (E). The facility was designed to have an infirmary, but due to the recent move, they have instead maintained this area as an observation area. There are 15 individual cells and four negative pressure rooms. Both males and females can be housed here as all rooms are single-celled. Some of the rooms have oxygen and suction. While the infirmary was not operational at the time of the survey, the infirmary will open and policies have already been written. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). Mental health services include individual counseling, group counseling, crisis intervention, and medication management. There are 42 beds designated for mental health patients. Inmates are transferred to a state psychiatric facility if it is clinically indicated. Mental health staff write and update individual treatment plans every 90 days or sooner as clinically indicated. If emergency mental health care is required, the inmate is sent to the local community hospital. The standard is met.

J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. We confirmed that COs and health staff have undergone suicide prevention training. Health staff complete a suicide prevention module. Changes that have been made as a result of the three suicides include the following: that no inmate be housed in a single cell prior to classification; inmates in intake are not permitted sheets; shower curtains in the special management unit were changed for half glass blocks; and inmates who have been on suicide watch are followed by a psychologist for a longer period of time once they are released from suicide watch. The standard is met.

J-G-06 Intoxication and Withdrawal (E). Protocols are in place to manage inmates who are withdrawing from alcohol or drugs. Inmates are assessed with a CIWA-AR or a COWS scale if they are thought to be withdrawing from an opiate or alcohol. Patients are housed in one of the observation units located in the medical unit. If clinically indicated, patients are transferred to an acute care hospital. The standard is met.

J-G-07 Care of the Pregnant Inmate (E). Prenatal care, specialized obstetrical services when indicated, and postpartum care are available to pregnant inmates. A high-risk clinic is available at the hospital. A list of pregnancies and their outcomes is maintained. There were two pregnant inmates on site at the time of the survey. The standard is met.

J-G-08 Inmates With Alcohol and Other Drug Problems (I). Self-help substance abuse programs (Alcoholics and Narcotics Anonymous) are offered on site. Inmates must complete an application and sign up for this program. The standard is met.

J-G-09 Pregnancy Counseling (I). Comprehensive counseling services are available to pregnant inmates at the clinic. If an inmate chooses to terminate the pregnancy, she is responsible for the fees. The standard is met.

J-G-10 Aids to Impairment (I). Documentation indicated that eyeglasses, walkers, and hearing aids are provided to inmates as clinically indicated. The standard is met.

J-G-11 Care For The Terminally Ill (I). Although it would be rare for a terminally ill inmate to be held at this facility, procedures are in place to have such patients released on their own recognizance or housed at an acute care facility. At the time of the survey, a cancer patient was being held at the facility and an agreement with hospice was made until his release. A policy for living wills and power of attorney is in place. The standard is met.

H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Inmate medical and mental health records are integrated in hard copy and electronic formats. Medical and mental health records are scanned into the computer after documentation is complete. Medication records are not scanned into the computer. The standard is met.

J-H-02 Confidentiality of Health Records (E). Health records are maintained under secure conditions. Staff have documented training on maintaining confidentiality, which is presented during their orientation. All heath staff have their own codes for accessing medical records. The standard is met.

J-H-03 Access To Custody Information (I). Qualified health care professionals have access to information in the inmate's custody record when such information may be relevant to the inmate's health and course of treatment. Health staff have access to the Jail Management System when indicated. The standard is met.

J-H-04 Management of Health Records (I). State statute requires that records be maintained for seven years, but now that medical records are scanned, they can be retained indefinitely. A transfer summary is sent when an inmate is transferred to another facility. A release of information is obtained before medical records are released. The standard is met.

I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

J-I-01 Restraint and Seclusion (E). Custody staff order restraints (restraint chair). The nurse is called to check the restraints for tightness and the inmate's vital signs are monitored every hour while he or she is restrained. By policy, the inmate cannot be restrained for more than three hours without further authorization from the shift commander. The standard is met.

J-I-02 Emergency Psychotropic Medication (E). Emergency forced medication is not implemented at this facility. If such intervention were required, the county's mental health team would be called and the inmate would be committed to a mental health hospital or to the state DOC. The standard is met.

J-I-03 Forensic Information (I). Health staff are not involved in collecting forensic information. The standard is met.

J-I-04 End-of-life Decision Making (I). Advance directives and durable power of attorney forms are in place. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). Consent and refusal of care forms were present in the health records, including those for dental extractions and psychotropic medication. The sick call request slips includes space for consent as well. The standard is met.

J-I-06 Medical and Other Research (I). No health-related research is conducted. The standard is met.

CARY McCLURE _ CCS Chief Operating Officer

EDUCATION
B.S., University of Kansas, 1976
Majors in Accounting & Business Administration

CERTIFICATIONS
- CPA: Certificate #2999, Kansas, 1979
- FHFMA: Fellow, HFMA, 1995
- CMPA (Certified Manager of Patient Accounts) 1995
- CMCP (Certified Managed Care Professional) 1995

PROFESSIONAL EXPERIENCE
Chief Operating Officer – Correct Care Solutions; Nashville, TN
Responsible for Field Operations, Care Management, and Network Development. Evaluates the financial performance of the company (actual vs. budget vs. industry benchmarks), develops financial best practices protecting company assets while maximizing return, and negotiates and manages banking relationships. Participates in the executive management team; reporting findings and results to ownership. *12/2004-Present*

CFO, Division II – Psychiatric Solutions, Inc. (PSI); Franklin, TN
Selected by PSI Senior Management to be promoted to Division CFO from Shadow Mountain/Whisper Ridge position. Full responsibility for financial operations of 8-10 facilities, including acute, RTC, and specialty service entities for this publicly traded behavioral health company. Responsible for annual EBITDA of $20-$25M. Directly assisted facility CEOs and CFOs with analyzing, planning, and impacting monthly operating results as necessary, including staffing and SWB analysis, net revenue and bad debt management, managed care contracting, physician contracts, vendor selection, lease/purchase decisions, and capital acquisitions. Oversaw facility annual operating and capital budget processes, new project pro formas, installation of financial information systems, special projects as needed. For first annual Division budget, created a format acclaimed by PSI CEO as best seen to date in HCA or Columbia or PSI. Created for the Division a format for the Monthly Operating Review (MOR) to present to PSI Senior Management the Division monthly operating and financial results. The MOR format was subsequently adopted by the company for the other three divisions of PSI. *2003-2005*

CFO – Shadow Mountain Hospital (SM); Tulsa, OK
CFO – Whisper Ridge Behavioral Health (WR); Charlottesville, VA
Full responsibility for the financial operations of both PSI for-profit facilities. SM is a 124-bed acute/RTC/OP/Specialty Services facility with multiple locations throughout the state and Oklahoma's largest behavioral health provider. SM consistently met or exceeded budgeted results. WR is a 60-bed RTC provider. Assigned the facility as a turnaround project. Within 12 months WR grew from a negative EBITDA position to one of the highest EBITDA margins for PSI's 50+ facilities. *2001-2003*

VP & CFO – SouthCrest Hospital; Tulsa, OK
Selected by Triad Senior Management in 1998 to handle all finance-related aspects of creating, opening, and running this $100M acute care 116-bed med/surg start-up facility and an associated medical office building. Was fourth employee hired of 400+ employees. Arrived 90 days prior to start-up, recruited all finance staff members, oversaw implementation of all financial systems, and assisted CEO with employed physician operations. Facility was considered a flagship hospital for Triad and consistently a top hospital for the company when measured for patient, physician, and employee satisfaction levels. *1999-2001*

VP, CFO, ECO – Columbia/HCA Bethany Medical Center; Kansas City, KS (1997-1999)
VP, CFO, Ethics & Compliance Officer – *1993-1997*
Controller – *1984-1993*
Assistant Controller – *1981-1984*
Full financial statement, budget, finance, and information system responsibilities for this 400-bed urban acute care med/surg facility, including a medical office building with $10M of assets. Monitoring and maintenance of Corporate Compliance Program. Supervision of 45+ employees and administration of finance department annual operating budget of $3,000,000. Helped lead transition from not-for-profit status to ownership and operation by Columbia/HCA, including cultural changes and replacement of all significant information systems (1998-1997). Negotiating team member for proposed sale to Columbia/HCA (1997). Selected by Board as ECO and to design, implement, and maintain Corporate Compliance Program resultant from settlement with Department of Justice (1996). Team leader for successful purchase and restructure of a 134-employee Management Services Organization for 42 independent physicians, equally capitalized and governed by the Medical Center and physicians (1995). Selected by Kansas Medicaid as an advisory team member for the development and creation of a capitated Medicaid managed care plan (1995). Developed detailed business plan for proposed startup of an in-house collection agency for Kansas City's largest acute care hospital (1992, accepted & successful for St. Luke's Hospital). Selected by Kansas Medicaid as the large urban hospital representative for a five-member statewide hospital task force to work with the Medicaid program to design and implement the Kansas Medicaid DRG reimbursement system (1989). Replacement of all significant financial information systems (1983-1992).

Controller – Colonial Savings & Loan; Prairie Village, KS
Responsible for all accounting and reporting functions for this medium sized savings and loan association. Resigned to enter the healthcare industry. *1980-1981*

Manager – Johnson & Company, CPAs; Kansas City, MO
Progressed from staff auditor to manager at this local firm which grew from 5 to 20+ employees during employment term. Experience was evenly divided between audit and management services. Management services consisted primarily of assisting clients with design, implementation, and maintenance of automated information systems. Received training through Fox & Company, a national CPA firm. Resigned to enter private accounting. *1976-1980*

PAST MEMBERSHIPS

- American Institute of Certified Public Accountants
- Mark Twain Bank Advisory Board member
- Healthcare Financial Managers Association (HFMA)
- Kansas City metro chapter; Co-Chairman, Technical Advisory Committee, 1984
- Board of Directors, 1992-94; Chairman, Special Projects Committee, 1992-94; Treasurer, 1994-95
- Rotary Club of Tulsa, Oklahoma
- Active in Bethany Foundation committees & fundraising
- Active in local community efforts

CHARLENE L. DONOVAN, Ph.D. CCS Vice President of Behavioral Health

EDUCATION

1997: University of Memphis
PhD, Clinical Psychology - Adult Clinical Track
Dissertation: Teaching Clients about Their Rights: The Role of Counselor Expertness and Method of Education

1994: University of Memphis
Master of Science in Psychology

1989: Rockhurst College
Bachelor of Arts in Psychology

LICENSURE

- Licensed Psychologist, State of Kansas, Tennessee
- National Register of Health Service Providers in Psychology
- ASPPB CPQ

PROFESSIONAL EXPERIENCE

Correct Care Solutions – Vice President of Behavioral Health. Primary duties include the oversight and development of a corporate wide mental health program for all CCS facilities nationwide, covering approximately 30,000 offenders. Provide on-site consultation and training for mental health staff, develop programs including suicide prevention and risk assessment training, monthly continuing education programs, quality improvement reviews, and treatment programs. Participate in site start-up activities, interface with facility administrative staff to ensure satisfaction with services offered, and assist sites with accreditation requirements. *09/2006-Present*

Correct Care Solutions – Program Mental Health Director – Kansas. Primary duties included the daily oversight of and responsibility for a multi-million dollar Mental Health Program provided to the Kansas Department of Corrections. The program included eight (8) state correctional facilities and over 90 employees, serving over 9,000 correctional inmates. Mental Health departments at each facility maintain NCCHC accreditation, and demonstrate adherence to CCS and KDOC policies and procedures, professional ethical standards, and state licensure requirements. Served as the CCS mental health consultant for the KDOC, and worked closely with the KDOC contract monitors. Provided clinical consultation and supervision for Mental Health facility staff, developed treatment programs, policies and procedures, conducted site audits and staff training, and directed recruitment and retention efforts for mental health staff. Other duties for CCS nationwide included consultation services for other jail and prison contracts. Assisted in the development of successful, comprehensive contract proposals, particularly related to mental health services, including CCS's successful proposal to renew its contract with the Kansas Department of Corrections, effective 7/1/05. *10/2003-08/2006*

Regional Mental Health Director ─ Prison Health Services ; Kansas Primary duties included oversight of the statewide mental health program for the Kansas Department of Corrections, to include approximately 65 mental health professionals located at 8 correctional facilities. Assuring compliance with accreditation bodies, developing effective programming, recruiting staff, and ensuring efficient and informative communication with Department of Corrections Contract Monitors were necessary components of the position. *10/2001-09/2003*

Prison Health Services - Clinical Supervisor - Lansing Correctional Facility. Primary duties involved supervising a staff of 17 clinicians in the provision of mental health services to a male inmate population, while maintaining my own client caseload. This position also included involvement in developing special projects such as: a special housing and treatment unit for mentally ill inmates, a hospice program for terminally ill inmates, the mental health component for a state-wide electronic medical records system, on-site consultation with other correctional facilities in Kansas, and assessment and psychotherapy provision to sexual offenders. *09/1997-10/2001*

Prison Health Services - Mental Health Professional - Lansing Correctional Facility. Duties included providing individual and group psychotherapy, crisis intervention, and psychological assessment and report writing services to a male inmate population. *08/1996-09/1997*

Pre-Doctoral Internship

Kansas City Veterans Affairs Medical Center - Pre-Doctoral Intern. 2000-hour APA-accredited clinical internship focused on primary care training. Duties included provision of psychological services to a predominately male veteran population. Training included outpatient and inpatient psychotherapy, psychological assessment including neuropsychological screening, and rotations through several medical clinics and units. *07/1995-07/1996*

Teaching Experience

- St. Mary College - Adjunct Instructor. Undergraduate psychology courses taught include Professional Ethics in the Helping Professions, Social Psychology, and Abnormal Psychology. *08/1996-05/2000*
- Rockhurst University - Adjunct Instructor. Undergraduate psychology section of Introduction to Psychology. *08/1999-12/1999*
- The University of Memphis - Instructor. Undergraduate psychology courses including Psychology of Personality and Introduction to Psychology. Also served as Continuing Education instructor for Assertiveness Training Course. *08/1994-05/1995*

Research

- Evaluating client satisfaction and the effectiveness of a specialized housing and treatment program for severely and persistently mentally ill inmates. This project is currently in the data collection phase.
- Evaluated the effectiveness of utilizing an active learning approach and impact of perceived level of counselor expertness on teaching students about their rights in a career counseling setting.
- Evaluated effectiveness of utilizing an informational brochure to teach psychotherapy clients about their rights in a psychotherapy setting.
- Assisted in development of a seminar for divorcing parents designed to educate them about the effects of divorce on children.
- Assisted in several studies in the area of behavioral medicine including smoking cessation, weight management and hypertension prevention.

DEAN RIEGER, M.D., M.P.H. CCS Chief Medical Officer

EDUCATION

- 1970 B.S. with High Honors; The University of Michigan
- 1974 M.D.; The Johns Hopkins University
- 1981 M.P.H.; The University of Michigan
- 1984 Board Certified, Preventive Medicine & Public Health

POSTGRADUATE TRAINING

- 1974-75 Internship (Medicine); The Nassau County Medical Center; The State University of NY, Stonybrook
- 1975-76 Residency (Psychiatry); The University of Michigan
- 1980-81 (1983) Residency (Preventive Medicine & Public Health/Health Planning & Administration); The University of Michigan

LICENSURE & CERTIFICATION

- Indiana ─ 01040892
- Michigan ─ 37557 (inactive)
- New York ─ 126311 (inactive)
- DEA ─ BRO438487
- Advanced Cardiac Life Support Certifications:
  - Provider since *1983*
  - Instructor since *1985*
  - Course Director *1988-1994*
- Advanced Trauma Life Support, Provider *1989-1995*
- HIV: Michigan Department of Public Health Certification, Counselor *1989*

PROFESSIONAL EXPERIENCE

Chief Medical Officer ─ Correct Care Solutions; Nashville, TN
Responsible for the clinical direction of all medical staff for Correct Care Solutions with direct supervision of all practitioners. Assist in the development of annual budgets and work with the corporate administrative staff and site medical directors to monitor and control the use of pharmaceuticals, medical supplies, and inpatient/outpatient utilization to provide appropriate and cost effective therapy for the population served by CCS. *2005-Present*

Medical Director ─ Indiana Department of Correction; Indianapolis, IN *2003-2005*
Clinical Assistant Professor ─ Indiana University School of Medicine *1991-2003*
The Indiana Department of Correction (IDOC) provides a full range of healthcare services to approximately 21,000 prisoners including adults and juveniles in 36 different facilities. Responsibilities included planning, implementing, leading, managing, and improving healthcare service delivery.

- Established centralized control over health services activities in 33 facilities.
- Established a standardized approach to reception screening activities.
- Created and implemented a structured approach to provision of chronic care and age appropriate healthcare services, including formal treatment planning activities.
- Established a prior review and approval program covering off-site referrals and covering surgical interventions.
- Wrote and implemented a formulary and associated process.
- Established a unitary health record including forms and format and implemented it statewide.
- Established the principle in Indiana corrections of using Advance Directives (living wills).

- Created and implemented routes for access to care, including both routine and urgent services as well as general and specialty care.
- Helped superintendents to appreciate the difference between demand for healthcare services and necessary interventions.
- Initiated quality improvement activities, including mortality reviews.
- Established critical infection control activities including a formal tuberculosis prevention and surveillance program and a blood borne pathogen control program.
- Wrote the first statewide healthcare services directives implemented in Indiana; these directives have formed the basis for subsequent accreditation by the National Commission on Correctional Healthcare.
- Wrote policies and procedures used by the contractual provider for service delivery and achievement of NCCHC accreditation.
- Campaigned successfully to build a new acute care mental health facility (which permitted closure of antiquated facility then in use).
- Established mid-level mental health treatment facilities to serve the needs of maximum security segregation offenders (this unit was recognized in 2000 as the "NCCHC Facility of the Year").
- Established expectations for use of diagnostic processes and treatment plans in the management of the seriously mentally ill.
- Established and implemented processes for use of therapeutic restraint or seclusion.
- Established and implemented a program for involuntary treatment of gravely disabled seriously mentally ill patients.
- Reduced per capita healthcare expenditures from approximately $3300 per offender per year to approximately $1800 per offender per year.

IDOC responsibilities underwent a change in 1997 when IDOC contracted with a private health management corporation for the bulk of the specialized service delivery. Role changed to work closely with the private company to help them deliver high quality services, to monitor their performance, and to help them succeed in the accreditation process. Remained the Health Authority for the Indiana Department of Correction.

Additional Indiana Accomplishments:

- Opened a new acute care mental health unit and closed the obsolete unit.
- Opened a new unit designed to support disabled offenders in an "assisted living" environment.
- Established hospice services in our infirmary settings.
- Created a containment-based sex offender management and monitoring program.

Related Activities

- Occasional consultation for attorneys (plaintiff and defense) in correctional healthcare issues (review and expert witness activity). While in Michigan became the preferred corrections consultant to the Michigan Deputy Attorney General Staff. *1981-2005*
- Member, Indiana State Department of Health Tuberculosis Medical Advisory Committee. *1992-2005*
- Surveyor, National Commission on Correctional Health Care *1993-2005*
- Society of Correctional Physicians Midwest Director *1997-1999*
- Society of Correctional Physicians, Editor, CorrDocs (formerly Desmoteric News) *1999-2005*
- Member, Editorial Board of Correctional Health Care Report *2000-2005*

Medical Director – Southwest Michigan Clinical Complex; Lansing, MI

Clinical complex included approximately 15 prison facilities (approximately 11,000 offenders) encompassing security levels from minimum to 23 hour lockdown, a "boot camp facility". Healthcare services delivered in the region included general ambulatory care; general medical/surgical, dental, and psychiatric care in licensed skilled nursing settings (one of which was the first in-house correctional health

care inpatient facility accredited by the Joint Commission on Health Care Organizations); hemodialysis and peritoneal dialysis; a range of specialty services including but not limited to surgical, obstetrical, ophthalmologic, and gynecological services; Reception Center services for men and women; a unit dedicated to managing self-injurious prisoners, and six separate residential psychiatric units for men and women. *(1986-1992)*

- Served as overall health authority for the region.
- Directed (professionally and administratively) approximately 200 healthcare staff members.
- Chaired the Michigan Department of Corrections Medical Advisory Committee (statewide advisory committee serving the Michigan Department of Corrections central office administrative staff).
- Planned, implemented, and managed various specialized units caring for seriously mentally ill prisoners.
- Planned, implemented, and managed the (then) only unit in country specifically dedicated to treating self-injurious prisoners who were neither seriously mentally ill nor developmentally disabled.
- Planned and established health services at a Special Alternative Incarceration (boot camp) Unit.
- Carried out various quality assurance and monitoring activities.
- Obtained and maintained JCAHO accreditation for a licensed nursing care unit for seriously mentally ill women.
- Assisted clinical complex prisons in obtaining accreditation from the American Correctional Association and National Commission on Correctional Health Care.
- Reviewed and wrote policies and procedures for local and statewide use.
- Audited and reviewed healthcare services delivered at various Michigan Department of Corrections facilities and county jail facilities.
- Provided direct patient care, especially in minimum custody settings.
- Wrote a new formulary for the Michigan Department of Corrections.

Expert Medical Consultant – Wayne County Jail Inmates vs. McNamara et al; Detroit, MI
Provided continuing expert advice regarding both the provision of healthcare services and improvement of the healthcare delivery system in the Wayne County Jail. *1987-1997*

Correctional Health Care Consultant
As a consultant assisted a limited by varying set of parties in litigation-related evaluations regarding healthcare services delivered to prisoners in various jurisdictions, assisting plaintiffs and defendants. Considered this a challenging and worthwhile part-time responsibility with limited time spent in this activity. *1981-2005*

Medical Director – State Prison of Southern Michigan; Jackson, MI
The Jackson Region includes the largest walled prison in the United States. Health services included ambulatory care services; a licensed hospital with medical, surgical and psychiatric units; a Reception Center for new male commitments to the prison system; a broad range of outpatient subspecialty services; and support for surrounding facilities including over 6,000 prisoners. *1981-1986*

- Served as health authority for the region.
- Supervised and directed approximately 200 healthcare employees.
- Established healthcare policies and procedures for the region and for statewide use.
- Planned service improvements including but not limited to establishment of new ambulatory care settings, expansion of the medical staff and specialty services, improvement of hospital services and obtaining state licensure, and developing a new 94-bed hospital.
- Established protective and supportive mental health residential settings.
- Established a living unit for disabled prisoners.
- Audited and reviewed healthcare services delivered at various Michigan Department of Corrections facilities and several county jails (on behalf of the Michigan Department of Corrections Jail Services staff).

- Provided direct patient care, especially in segregation settings.
- Wrote the first zero-based staffing plan for the region.

Medical Director ─ Huron Valley Women's Facility (Detroit House of Corrections, Women's Division); Detroit, MI

The old Detroit House of Corrections, Women's Division, served female offenders at both the state and county levels. Closed in August 1977, at the same time that the Huron Valley Women's Facility opened, approximately three months into employment. At that time, DeHoCO was the only facility for female felony offenders in Michigan, and it supplied all services to them in addition to providing services to all incarcerated Detroit (and Wayne County) female sentenced county offenders. *1977-1981*

- Served as health authority for the facility.
- Provided direct patient services to prisoners.
- Supervised approximately 25 health care employees.
- Established a healthcare delivery system where none had previously existed.
- Planned and established the first supportive and protective housing unit for mentally ill female offenders in Michigan.
- Wrote and lectured for the Law Enforcement Assistance Administration's Correctional Health Care Project.
- Wrote a healthcare manual for prisoner self-help.

DEBORAH L. KELLER, RN, BSN, CCM
CCS Managed Care Clinical Services Leader

CERTIFICATIONS & MERITS

- CCM, CPUR, ACLS, PALS, BLS
- Military Service Medal

PROFESSIONAL EXPERIENCE

Director of Care Management — Correct Care Solutions; Nashville, TN
Program and operational oversight for care management services provided to correctional clients including the processes of prior authorization, concurrent review, retrospective review, population management, and care management systems. *(03/2011-present)*

University Physician's Health Plan

- **Director of Clinical Services** — Responsible for management of 68 employees in two locations across Arizona during transition to an interdisciplinary model including medical and behavioral health services. Process oversight for Utilization Management, Case Management, Prior Authorization, Maternal Child Health, and Behavioral Health. Wrote medical portion of SNP Model of Care and SNP Structure and Process Measures. Eight million dollar budget development and oversight. Oversight of OFR which resulted in full compliance. Clinical oversight of Medical Software System implementation Cerecons/TCS (Acuity). Wrote transition plan for Medical Management "Go Live" with 65,000 new lives. Implementation of web-based Milliman Care Guidelines throughout Clinical Services. Implementation and oversight of multidisciplinary rounds. *(12/2008-03/2011)*
- **Manager of Case Management** — Advanced case management from functioning at a second tier member services level to a much higher level of effort. Initiated a Dual Case Management model to address the "gray space" created by a Behavioral Health carve out. Developed and implemented "Home Safe" Program. Developed and implemented an ER Reduction Program. Developed and implemented Case Management ROI reporting (SNP). Implementation of template documentation. *(01/2008-12/2008)*

Manager of Utilization Management — United Healthcare Group; Nashville, TN
Instrumental in building a UM team responsible for all UM functions. Direct management of seventeen employees in three locations across Tennessee. Build-up of Utilization Management team within a start-up company. Transition of 165,000 members on "Go Live" with no breaks in care. Decreased average length of stay from 5.64 to 3.6 bed days. Implementation and oversite of multi-disciplinary rounds. Implementation of template documentation. Implementation of Milliman Care Guidelines. *(01/2007-01/2008)*

Surgical Services Team Lead/Case Management Team Lead — Vanderbilt University Medical Center; Nashville, TN
Directly led surgical teams for scheduled and trauma cases. Team Lead, Surgical Services. Magnet Champion during successful bid for Magnet Status. *(12/2000-12/2006)*

GERARD F. BOYLE CCS Chief Executive Officer

SUMMARY STATEMENT

Over 30 years of correctional service, including 15 years of employment within a state prison system and ten years of experience in the provision of comprehensive correctional healthcare/mental healthcare. Particular expertise in development, operation, management, and marketing of private/public partnerships committed to correctional excellence. Significant experience managing company's P&L and growth strategies.

EDUCATION

Bachelor of Science, Human Services; Fitchburg State College; Fitchburg, MA, 1985

PROFESSIONAL EXPERIENCE

Chief Executive Officer – Correct Care Solutions; Nashville, TN
While at the helm of HCS, as President & CEO, Mr. Boyle took on dual responsibility for Correct Care Solutions (CCS) as CEO, responsible for growth, acquisition, and development for both organizations. Mr. Boyle led CCS to growth of over $30 million in annual revenue in less than one year. The organization has quickly become one of the leading correctional healthcare providers by recruiting the brightest minds in the industry. *2003–Present*

President & Chief Executive Officer – Health Cost Solutions; Nashville, TN
As President & CEO of Health Cost Solutions (HCS), Mr. Boyle held responsibility for growth, acquisition and development. HCS remains one of the largest third party administrators in the country. Mr. Boyle positioned HCS for tremendous growth in the marketplace. *2003–2006*

President & Chief Executive Officer – Prison Health Services; Brentwood, TN *1997–2003*
President & Chief Development Officer – America Service Group; Brentwood, TN *2000–2003*
In a dual role as the CEO for PHS and CDO for ASGR, Mr. Boyle's responsibilities included executive-level oversight of PHS management team with focus on acquisition and development strategies designed to advance company growth in the corrections field. Revenues during the three and-a-half years under Mr. Boyle's tenure increased from $120 million to $550 million through acquisitions and greenfield growth.

Vice President of Operations – EMSA Correctional Care; Ft. Lauderdale, FL
Directly responsible for the oversight and management of 61 contracts, containing over 55,000 inmates at 100 sites with annual revenues of over $110 million. Direct supervisor of six Regional Vice Presidents. Company was purchased by ASGR in January of 1998 as part of an industry consolidation. *1996–1997*

Administrator of Sales & Marketing – EMSA Correctional Care; Ft. Lauderdale, FL
Responsible for nationwide marketing, sales, and business development division for one of the leading providers of correctional healthcare. Developed an innovative business plan that resulted in increasing revenues by $60 million in just over two years. Completed all aspects of proposals, including technical writing, pricing, and contract development. Represented company through presentations at national conferences. *1996–1997*

Regional Administrator of Operations – EMSA Correctional Care, Ft. Lauderdale, FL
Responsible for direct oversight and operations of four EMSA Correctional Care contracts covering seven sites and over 700 ADP, valued at more than $25 million. Responsible for annual P&L, accreditation, and staff development. *1993–1996*

Associate Commissioner for Health Services – Massachusetts Dept. of Corrections; Boston, MA
Responsible for the day-to-day operations of the Department of Corrections' Health Services Division that serves 22 facilities of various security levels and over 10,000 inmates/patients. Direct authority, control and responsibility for more than 500 staff and the division's annual budget of $40 million.
1991–1992

Superintendent/Chief Executive Officer – Bridgewater State Hospital; Bridgewater, MA
Responsible for 400-bed maximum security, psychiatric facility. Direct authority, responsibility, and control of more than 550 staff and a facility with an annual operating budget in excess of $20 million.
1987–1991

Massachusetts Correctional Institution – Shirley, MA *1977–1987*
Positions Held:

- Deputy Superintendent of Operations
- Director of Programs
- Director of Classification and Programs
- Special Assistant to the Associate Commissioner of Operations
- Administrative Assistant to the Superintendent
- Correctional Counselor
- Correction Officer

JON SCOTT BOSCH ___ CCS Chief of Institutional Operations

EDUCATION

1990: The George Washington University, Master of Health Services Administration
Washington, D.C.

1984: University of North Dakota, Bachelor of Science in Nursing
Grand Forks, North Dakota

PROFESSIONAL EXPERIENCE

- Correct Care Solutions (CCS); April 2004 to present
- Prison Health Services (PHS); January 1999 to April 2004
- Emergency Medical Services Associates (EMSA); November 1993 to January 1999
- National Commission on Correctional Health Care (NCCHC); September 1990 to November 1993
- Registered Nurse: United States Army Nurse Corp; October 1984 to October 1987
  George Washington University Hospital; December 1987 to December 1989
  Star Med Staffing; January 1990 to September 1990

I have held a variety of positions in the health care field. Upon completion of my master's degree in health services administration I entered the managed care environment specializing in correctional health care. My initial administrative position was with the accrediting agency, the National Commission on Correctional Health Care (NCCHC) located in Chicago Illinois. While working for NCCHC I held the positions of Director of Quality Improvement and Director of Accreditation. Duties included standards development, program development, on-site surveys and educational presentations.

My next position was with the correctional care division of Emergency Medical Services Association (EMSA), based out of Fort Lauderdale Florida. While with EMSA I held the following positions, Accreditation and Quality Improvement Specialist, Marketing Director and Regional Administrator. With each title change, more responsibility was assumed.

In January 1999 Prison Health Services, Inc. (PHS) purchased EMSA Correctional Care. I held the following positions with PHS, Vice president of Staff Development and Accreditation, Vice President of Quality Improvement and Vice President of Business Development. During my employment in the clinical services division of PHS, I was instrumental in the development and implementation of managed care programs to include quality improvement, utilization management, credentialing, staff development, and accreditation. In my role as Vice President of Business Development I have established and implemented business development strategies, business proposals, established and presented oral presentations utilizing power point programs, and identified new target markets. Following is a summary of the various managed care programs where I have assumed progressive leadership responsibilities.

QUALIFICATIONS

- **Contract Management:** As a Regional Administrator for EMSA, I was responsible for the administration of contract sites to include jails, prisons and juvenile detention facilities. The duties of this position included ensuring compliance with contract requirements, financial performance and client satisfaction. At one point as a Regional Administrator I was responsible for the administration and financial performance of 19 contracts in 12 states totaling more than $20,000,000 in annual revenues. Many of these facilities had inpatient infirmary wards that provided skilled nursing care.

- **Quality Improvement:** The initial Quality Improvement program that I established for NCCHC was designed to be an educational tool and addressed the basics of the QI process. Following the development of this program I toured the country presenting the program at educational seminars. The most recent QI program established for PHS is based on the Institute of Medicine (IOM) reports addressing the status of the current health care system. The QI program emphasizes the five aims addressed in the most recent IOM report; preventative care, acute care, chronic care, palliative care and coordination of care. This QI program includes components addressing medication errors, mortality reviews, sentinel events, peer review and the root cause analysis process. The medication error component of the QI program in based on the program established by the National Coordinating Counsel for Medication Error and Prevention. I believe that the best QI programs address reducing variability through development and evaluation of effective health care systems and processes.

- **Utilization Management:** Under the direction of the PHS Corporate Medical Director I established and implemented utilization management systems and processes. The utilization management program is detailed in a resource manual that addresses the effective utilization of health care resources including specialty services, pharmaceuticals, laboratory services and medical supplies.

- **Credentialing:** I have also developed and implemented a credentialing program that is based on standards established by the National Commission for Quality Assurance. Following the development of the program, forms and resource manual the program was implemented company-wide. Within the first year of the credentialing program more than 300 providers were credentialed. The credentialing program addresses initial credentialing, interim privileges, the re-credentialing process and professional review guidelines.

- **Staff Development and Training:** Responsible for the development, implementation and presentation of new employee orientation programs, health services administrator-training programs, nursing continuing education programs and a physician orientation programs. A component of the staff development and training program has been the development of resource manuals. I have worked in close coordination with the PHS Corporate Medical Director to establish resource manuals addressing utilization management, Hepatitis C, contract administration, mental health care, and quality improvement. These resource manuals were implemented nationally.

- **Business Development:** Throughout my professional career I have been involved in various aspects of the business development process to include attending pre-bid conferences, proposal writing and development, oral presentations, contract negotiations and program implementation.

- **Accreditation:** As the designated company expert regarding the interpretation and application of accreditation standards, I have assisted multiple facilities to establish and implement systems to ensure compliance with accreditation standards. I have also developed and implemented an accreditation evaluation tool that is used by PHS sites when preparing for accreditation.

- **Committee Membership:** I have actively participated in a number of managed care committees to include the pharmacy and therapeutics committee, HIV task force, Hepatitis C task force, quality improvement committee, mortality review committee, and the mental health task force.

GRADY JUDSON BAZZEL, M.D. CCS Deputy Chief Medical Director

UNDERGRADUATE EDUCATION

1988-1992 University of South Alabama, Mobile, Alabama
B.S. in Biomedical Sciences, Minor in Chemistry, March 1992
G.P.A. – 3.61

MEDICAL EDUCATION

- Accepted as Early Decision Candidate to the University of South Alabama College of Medicine; Mobile, AL; Master's Degree in Medicine (MD) awarded on June 9, 1996 *1992-1996*
- University of South Alabama Family Practice Residency Program *1996-1999*
- Chief Resident University of South Alabama Family Practice Residency Program *1999*
- Logged over 1000 hours of continuing medical education with the American Academy of Family Practice *1999-2009*
- Received Board Certification in Family Practice *1999*
- Certified in BLS *2002-present*

HONORS

- Three year undergraduate degree program
- President's list for three quarters
- Dean's list for seven quarters
- Recipient of full academic scholarship
- Alpha Chi National Honor Society member
- Alpha Lambda Delta National Honor Society member
- Phi Eta Sigma Freshman Honor Society member *Students of America*
- Graduated *Cum Laude*

PROFESSIONAL LICENSES

- Tennessee License #31177
- Alabama License #21100
- California License #C53908
- Kansas License # 0434007

EMPLOYMENT EXPERIENCE

Deputy Chief Medical Director – Correct Care Solutions; Nashville, TN *2005-Present*
Responsible for the clinical elements of the entire system including professional duties. Supervise physicians and mid-level practitioners. Provide general supervision to practitioners in clinical disciplines other than medicine. Provide services to patients depending upon assignment. Provide consultation to professional and custodial staff. Interface with nursing staff and client facility staff. Assist in the development of the clinical and managerial skills of the site medical staff. Assume responsibility for clinical program operations in accordance with ACA, NCCHC, CCS and facility policy and procedure and state standards and regulations. Previous CCS positions:

- **Medical Director – Davidson County Sheriff's Office; Nashville, TN** *09/2005-02/2009*
- **Medical Director – Correct Care Solutions/Montgomery County Jail; Clarksville, TN** *06/2005-12/2006*

Medical Director – Southern Health Partners/Rutherford County Work Release Center; Murfreesboro, TN
06/2005-10/2005

Medical Director – Southern Health Partners/Williamson County Jail; Franklin, TN
03/2005-10/2005

Attending Physician – Maury Regional Hospital Ambulatory Care Center; Columbia, TN
07/1999-03/2005

Emergency Room Physician (part-time) – Washington County General Hospital; Chatom, AL
10/1997-06/1999

Co-attending physician – Mobile County Metro Jail; Mobile, AL
Received citation of excellence from the warden for the medical care provided.
10/1997-06/1999

Research Assistant, Dept. of Comparative Medicine – University of South Alabama; Mobile, AL
Job required performing behavioral observations on captive squirrel monkeys, collating data, performing statistical analysis, and interpreting results.
06/1993-08/1993

PUBLICATIONS

Allomaternal Interactions in the Bolivian Squirrel Monkey. Williams, Lawrence; Gibson, Susan; McDaniel, Margaret; **Bazzel, Judson;** Barnes, Sue; Abee, Christian. American Journal of Primatology, 34: 145-156 (1994)

ACTIVITIES

- Research Assistant, U.S.A. Department of Biomedical Sciences, Dr. Michael Spector.
  Summer of 1991
- Research Assistant, U.S.A. Department of Comparative Medicine, Dr. Lawrence Williams.
  Summers of 1992 and 1993
- Representative to the American Academy of Family Practice Convention in Kansas City, Missouri.
  08/1997

PROFESSIONAL SOCIETIES

- American Medical Association
- American Academy of Family Practice
- Society of Correctional Physicians
- Academy of Correctional Health Professionals

KATHY KOLWYCK
CCS V.P. Network Development & Provider Relations

EDUCATION

- **The University of Tennessee, Memphis, B.S. Physical Therapy**
  Graduate with High Honors
- **Lambuth College, Jackson, TN**
  Dean's List

PROFESSIONAL EXPERIENCE

V.P. Network Development & Provider Relations – Correct Care Solutions; Nashville, TN
Member of the CCS Executive Team. Leadership of the department responsible for hospital, physician, and ancillary contract negotiations. Responsible for all provider relations areas. Business development including proposal writing and pre-bid conferences. Analysis and monitoring of hospital, physician and ancillary utilization. Budget preparations and review. Successfully converted state-wide provider network in Kansas. *10/2003-Present*

Contract Manager – Prison Health Services; Brentwood, TN
Oversight, coordination, and development of provider networks for jail and prison facilities. Hospital, physician, and ancillary contract negotiations. Hospital case rate and prompt pay negotiations. Negotiations for national contracting. Review and analysis of contracts for financial viability and budgetary impact. Facilitate provider relations issues between multiple corporate departments and regions. Successfully negotiated and managed laboratory contracts in excess of $5M. Presented at Regional Medical Directors Annual Conference. Developed and implemented company-wide laboratory formulary resulting in 30% reduction of laboratory costs. Prompt pay negotiations in excess of $100,000.00, 2nd quarter 2003. Identified a cost savings in excess of $60,000.00 thru report analysis. *3/2000-10/2003*

Manager, Contract Implementation – Theraphysics; Brentwood, TN
Integrate and coordinate all risk contracts with various internal and external departments. Review payor contracts for operational compliance. Participate in payor meetings to resolve contractual and implementation issues. Troubleshoot and facilitate workflows for all internal departments to ensure contractual compliance. Developed workflows to reduce duplicitous process. 100% completion on meeting implementation deadlines. Presented to physician group which led to award of risk contract identified over $150,000 in recoverable claims for services that were contractual exclusions. *4/1999-3/2000*

Manager, Quality Improvement – Theraphysics; Brentwood, TN
Oversight of compliance with NCQA and MCO standards. Liaison to healthplan for delegation of utilization management, claims, and credentialing. Investigation, resolution and reporting of grievances and appeals. Chairperson of Quality Improvement Committee. Scores in excess of 98% for delegated audits performed by payors. Key presenter for Beverly 1999 Managed Care Conference. Revised 2000 QI manual to meet company, payor, NCQA and HCFA guidelines. *6/1998-3/2000*

Manager, Health Services – Theraphysics; Brentwood, TN
Oversight of clinical and clerical staff for the utilization of 1.3 million capitated lives. Development and design of protocols and clinical pathways for outpatient rehabilitation. Creation and implementation of UM policies and procedures. Provide quarterly reporting in accordance to payor contractual obligations. Monitor utilization of out of network contracts. Reduction of outpatient rehabilitation utilization in excess of 30%. Developed UM training materials for providers/payors. Integral member in development and

coordination of FACETS for the automation of utilization review for tracking and trending. Identified key markets where out of network arrangements were in excess and worked with provider relations to contract appropriate providers. *1/1995-6/1998*

Health Service Advisor – Theraphysics; Brentwood, TN
Managed patient care of 100,000 members for Northeast MCO. Coordinated communication and interactions with multiple payors for eligibility and benefits of members. Negotiate out of network contracts with providers. Assisted in integration of newly purchased networks into operational process. Promoted to Manager of Health Services. Maintained all out of network negotiations for all risk contracts. *8/1994-1/1995*

Staff Therapist – TriCare Rehabilitation; Nashville, TN
Provided daily outpatient rehabilitation with focus on orthopedic and neurological disorders. Coordinated all staff inservices and safety committee meetings. Developed Aquatic Therapy program and guidelines. *4/1992-7/1994*

Staff Therapist – Centennial Medical Center; Nashville, TN
Provided daily inpatient and outpatient orthopedic and neurologic rehabilitation. Instructor for prenatal exercise class. Coordinator for NICU (Neonatal Intensive Care Unit) follow up clinic. Achieved Level III Clinical Ladder. Developed NICU program. Developed multidisciplinary follow-up clinic for NICU graduates. Guest lecturer at Tennessee State University. *2/1990-3/1992*

KIM CHRISTIE, RN, BSN, CCHP, CCN/M
CCS Director of Business Development and Transition Coordinator

SUMMARY STATEMENT

Over 20 years of experience in correctional health care in both jail and prison settings. Particular expertise in program and policy development, operations, facility accreditation, contract compliance and commitment to quality care and client satisfaction.

EDUCATION

- Thomas Jefferson University – Philadelphia, PA; Bachelor of Science-Nursing; 1983
- West Chester University – West Chester, PA; 1978–1981

CERTIFICATIONS

- Professional Nurse, Pennsylvania, RN 262415-L Active
- NCCHC Certified Correctional Health Professional
- ACA Certified Corrections Nurse Manager
- American Correctional Health Services Association, Chesapeake Chapter Representative

PROFESSIONAL EXPERIENCE

Director of Business Development – Correct Care Solutions; Nashville, TN
Contract and client liason services and operations transition coordinator. *10/2008-present*

Regional Vice President – Correct Care Solutions; Nashville, TN
Specialize in contract start-up and facility healthcare management. Responsibilities include oversight of multiple contract medical, dental, mental health and related professional healthcare services. Functions as a liaison between correctional officials, on-site CCS staff, and corporate office. *10/2004-10/2008*

Division Vice President – Prison Health Services; Nashville, TN
Responsible for oversight of multiple jail and comprehensive State Department of Corrections facilities. Coordinated medical, dental, mental health, and all related off- and on-site healthcare services. Management of all areas of care for quality, contract compliance, and financial performance. *01/1999-10/2004*

Regional Vice President – EMSA Correctional Care; Ft. Lauderdale, FL
Responsible for contract start-up and oversight of multiple jail and prison contracts throughout the Northeast. Management experience included comprehensive responsibility for 18 contracts in 8 states. *01/1993-01/1999*

Health Services Administrator – Delaware County Prison; Thornton, PA
08/1991–01/1995

Registered Nurse *1983 – Current*

- Delaware County Prison 1988 - 1991
- Professional Staffing 1984 - 1988
- Lankenau Hospital 1983 – 1984

LAWRENCE RECCOPPA, M.D. CCS Licensed Psychiatrist

EDUCATION

1991: Psychiatry Residence; University of Florida
1987: M.D., University of Florida
1983: B.A., Cornell University

LICENSURE & BOARD CERTIFICATION

1997: Florida, No. 53986
1993: American Board of Psychiatry and Neurology

PROFESSIONAL EXPERIENCE

2008-Present: Licensed Psychiatrist; Correct Care Solutions; Nashville, TN
2004-2006: Chief Psychiatrist; Alachua County Jail; Gainesville, FL
2005-2007: Chief of Inpatient Services; Meridian Behavioral Health; Gainesville, FL
1994-Present: Courtesy Clinical Assistant Professor; Department of Psychiatry; University of Florida
1994-Present: Private Practice; Gainesville, FL
1993-2006: Chief Psychiatrist; Union Correctional Institution; Raiford, FL
1991-1994: Staff Psychiatrist / Major; United States Air Force, MC
1990-1991: Chief Resident, Psychiatry; University of Florida

MEMBERSHIPS

1997-1998: President, North Central Florida; Psychiatric Society
1987-Present: American Psychiatric Society & Florida Psychiatric Society

ACADEMIC HONORS/AWARDS

1994: United States Air Force Commendation / Medal for Meritorious Service
1991: United States Air Force Professions / Scholarship Program
1991: John E. Adams Award / Excellence in Research and Education
1991: Anclote Manor Foundation Award / Outstanding Resident in Psychiatry
1983: Phi Beta Kappa / Cornell University

PUBLICATIONS

- Gabapentin Abuse in Inmates With Prior History of Cocaine Abuse; Reccoppa, L., Ware, M.R., Malcolm, R.; The American Journal on Addictions *(2002)*
- Malignant Sex and Aggression: An Overview of Serial Sexual Homicide; Myers, W., Reccoppa, L., Burton, K.; Bulletin American Academy of Psychiatry Law, Volume 21, Number 4 *(1993)*
- Acute Dystonia and Fluoxetine; Reccoppa, L., Welch, W.A., Ware, M.R. *(1990)*

PRESENTATIONS

- "Clinical Challenges in Correctional Psychiatry: Focus on Schizophrenia"
- "Safety Considerations with Antipsychotics"
- "Management of the Violent Patient"
- "Selection of Antidepressant: Cormorbidity Issues"
- "Gabitril: Novel Mechanism and Potential Applications"
- "Clinical Challenges in Corrections: Focus on ADHD"
- "Clinical Challenges in Corrections: Self-Injurious Behaviors"
- "Atypical Antipsychotics: Cost and Utilization Issues in Corrections"
- "Sex and Aggression: An Overview of Serial Sexual Homicide"
- "Radiograpic Findings in the Phakomatoses"; Grand Rounds; Department of Radiology

LEILANI S. BOULWARE
CCS Chief of Administrative Services & General Counsel

SUMMARY STATEMENT

Executive Management and Chief Legal Counsel, leading strategy, compliance and change management in fulfillment of organizational vision, mission, and goals. Sixteen-year record of success delivering sound legal counsel and representation for corporate and institutional clients, synthesizing complex information targeting diverse audiences, and initiating mission-centric application by senior management and operations staff. Proven capacity to conceptualize, develop and drive strategic direction through consensus building among key stakeholders regarding bet practices. Forward-thinking, solution-driven innovator, utilizing seasoned interpersonal and communication skills to elicit collaboration and value-added teamwork. Exceptional insight guiding complex, multifaceted organizations toward achievement of sustained operational excellence. Uncompromising commitment to ethical standards and sound professional judgment.

EDUCATION

Juris Doctor, Vanderbilt University School of Law – Nashville, TN
- Patricia Harris Roberts Fellowship
- Bennett Bell Award

Bachelor of Science, Western Kentucky University – Bowling Green, KY
- Magna Cum Laude
- Double Major, Accounting and Economics

PROFESSIONAL EXPERIENCE

Chief of Administrative Services & General Counsel ─ Correct Care Solutions; Nashville, TN
Leads the Divisions of Administration and Clinical Services responsible for People Strategies, Risk Strategies, and Clinical Strategies through the leadership and management of operational goals and objectives designed to build strong legal, risk management, human resources, people development, clinical quality improvement, and clinical services functions. *05/2008-Present*

Court Appointed Monitor ─ United States District Court; Nashville, TN
Monitor appointed by the United States District Court, Tennessee Middle, in the case of *John B.,et al.v. Goetz, et al.*3:98-cv-168. Served in a quasi-judicial capacity on five-person team of monitors, principally as follows: monitored the State of Tennessee's compliance in designated areas; identified issues and reasons therefore to direct the parties' and the Court's inquiry; and filed requisite reports. *2006-2007*

Vice President for Administration, General Counsel, and Corporate Secretary ─ Meharry Medical College; Nashville, TN
Member of eight-person senior executive team charged with reformation and revitalization of an institution with a $130 million+ annual operating budget and 1,000 employees. Meharry Medical College is a private, independent health professions training institution, research facility, and health services provider that strives to eliminate the health disparities experienced by minority and disadvantaged populations. Developed and led effective and highly-responsive Office of the General Counsel and Division of Administration in support of the core business of the College, through the establishment and implementation of strong compliance, human resources, and public safety/security departments. Provided legal counsel and support to multiple operations and supervised legal affairs, assured maintenance of physical properties and proper real estate management, instituted administrative policy management, facilitated governmental affairs activities, oversaw administration of the Board of Trustees for the College, assured appropriate budget management, served as liaison to the Meharry/Vanderbilt Alliance Board, and provided interim oversight Information Technology operations. *2004-2006*

Vice President for Management and Policy, General Counsel, and Corporate Secretary
Supervised legal affairs. Established and administered robust compliance requirements. Instituted administrative policy management, exercised oversight of governmental affairs activities, and served as liaison to the Meharry/Vanderbilt Alliance Board. Served as Corporate Secretary to the Board of Trustees for the College. Spear headed divisional turn-around, through department leadership re-staffing and recruitment of qualified personnel, introduction of comprehensive internal training programs, and redesign of core processes. *2003-2004*

Attorney/Shareholder – Harwell Howard Hyne Gabbert & Manner, PC; Nashville, TN
Handled federal and state civil cases encompassing a broad range of legal issues, including complex contract, employment, insurance, intellectual property, unfair business practices, and defamation disputes. Arbitrated and mediated disputes. Counseled employers regarding employment law matters. Conducted employment law seminars. Drafted federal affirmative action plans. Managed corporate transactions including mergers, asset purchases, stock purchases, conduct of transactional due diligence, and lease negotiations. Worked on proxy statement development. Supervised associates mentored and provided guidance regarding litigation and transaction matters. *1992-2003*

Intern to the Honorable Judge John Penn, United States District Court, District of Columbia– Washington, D.C.
In relation to pending court cases, researched case law, drafted legal memoranda, and consulted the court regarding legal issues. *Summer 1990*

Winn-Dixie Food Stores– Kentucky and Tennessee
Promoted through a series of increasingly responsible positions, including general merchandise management, front-end service, and delicatessen departments. Managed staff, operational planning, and profit/loss control. *1974-1989*

COMMUNITY LEADERSHIP & PROFESSIONAL AFFILIATIONS

- Young Men's Christian Association of Middle Tennessee (YMCA), Chairman-elect; People Services Committee, Chairman; Former Corporate Secretary
- The Women's Fund of the Community Foundation, Board Member
- Nashville Alliance for Public Education, Board Member, Corporate Secretary
- LEAD Academy Charter School, Board Member
- YMCA of the USA National Governmental Relations Advisory Committee, Member
- Tennessee Lawyers for Client Protection Fund (TN Supreme Court Appointment), Member
- Nashville Rotary, Member
- Leadership Nashville, Class of 2003
- Tennessee and Nashville Bar Associations, Member
- Harpeth Heights Baptist Church, Member

LORI ELLIS, RN, BSN, CCHP CCS Regional Vice President

EDUCATION

- Master of Science Education ─ Temple University; Philadelphia, PA
- Bachelor of Professional Studies/Health Administration ─ Elizabethtown College; Elizabethtown, PA
- Registered Nurse Diploma ─ York Hospital; York PA

PROFESSIONAL EXPERIENCE

Regional Vice President ─ Correct Care Solutions; Nashville, TN
Monitor and maintain all aspects of operations, sales and marketing for assigned division/region. Provide necessary guidance to assist executive management team in making business decisions. Ensures medical, dental, and mental health program activities are based upon goals, objectives, aims, and policies and procedures of CCS and the facility and are compliant with ACA, NCCHC, and State accreditation standards. Provides supervision of Case Managers and participates in UM activities. *11/2011-Present*

Regional Manager, Virginia Region ─ Prison Health Services; Richmond, VA
Regional over-site of eight institutions thru 2006**,** managed over-sight of five institutions housing over 10,000 offenders**.** Assist in facilitating the implementation of Correctional Care contracts to include staffing compliance with contract requirements**.** Responsible for the development and implementation of site-specific Correctional Care programs to include policies and procedures, quality improvement, infection control and staff orientation and education**.** Monitoring compliance with national correctional standards set forth by the American Correctional Association (ACA)**.** Maintain monitoring of financial performance of each designated site as well as evaluation of HSA's performance. *2005-2011*

Interim Health Services Administrator ─ Greensville Correctional Center, Prison Health Services; Jarret, VA
In addition to Regional Manager responsibilities, performed duties as an interim Health Services Administrator for two years**.** Instrumental in resurrecting on-site operating room, providing on-site surgical clinic, CT, ultrasound; ultimately reducing off-site transportation trips**.** Provided oversight for the sites 40-bed infirmary, 80-bed licensed sheltered MH unit, and on-site dental and ancillary clinics to include telemedicine and optometry**.** Instrumental in bringing tele-psychiatry onboard as well as chronic care clinics via tele-med**.** Managed overall contractual staffing responsibilities which resulted in a significant reduction of agency nursing use and monthly penalties. *2006-2008*

Senior Health Service Administrator ─ Sussex I and Sussex II State Prison, Indian Creek Correctional Center, Lunenburg Correctional Center, Prison Health Services; Richmond, VA
Responsible for the regional oversight of four institutions within the Virginia Region**.** Supervised Health Services Administrators in budget, quality assurance, accreditation process, labor control, etc. Responsible for the contractual agreement between PHS and the Virginia Department of Corrections. *2003-2005*

Health Service Administrator ─ Sussex II State Prison, Prison Health Services; Waverly, VA
Responsible for the overall operations of the medical department in delivery of healthcare to over 1,200 offenders**.** Overall responsibility for the administrative oversight of medical physicians, dental department, and mental health**.** Managed the contractual agreement between the State and PHS Budget Control related to all expenditures within the medical department; developed operating policies/procedures and management of the quality control program**.** Responsible for tracking of grievances and/or legal matters related to medical services**.** Managed the availability of off-site services and inpatient services. *2001-2003*

Director of Nursing – Sussex II State Prison, Correctional Medical Services; Waverly, VA
Responsible for maintaining 24-hour clinical services to offenders with multiple chronic medical and mental health conditions**.** Supervised nursing in the daily operations within the institution providing care to approximately 1,200 offenders**.** Interacted with security supervisors within the prison in regards to medical issues, grievances, and off-site transportation**.** Assist in managing the ACA accreditation process and successfully meeting re-accreditation for the institution with a score of 100%**.** Implemented monthly QI/Quality Assurance tracking tools**.** Managed staffing shortages, recruitment, and retention initiatives**.** Assisted the Health Service Administrator with budget management strategies. *2000-2001*

Registered Nurse – Sussex II State Prison, Correctional Medical Services; Waverly, VA
Responsible for the health and well-being of over 1,200 inmates**.** Coordinated medical services between LPNs, dentists, correctional officers and other Department of Corrections staff**.** Supervised LPNs and trained new RNs**.** Responsible for record documentation according to Standards of Nursing and pharmaceutical standards**.** Perform comprehensive evaluations, assessment, and treatment regarding emergency and non-emergency situations**.** Treatment planning, implementation, and referrals**.** Work independently as well as with various institutional teams. *1999-2000*

MEL WAYMASTER, PHR CCS Vice President Human Resources

EDUCATION

Capella University; Minneapolis, MN ─ Master of Science, Human Resources (2005)
University of Central Florida; Orlando, FL ─ Bachelor of Science, Business Administration (1995)

PROFESSIONAL EXPERIENCE

Vice President, Human Resources ─ Correct Care Solutions; Nashville, TN
Provide leadership to the Human Resources function for a successful, growing healthcare corrections company with over 500 employees located throughout the country. Successfully create, implement, maintain, and lead all aspects of human resources, including employee relations, recruitment and employment, compensation, benefits administration, payroll, and training. Partners with management to create a strategy that supports and enhances the strategic goals of the company. Accomplishments include building and leading a human resources department from the ground up, with strategy to closely align human resources goals with the overall strategic goals of the company. *2003-Present*

Human Resources Manager ─ AIM Healthcare Services; Franklin, TN
Manage Human Resources function for a rapidly expanding healthcare company comprised of over 1,200 employees located nationally. Developed and implemented policies relating to employee relations, records management, employment and recruitment, internal transfers, orientation, benefits administration, compensation, and human resources compliance. Accomplishments include decreasing operations costs through the reduction of employee turnover by nearly 50%, by improving employee relations and recruitment strategies through the development and implementation of a policy manual, employee handbook, supervisor training, employee performance appraisal, behavioral interviewing, employee orientation, exit interviewing, and other professional development tools. *1998-2003*

Recruitment Manager ─ Opryland USA; Nashville, TN
Managed recruitment function for established hospitality and entertainment company comprised of more than 3,500 employees. Developed and implemented staffing strategies to include traditional recruitment, as well as non-traditional recruitment such as recruiting programs designed to attract international employees. *1997-1998*

Operations Lead ─ Walt Disney World Co.; Orlando, FL
Supervised daily operations for highly successful hospitality and entertainment company. Duties included scheduling and coordination of operations, training, daily payroll submission, staffing and budgeting, and coordination of special events. *1990-1996*

Sergeant ─ United States Army; Ft. Campbell, KY
Supervised maintenance squad for communications battalion. Duties included scheduling of personnel, providing leadership to a team of maintenance personnel, tracking inventory, and creating operational budgets for the communications entity of a maintenance battalion. *1986-1990*

Court Appointed Monitor ─ United States District Court; Nashville, TN
Monitor appointed by the United States District Court, Tennessee Middle, in the case of *John B.,et al.v. Goetz, et al.*3:98-cv-168. Served in a quasi-judicial capacity on five-person team of monitors, principally as follows: monitored the State of Tennessee's compliance in designated areas; identified issues and reasons therefore to direct the parties' and the Court's inquiry; and filed requisite reports. *2006-2007*

PROFESSIONAL AFFILIATIONS

- Member of the Society of Human Resource Management
- Member of Human Resources Association of Middle Tennessee

PATRICK J. CUMMISKEY CCS Chief of Development & Client Relations

SUMMARY

Marketing, Sales and Brand Executive with broad based, diverse background in both direct consumer, and distribution based industries. Skilled in guiding new and mature brands, while driving sales and profitability through strategic development, prioritization, and execution. Experienced in establishing and negotiating strategic partnerships and distribution both domestically and internationally. An ambitious, result-oriented leader who consistently fosters strong internal and external relationships.

EDUCATION

Georgia State University; Atlanta, GA
Masters of Business Administration; Major: Marketing, 1996

University of Georgia; Athens, GA
Bachelor of Business Administration; Major: Finance, 1993

University of Innsbruck, Austria
International Business; Summer 1992

PROFESSIONAL EXPERIENCE

Chief of Development & Client Relations – Correct Care Solutions; Nashville, TN
Responsible for Federal contracting; new product development; state/county business; and supporting Operations with on-going Client Relations initatives. Manage and motivate team oriented sales force while establishing product and service offerings. Responsible for P&L with incentives focused on client satisfaction. *06/2002-Present*

Vice President, Sales & Marketing – EcoSMART Technologies, Inc.; Franklin, TN
A 10-year-old biotechnology company focused on the development, formulation, manufacturing, and sales of pharmaceutical and pesticide products. Oversee the strategic development, operations, product development, sales and marketing of the commercial and agricultural divisions, including P&L responsibilities. Manage and motivate team oriented sales force while establishing distribution network.

- Revenue growth of over 100% per year while achieving and maintaining profitability.
- Negotiate and establish international distribution and strategic partners both domestically, as well as in Asia, Europe, and Australia.
- Successfully manage dynamic distribution channels and excel in both a relationship driven marketplace and a "bid determined" selling environment.
- Handle the prioritization of product development and initiated launch of two divisions, one of which reached positive cash flow within six months.
- Work closely with federal agencies, including the EPA, FDA, and state regulators.

1999-2002

National Marketing Manager – Orkin Pest Control, Rollins, Inc.; Atlanta, GA
A $650 million (NYSE) service company (better known for Orkin Pest Control). Managed Orkin's largest brand, residential pest control. Responsibilities included all customer interaction, lead generation/facilitation, sales, service offerings, pricing, and customer communication. Managed marketing team, which developed and presented "Strategic Brand Plan" semi-annually to senior management prior to implementation.

- Oversaw strategy, planning, purchasing, creative, and production of all advertising and lead generation mediums; including radio, television, outdoor, newspaper, and direct response resulting in reversing a two-year trend of decreasing leads.

- Successfully exceeded goal of 10% annual decrease in customer cancellations through innovative and new customer retention and communication programs.
- Increased profitability and retention through project leadership of creation and implementation of new sales offerings based on demographics and geography.
- Controlled and assigned all rate cards and managed price increase programs, which generated over $2,000,000 annually towards Orkin's EBITA.

1996-1999

Director of Marketing – Atlanta Oil Exchange, Inc.; Atlanta, GA
A preventative care maintenance center servicing high-end office facilities. Co-founded company and handled all marketing, sales, and accounting responsibilities. Developed and executed business plan while attending graduate school during the evenings. Responsible for marketing strategy, advertising, sales, and direct client contract.

- Negotiated all contracts and licensing agreements (both client and vendor).
- Designed customer and daily revenue database which also generated weekly reports.
- Company grew from start-up to three operating stores in just 18 months.

1994-1996

Manager, Return Check Department – BUYPASS the System; Atlanta, GA
One of the world's largest point of sale transaction companies. Supervising liaison between return check research and accounting departments. Role was expanded to include heading committee of outside consultants, from large accounting firms, to refine control processes and handled massive bank reconciliation process.

- Handled large volume accounts averaging over $100,000 per month.
- Responsible for identifying and recovery of over $150,000 in missing funds.

1993-1994

Merchandiser – Pepsi-Cola; Atlanta, GA
A division of PepsiCo. Managed and worked "bulk" (large grocery) route consisting of Kroger, Cub Food, Big Star, Drug Emporium, and A&P stores. Job was critical in subsidizing college expenses. Developed loyal customer base through client contact and negotiation. *Summers 1998-1991*

RANDY MARSHALL, CPA CCS Senior Vice President - Finance

EDUCATION

- 1997: B.S., Business Administration, Major in Accounting
  Tennessee Technological University; Cookeville, Tennessee

LICENSURE:

- CPA licensed in Tennessee. Member of TSCPA.

PROFESSIONAL EXPERIENCE

Senior Vice President - Finance ─ Correct Care Solutions; Nashville, TN *1/2012-Present*
Vice President and Controller ─ Correct Care Solutions; Nashville, TN *2008-2012*

- Correctional healthcare company with annual revenues of $250 million (proforma).

Member of Executive Management Team. Responsible for the departments of Accounting, Treasury, Accounts Payable, and Payroll. Analyzes and reports on the financial performance of the company to all stakeholders and negotiates and manages banking relationships. *2008 - 2012*

Assistant Controller ─ Psychiatric Solutions, Inc. (PSI); Nashville, TN *(PSI purchased by Universal Health Services May 2010)*

- PSI was a public healthcare company with annual revenues of $2 billion.

PSI grew from owning/leasing 10 hospitals to 91 during the time of employment primarily through a buy and build acquisition strategy. Responsible for corporate accounting, self-insured reserves, and purchase accounting. Participated in the preparation and filing of numerous SEC filings. Assisted with Sarbanes-Oxley compliance. *2003 - 2008*

Manager, Assurance and Advisory Business Services ─ Ernst & Young LLP; Nashville, TN
Served public, private, tax-exempt, and closely held companies, including one teaching hospital subject to government accounting standards. Participated in the financial audits of more than 20 hospitals ranging from approximately 65 to 600 beds. *1997 - 2003*

Allyson L. Galloway, Psy.D.

212 Wildwood Avenue Media, PA 19063 • 610-804-7217 • DrAllysonGalloway@gmail.com

EDUCATION:

Psy.D. ***Immaculata University***, Immaculata, PA
Clinical Psychology**,** May 2007
American Psychological Association-approved program
Cumulative GPA: 4.0
Advisor: Pamela Abraham, Psy.D.
Dissertation Title: "Qualitative Analysis of Relational Aggression in Young Adult Women"
Dissertation Committee Chair: Janet Etzi, Psy.D.,
Dissertation Defense: 4/26/06

M.S.Ed. ***University of Pennsylvania Graduate School of Education***, Philadelphia, PA
Psychological Services**,** August 2000

B.A. ***Villanova University***, Villanova, PA
Psychology, May 1999

PROFESSIONAL LICENSURE:

Licensed Psychologist, **State of Delaware License No. B1-0000812**
Licensed Psychologist, **Commonwealth of Pennsylvania License No. PS016497**

PROFESSIONAL AFFILIATION MEMBERSHIPS:

PennPsyPac Board of Directors
Pennsylvania Psychological Association
- Early Career Psychologists Committee Member
- Convention Committee Member
- Forensic & Criminal Justice Committee

Philadelphia Society of Clinical Psychologists
American Psychological Association

HONORS:

Pennsylvania Psychological Foundation Education Award Recipient, June 2007
Pennsylvania Psychological Foundation Education Award Recipient, June 2006
Pennsylvania Psychological Foundation Education Award Recipient, June 2005
Immaculata University Graduate Scholarship Recipient, 2003-2004
Recognized for Distinguished & Outstanding Community Service by People's Emergency Center, April 2000
Villanova University Dean's List, 1998-1999

PROFESSIONAL COUNSELING & FIELDWORK EXPERIENCE:

Acting Mental Health Director (April 2012-Present)
Licensed Psychologist (July 1, 2010-Present)
MHM Services, Inc.
at **Howard R. Young Correctional Institution,** Wilmington, DE
& **Baylor Women's Correctional Institution,** New Castle, DE

- Provide individual and group psychotherapy and psychological assessment to adult men and women and male juveniles adjudicated as adults in two level five integrated prison/jail facilities.
- Work with interdisciplinary team and primarily responsible for management of patients housed on Psychiatric Close Observation Status in an infirmary setting.
- Assist with administrative duties and program management.
- Supervision and oversight of sexual offender psychological evaluations.
- Provide clinical supervision to master's level mental health staff.

Licensed Psychologist/Mental Health Director (March 2009-June 30, 2010)
Correctional Medical Services
at **Baylor Women's Correctional Institution,** New Castle, DE

- Provide individual and group psychotherapy and psychological assessment to adult women in a corrections environment.
- Provide group & individual clinical supervision to all mental health professionals.
- Responsible for both clinical and administrative oversight of the mental health departments in level five integrated prison/jail facility and three off-site level four community corrections locations.

Adjunct Instructor (May 2009-December 2009)
Immaculata University Graduate Psychology Department, Immaculata, PA
- PSYC 745 Social Psychology
- PSYC 712 Existential and Humanistic Theories and Therapies

Outpatient Therapist (May 2008-April 2009)
Post-Doctoral Residency (May 2007-May 2008)
Pre-Doctoral Internship (May 2006-May 2007)
Associates of Springfield Psychological, Springfield, PA
- Provide individual psychotherapy and psychological assessment to adults, children, and adolescents in an outpatient setting.

Pre-Doctoral Internship (August 2006-May 2007)
Saint Joseph's University Counseling Center, Philadelphia, PA
- Provide individual psychotherapy, outreach, and crisis services to young adults in a university counseling center setting.

BHRS Program Clinical Coordinator (February 2002-August 2006)
Holcomb Behavioral Health Systems, Upper Darby, PA
- Provide clinical and administrative supervision for all Master's and Bachelor's level staff in BHRS/EPSDT Wraparound Program serving Delaware County.

- Coordinate all aspects of EPSDT program including overseeing the service delivery for all active clients with emotional, behavioral, and drug and alcohol difficulties, implementing psychotherapy, behavior modification, and case management services.
- Responsible for training and staff development, budget management, and program development.
- Previous positions held within this organization and program include Behavior Specialist Consultant and Mobile Therapist, 9/00-2/02, and Therapeutic Staff Support, 12/99-9/00.

Behavior Specialist Consultant & Mobile Therapist (November 2004-August 2006)
Elwyn, Inc., Elwyn, PA

- Develop and implement behavior modification plans, using applied behavior analysis, and provide psychotherapy services, including individual and family therapy modalities, for children with emotional support difficulties and their families.

Psychotherapy Practicum Intern (May 2004-December 2004)
Partial Hospitalization Program, Lenape Valley Foundation, Doylestown, PA

- Provided individual and group psychotherapy in a long-term partial hospitalization program for adult and geriatric clients with Axis I and Axis II major mental health diagnoses, including Major Depression, Bipolar I Disorder, Post Traumatic Stress Disorder, Schizophrenia, and Borderline Personality Disorder.
- Conducted an ongoing Anxiety Management Group.

Diagnostic Practicum Intern (August 2003-April 2004)
Education Division, Elwyn, Inc., Elwyn, PA

- Conducted psychological assessment batteries with special education and emotional support students.
- Integrated intellectual, personality, and emotional functioning measures for the purposes of emotional support and IEP planning.

Counseling Intern (September 1999-May 2000)
Intensive Outpatient Program, Rehab After Work & Rehab After School, Malvern, PA

- Assisted with all aspects of adult and adolescent intensive outpatient drug and alcohol therapy, including group, individual, and family counseling.

Community Outreach Intervention Intern (March 2000-May 2000)
People's Emergency Center, Philadelphia, PA

- Assisted in Community Psychology project located at People's Emergency Center, a shelter program for women and children. Renovated the library, developed a check-out system, and created a story-time for mothers and children.

CONFERENCE PRESENTATIONS:

Herrigel, M. L. & Galloway, A.L. (2010, June). *I Just Graduated! Now What? Issues Facing Early Career Psychologists.* Three Hour Workshop Presented at the Pennsylvania Psychological Association Annual Convention, Harrisburg, Pennsylvania.

Herrigel, M. L. & Galloway, A.L. (2009, November). *I Just Graduated! Now What? Issues Facing Early Career Psychologists. Three Hour* Workshop Presented at the Pennsylvania Psychological Association Fall Conference, Exton, Pennsylvania.

CURRICULUM VITAE
Troy L. Thompson II, M.D.

Telephone number (m): 610-804-5795
E-mail addresses: troylthompson@gmail.com

Private practice and Correspondence address: 109 Hickory Spring Rd.
Wilmington, DE 19807-2405

Birth: November 5, 1946, U.S.A.

Current positions

1976 - Private practice: psychiatry (adult, geriatric, couples, family therapy); psychoanalysis; consultation (clinical, forensic, educational, administrative)

1987 - Professor of Psychiatry and Human Behavior, (The Daniel Lieberman Professor (tenured) and Chair of the Department, 1987 – 97), Jefferson Medical College (JMC), Philadelphia, PA

Recent positions

1990-2005 Alpha Omega Alpha Honor Medical Society, Councillor (faculty advisor), JMC; National Board of Directors, 1993 – 2005

1997-2004 Psychiatry Director, University Health Services, JMC

2006-08 President, Executive Medical Staff, DPC

2004-11 Psychiatry Residency Program Teacher
Inpatient Unit Treatment Team Leader
Delaware Psychiatric Center (DPC), New Castle, DE

2011-12 State Medical Director, Psychiatry & Mental Health, MHM Services, contract with Delaware Department of Corrections

Specialty Certifications

1978 - General Psychiatry, American Board of Psychiatry and Neurology (ABPN)

1988 - Psychoanalysis, American Psychoanalytic Association

1991-2001 Added Qualification in Geriatric Psychiatry, ABPN

1997 - Administrative Psychiatry, American Psychiatric Association

Medical Licensure

1974-77 Georgia, Connecticut, California

1977-88 Colorado

1988 - Pennsylvania

2004 - Delaware

Education

1968 B.A., biology, Emory College, Atlanta, GA

1971-72 Behavioral Science Fellowship, Department of Psychiatry, Emory University School of Medicine, Atlanta, GA

1973 M.D., Emory

1973-76 Psychiatry Resident, Yale University School of Medicine, New Haven, CT
1974-76 Clinical Research and Teaching Program in Psychiatry, Yale
1983-88 Candidate, Denver Institute of Psychoanalysis, Denver, CO

Administrative Continuing Education

1988 Program for Clinical Service Chiefs, Harvard School of Public Health, Boston, MA (two week course)
1995 Executive Development Seminar for Associate Deans and Department Chairs, Association of American Medical Colleges (one week course)

Academic and Hospital Appointments

1973-76 Psychiatry House Staff: Yale-New Haven Hospital; Connecticut Mental Health Center, New Haven, CT; VA Medical Center, West Haven, CT
1976-77 Attending Physician: Yale-New Haven Hospital, Connecticut Mental Health Center, West Haven VA Medical Center
1976-77 Instructor in Psychiatry, Yale
1977-83 Assistant Professor of Psychiatry and Medicine, University of Colorado School of Medicine, Denver, CO
1977-88 Attending Physician, University Hospital, Colorado Psychiatric Hospital, Denver, CO
1978-81 Attending Physician, VA Medical Center, Denver, CO
1983-88 Associate Professor of Psychiatry and Medicine, Colorado
1988- Attending Physician, Thomas Jefferson University Hospital, Philadelphia, PA
2004- Medical Staff, Delaware Psychiatric Center, New Castle, DE

Past Positions

1975-76 Chief Resident in Psychiatry, Yale
1975-76 Assistant to Director of Graduate Education in Psychiatry, Yale
1976-77 Inpatient Psychiatry Ward Chief, Evaluation and Brief Hospitalization Unit, Connecticut Mental Health Center, Yale
1976-77 Consultation-Liaison Psychiatrist to Department of Medicine, West Haven VA Medical Center, Yale
1977-84 Co-Director of Residency Program in General Internal Medicine, Colorado
1977-87 Consultation-Liaison Psychiatrist to Division of Internal Medicine and University Medical Group Practice, Colorado
1978-80 Chief of Geriatrics, VA Medical Center, Denver, CO
1982-84 Director of Medical-Psychiatric (Med H) Outpatient Clinic, Colorado\
1984-86 Acting Director, Psychiatric Liaison Division, Colorado
1986-88 Director, Division of Consultation-Liaison Psychiatry, Colorado

Honors, Awards, Visiting Lectureships

1966 Alpha Epsilon Delta (premedical honorary)
1966 Sigma Delta Psi (national collegiate athletic honorary)
1967 Phi Beta Kappa
1967-68 Emory College Council, Student Government Class Representative
1978 Visiting Professor, Department of Medicine, University of Virginia School of Medicine
1981 Honorable Order of Kentucky Colonels by Governor John Y. Brown, Jr.

1986 International Who's Who in Medicine
1988 Visiting Professor, Cleveland Clinic
1988 David J. Fish Memorial Lecturer, Brown University
1989 V. Terrell Davis Lecturer, Medical Center of Delaware
1989 12th Annual John B. Atkinson Lecturer in Psychosomatics, Carrier Foundation, New Jersey
1990 Visiting Professor, University of Medicine and Dentistry of New Jersey
1990 Invited Participant and Winner, Raft Debate, Hobart Amory Hare Medical Honor Society, Jefferson Medical College
1991 Honorary Member, Hobart Amory Hare Medical Honor Society
1991 External reviewer of Department of Psychiatry for President, New England Medical Center Hospitals, and Dean, Tufts University School of Medicine
1991 The Christian R. and Mary F. Lindback Award for Distinguished Teaching in Clinical Sciences, presented by Jefferson Medical College Class of 1993
1992 American Psychiatric Association Third Annual Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Student Education
1992 Lifetime Achievement Award from Society for Liaison Psychiatry
1992 Visiting Professor, Mayo Clinic
1992 Distinguished Professor Award, Florida Hospital, Orlando, FL
1993 Faculty Member of the Year Award, presented by Jefferson Medical College students at their 59th Annual Banquet and Ball
1993 The Marvin Stern, M.D., Annual Lecture, Department of Psychiatry, New York University School of Medicine
1994 Listed among "The 327 Best Mental Health Experts" in America, Good Housekeeping, February, 1994
1994 Listed among "The Best Doctor's in "Psychiatry", Philadelphia Magazine, March, 1994
1995 Selected for Oil Portrait as "Most inspiring teacher," presented to Jefferson Medical College, by Class of 1995
1999 Advisory Committee, MacArthur Foundation Depression in Primary Care Project
2000 Alpha Omega Alpha Honor Medical Society Visiting Professor, University of Puerto Rico
2004 Outstanding Teacher Award, Psychiatry Residency Program, Delaware Psychiatric Center
2007 Inaugural Distinguished Life Fellow, Association for Academic Psychiatry

Editorial Activities: Journal Referee and Consultant

Acad Psychiatry
Am J Geriatric Psychiatry
Am J Med
Am J Psychiatry
Ann Intern Med
Am Psychiatric Press
Consultant: Consultations in Primary Care
Elsevier
Gen Hosp Psychiatry
Hosp Comm Psychiatry (Psychiatric Services)
Intl J Psychiatry Med

John Wiley
JAMA
J Am Psychoanalytic Assn
J Neuropsychiatry
J Psychiatric Educ
Mayo Clinic Proceedings
Medscape Mental Health
N Engl J Med
Psychosomatic Med
Psychosomatics
Science

Editorial Boards

1968-70 Editorial Board, Anlage, Emory University School of Medicine Quarterly
1969-70 Editor, Anlage
1981-85 Associate Editor, Association for Academic Psychiatry Newsletter
1982-84 Associate Editor, Medical Encounter, Newsletter of the Society for Research and Education in Primary Care Internal Medicine (SREPCIM)
1984-87 Medical Advisory Board, Psychiatry 85, 86, and 87
1985- 2004 Editorial Board, Psychosomatics
1986-91 Editorial Board, International Journal of Psychiatry in Medicine
1987-92 Editorial Board, Psychiatric Medicine
1988-89 Editorial Associate, Journal of American Psychoanalytic Association
1988-91 Editor, Psychiatry Audio Review, Merrell Dow USA, Parker Communications
1989-91 Editorial Advisory Board, Medical-Psychiatric Practice, American Psychiatric Press
1990-91 Head, Governance Board, Academic Psychiatry (as President, Association for Academic Psychiatry
1992-96 Editorial Board, Textbook of Consultation-Liaison Psychiatry, American Psychiatric Press
1994-96 Editorial Board, Medical-Psychiatric Practice, Volume 3, American Psychiatric Press
1995-96 Consultant and Editorial Review Panel, Time Life Medical Series, C. Everett Koop, M.D., Medical Director
1996-97 Advisor, Somatoform and factitious disorders section, Handbook of Psychiatric Measures and Outcomes, American Psychiatric Association
1997-98 Advisory reviewer, Disease Management in Managed Care Monograph American Psychiatric Association

Professional Organizations, Positions

Academy of Psychosomatic Medicine
1986- Fellow
1986-95 Executive Council
1986-91 Membership Committee
Chair, 1989-90
1987-89 Educational Directorate Committee

Chair, 1988-89
1987-89 Program Committee
Chair, 1988 Annual Meeting
1988-95 Executive Committee
Chair, 1991-92
1989-90 Audit Committee
Chair, 1989-90
1989-90 Long Range Planning Committee
1989-90 Constitution and Bylaws Committee and ex-officio member, 1992-93
1989-90 Vice President
1990-92 Finance Committee
1990-91 President-elect
1991-93 Fellowship and Awards Committee
1991-92 President
1991-93 Nominating Committee
Chair, 1991-92
1992-95 Governor
1993-95 Presidential Task Force to Develop Wm. L. Webb, Jr., M.D., Fellowship

Accreditation Council for Graduate Medical Education
1984-84 Specialist site visitor for Residency Review Committee for Psychiatry

Alpha Omega Alpha Honor Medical Society
1990-2005 Councillor (Faculty Advisor) of Jefferson Chapter, PA Alpha
National organization:
1993-96 Councillor Director, Board of Directors
1993-96 Honorary Membership Committee; Chair, 1995-96
1993-98 New Chapters Committee (changed to New Chapters and
AOA Associations Committee, 1998); Chair, 1993-98
1994-99 Program and Planning Committee
1995-2000 Chapter of the Year Award Committee (changed to Chapter Development
Awards Committee, 1998)
1993-2005 Board of Directors
1997-2000 Bylaws Committee
1998-2003 Regional Councillor (11 medical schools in PA, MD, and DC)

American Association of Chairman of Departments of Psychiatry, 1988-97
1994-95 Task Force on Effects of Managed Care on Education
1995-96 Public Sector Committee
1995-97 Representative to Council of Academic Societies meeting,
Association of American Medical Colleges

American Board of Psychiatry and Neurology
1981-2000 Examiner, oral certification examinations
1990-2000 Senior Examiner
1992-93 Part I Written Examination Committee

American College of Psychiatrists, 1988-2000

1988-90 Subcommittee on Contributions
1991-94 Committee on Long Range Planning and Policy
1993-2000 Fellow
1995-96 Chair, Committee on Education
1995-99 Liaison to American College of Physicians
1997-00 Committee on the Education Award
2000-03 Committee on Membership Development

American College of Psychoanalysts, 1993-2004

1995-98 Recruitment to Membership Committee
Chair, 1997-98
1997-99 Board of Regents
1999-2003 Treasurer and Trustee, Laughlin Fund
2003-04 President-elect

American Medical Association, 1983-98

1984-88 Advisory Panel on Organ Transplantation, Council on Scientific Affairs
1985-90 Diagnostic and Therapeutic Technology Assessment (DATTA) Reference Panel

American Psychiatric Association

1983-87 Task Force on Cost Effectiveness in Consultation-Liaison Psychiatry
1984-88 APA representative to AMA Advisory Panel on Organ Transplantation (See AMA)
1985-89 Psychiatric Education Consultation Service
1985-89 Speakers' Bureau, Hospital and Community psychiatry Service
1985-89 Committee on Consultation-Liaison Psychiatry and primary Care Education
Chair, 1987-89
1988-2003 Fellow
1989-90 Advisory Committee, Program on Educating Family Physicians About Depression
1989-90 Advisory Committee, Medical Workshop program. Panic: Recognition, Diagnosis and Referral
1989-92 Member, Council on Medical Education and Career Development
1989-93 Representative to National Board of Medical Examiners Annual Meeting
1989-91 Consultant to Work Group on Psychological Factors Affecting Physical Conditions (PFAPC), Diagnostic and Statistical Manual, 4th Edition, (DSM_IV)
1993-94 Task Force on Local Arrangements, 1994 Philadelphia APA Annual Meeting
1993-2000 Vestermark Award Board, Council on Medical Education and Career Development
Chair, 1999-2000
1994 Marshall Convocation of Fellows, 1994 Philadelphia APA Annual Meeting
1994-2000 Institute on Psychiatric Services Annual Meeting Scientific Program Committee
Vice-Chair, 1997-98
Chair, 1998-99
Consultant, 1999-2000
1995-2000 Committee on Exhibits and Industry, Council on Internal Organization
1995-2000 APA Representative, Council of Academic Societies, Association of American Medical Colleges

1998-99 Chair, Presidential Initiative Advisory Committee on Psychosocial Rehabilitation of the Severely and Persistently Mentally Ill
1998-2000 Committee on Grants and Awards
2003 - Distinguished Life Fellow

American Psychoanalytic Association, 1988-98
1972-74 Commission on Psychoanalytic Education and Research, Committee on the Tripartite System of Psychoanalytic Education
1984-88 Affiliate Member
1986-90 Joint Committee on Associate and Affiliate membership
1988 Associate Member
1988-94 Committee on University and Medical Education

Association for Academic Psychiatry
1982-85 Liaison to SREPCIM
1983 Nominating Committee
1983-84 Consultation-Liaison (C-L) Task Force: C-L Objectives and Curriculum
1985-89 National Coordinator of Regional Network
1985-91 Executive Council
1986-91 Finance Committee
1988-90 Education Award Selection Committee
Chair, 1989-90
1989-90 President-elect
1990-91 President
1993-95 Long-Range Strategic Planning Committee
2007- Inaugural Distinguished Life Fellow

Association of American Medical Colleges
1995-2000 Council of Academic Societies, representative from American Psychiatric Association
1997-98 AAMC representative to David E. Rogers Award Selection Committee, Award jointly sponsored by Robert Wood Johnson Foundation

College of Physicians of Philadelphia
1990-97 Fellow

Colorado Psychiatric Society, 1979-88
1979-80 Continuing Education Committee
1985-88 Public Information and Education Committee
Chair, 1986-88

Consortium on Consultation-Liaison Psychiatry, 1988-90
1988-90 Steering Committee, Representative of American Psychiatric Association

Delaware Psychiatric Society, 2004 -

Denver Medical Society
1979-80 Special Committee on Aging

Denver Psychoanalytic Institute and Society
1983-85 Curriculum Committee
1983-88 Affiliate Member
1985-86 Clinic Committee
1988-90 Corresponding Member

International Psychoanalytic Association, 1988-98

Mensa, Life member, 1994-

National Alliance for the Mentally Ill (NAMI), 1990-

Pennsylvania Medical Society, 1989-98
1991-92 Council on Education and Science

Pennsylvania Psychiatric Society and Philadelphia Psychiatric Society, 1988-2004

Phi Beta Kappa Society, 1967 -

Philadelphia Association for Psychoanalysis
1988-89 Associate member
1989-93 Member

Philadelphia County Medical Society, 1989-98
1991-92 Committee on Medical Education

Philadelphia Psychiatric Society, 1988-

Philadelphia Psychoanalytic Institute and Society
1988-89 Associate Member
1989-2004 Member
1990-2004 Faculty
1990-91 Program Committee
1990-92 Soviet Curriculum Committee
1991-93 Education Committee
1991-94 Board of Advisors
1992-2004 Philadelphia Psychotherapy Training Program; Faculty
1994-96 By-laws Committee

Society for Research and Education in Primary Care Internal Medicine (SREPCIM) -- renamed Society for General Internal Medicine (SGIM), 1980-84
1981-84 National task forces on:
Teaching interviewing: approaches and strategies
Committee to integrate psychosocial skills in medical interview
Committee to develop a model curriculum for medical interviewing

Teaching

Yale

1973-77 Discussion group leader, first year medical student psychiatry course
1975-76 Co-leader, discussion group for psychiatry interns
1976-77 Supervision of medical students, residents, and chief residents; Evaluation Unit, Connecticut Mental Health Center

Colorado

1977-78 Teacher, Interviewing and Clinical Problem Solving, Introduction to Clinical Medicine, first year medical students course
1977-81 Teacher, psychiatric interviewing elective for medical students
1977-87 Lecturer and discussion group leader, second year medical student psychiatry course
1977-82 Lecturer and co-coordinator of psychiatry and primary care psychiatry differential diagnosis course for third and fourth year medical students on psychiatry clerkship
1978-86 Co-director (with RL Byyny and LE Feinberg), Division of Internal Medicine Annual CME course, New Approaches to Clinic Problems in Internal Medicine
1978-87 Supervision of psychiatry residents in individual psychotherapy, medical-psychiatric clinic, and consultation-liaison psychiatry
1980-82 Organizer and supervisor of consultation-liaison elective for senior psychiatry residents to University Medical Group practice
1982-84 Course Director, Interviewing and Clinical Problem Solving, Introduction to Clinical medicine first year medical student course
1983-86 Co-teacher, consultation-liaison seminar for senior psychiatry residents

Jefferson

1988-98 Discussion group leader, freshman medical student small group program (Doctor in Health and Illness course)
1988-98 Teacher, psychiatry clerkship didactic program
1988 - Psychiatry resident supervisor
1989-98 Medical student advisor program
1990 - Teacher, History of psychiatry and other didactic courses for residents
1991-94 Co-director, Life Cycle Course, Freshmen medical Student Human Behavior and Introduction to Clinical Medicine Course
1995-97 Teacher, Psychiatry resident journal club (Chair's Hour)
1999 Teacher, Board preparation for residents
1999-2000 Faculty advisor, Medical students supporting students, peer support/referral network

Philadelphia Psychoanalytic Institute

1990-2000 Co-teacher, Continuous Case Seminar
1992-93 Co-teacher, course on pathological formations

Delaware Psychiatric Center

2004 - Psychiatry resident supervisor
2005 - Teacher, psychiatry resident didactic courses

Other Departmental and University Positions

Yale

1973-74 First Year Psychiatry Residency Coordinating Committee
1973-75 Psychiatry Residents' Association Representative to Departmental Advisory Council
1975-76 Study Group of Undergraduate and Graduate Psychiatric Education
1975-76 Psychiatry Resident Review Committee
1975-76 Psychiatry Resident Selection Committee

Colorado

1978-81 VA Long-Term Care Committee
1980-81 VA Geriatrics Steering Committee
1980-81 Quality Advisory Panel, Nursing Home Study Center for Public Health Services Research; led to publication of: Woodson AS, Foley SM, Daniels PJ, Landes DP, Kurowski BT. Long-Term Care: Guidelines for Quality. Denver: Center for H Health Services Research, University of Colorado Health Sciences Center, 1981
1982-84 School of Medicine Gerontology Committee
1982-84 School of Medicine Substance Abuse Study Committee
1982-86 Faculty Senator from Psychiatry
1983-88 Consultant, Colorado State Hospital, Pueblo, CO
1983-88 Medical School Student Advisor
1983-84 Faculty Advisor, Psychiatry Intern Program
1984 Chair, School of Medicine Gerontology Long Range Planning Committee
1984-88 Executive Committee, Department of Psychiatry
1984-87 Psychiatry Residency Education Committee
Chair, C-L and Geriatrics Subcommittee for Curriculum Transition, 1885-86
Resident Appointments and Awards Subcommittee, 1986-88
1986-86 Physicians' Assistance Committee, Department of Medicine
1986-88 Expert panel member, Enhancing the Geriatric Skills of Primary Care Professionals Project: Assessment of the Confused Elderly patient. Healthbridge, Boulder, CO
1986-88 Physicians' Rehabilitation Program, University Hospital Committee

Jefferson

1988-97 Executive Council, Jefferson Medical College
1988-97 Executive Committee of the Medical Staff, Jefferson Hospital
1988-90 Dean's Committee and Consultant, Coatesville VAMC
1888-90 Members of Institute of Human Behavior, Division of Alcoholism, Drug Abuse, and Mental Health, Department of Health and Social Services, State of Delaware and Jefferson Medical College
Chair, Advisory Committee, 1988-90
1988-90 Committee on Research
1988-91 Medical College Medical Practice Plan Steering Committee
1988-97 Committee on Affiliated Hospitals
1988-91 Ethics Committee, Jefferson Hospital
1989-97 Strecker Award Selection Committee, Institute of Pennsylvania Hospital, from 1994-96 co-sponsored by Jefferson Department of Psychiatry

1990-92 Member, Search Committee for Chair of Internal Medicine
1990- Alpha Omega Alpha Honor Medical Society, Jefferson Medical College Chapter
1990-91 Interim Chair Medical Staff Affairs Committee, Jefferson Hospital
1991 Search Committee, Chair of Medicine
1993-96 Member, Committee on Committees, Jefferson Medical College
Chair, 1995-96
1995-97 Board of Directors, Practice Plan Foundation
Managed Care/Quality Assurance Committee, 1995-97
1996 Search Committee, Chair of Medicine
Charm Medical Records, Committee Community Activities

Delaware Psychiatric Center
2006-08 President, Executive Medical Staff
2008 - Chair, Medical Records Committee

Community Activities
Leadership, Inc., Executive Program, Philadelphia, 1988-89
Cosmos Club, Washington, DC, 1989-93
Union League, Philadelphia, 1989 - 2000
Union League of Philadelphia Yacht Club, 1991- 2000
Emory Club of Philadelphia, 1989-2000
Yale Club of Philadelphia, 1990-2000
Youth Soccer League Assistant Coach, 1994-97
Boy Scouts: Assistant Scoutmaster, 1998-99
Troup Committee, 1998-99
Eagle Candidate Advisor, 1998-99

Research Grants

Co-investigator (wht RL Byyny, M.D., Colorado), Fluoxetine Obestity Study. Lilly Research Laboratory, $100,000; 1985-86.

Principal investigator. Hydergine-LC in Outpatients with Primary Degenerative Dementia Study. Sandoz Research Institute, $210,000; 1986-87.

Principal investigator. Fluvoxamine in the treatment of depression: a multicenter double-blind placebo-controlled comparison with desipramine in outpatients. Kali-Duphar Laboratories, $117,700; 1987-88.

Co-investigator (with George Spaeth, M.D., Wills Eye Hospital). Dysphoria in glaucoma trabeculectomy patients. American Health Assistance Foundation/National Glaucoma Research, $24,820; 1994-96.

Co-principal investigator (with David Brody, M.D.). Improving primary care physicians' care of patients with depressive symptoms. National Institutes of Mental Health, $739,000; 1993-98.

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Thompson TL II, Byyny RL, eds: The Education of the General Internist. Fulton: Ovid Bell Pres, 1982 (republished as Primary and Team Health Care Education. New York: Praeger, 1983).

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Hales RE, Thompson TL II, section eds: Consultation-Liaison Psychiatry. In: Tasman A, Goldfinger SM, Kaufmann CA, eds. Review of Psychiatry. Washington, DC: American Psychiatric Press, 1990.

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Papers

Thompson TL II, ed: Anlage. Atlanta: Emory University School of Medicine Quarterly 2: November, 1969.

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Stoudemire A, Thompson TL II: Recognizing and treating dementia. Geriatrics 136: 112-120, 1981. (reprinted in: Laboratory Anphar, Rolland, Paris, 1982.)

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Stoudemire A, Thompson TL II: The borderline personality in the medical setting. Ann Intern Med 96: 76-79, 1982. (abstracted in Psychosomatics 23: 447, 1982.)

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Stoudemire A, Thompson TL II, Mitchell W, Grant RL: Family physicians' perceptions of psychosocial disorders: Survey report and educational implications. Int J Psychiatry Med 12: 281-287, 1982-83.

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Mitchell WD, Thompson TL II: Selection biases versus training in the psychosocial aspects of primary care. J Med Educ 58: 487-489, 1983.

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Stoudemire A, Thompson TL II: Medication noncompliance: Systematic approaches to evaluation and intervention. Gen Hosp Psychiatry 5: 233-239, 1983.

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Moran MG, Thompson TL II, Nies AS: Sleep disorders in the elderly. Am J Psychiatry 145: 1369-1378, 1988.

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Thompson TL II, Filley CM, Mitchell WD, Culig KM, LoVerde M, Byyny RL: Lack of efficacy of Hydergine in patients with Alzheimer's Disease. N Engl J Med 323: 445-448, 1990.

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Mann J, Christ J, Dewald PA, Karush A, Thompson TL II, Tyler RW: The theoretical phase. In: Fleming J, ed. The tripartite system of psychoanalytic education. New York: Conference on Psychoanalytic Education and Research, American Psychoanalytic Association, 1974: 21-38.

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Moderator, Journal Club: Psychiatry (audiotape), vol. 3, no. 1. R. Michels, ed. Merrell Dow/Omega Communications, Cincinnati, OH, 1986.

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Moderator (with martin MJ and Schwab JJ, discussants), Interface of physical and mental health in later life (audiotape). Vol. 11, no. 2, ACP Psychiatric Update, American College of Psychiatry, Medical Information Systems, Port Washington, NY, 1991.

Speaker (with Stoudemire A and Wise MG, moderator), Consultation-liaison psychiatry (audiotape). Vol. 12, No. 8, ACP Psychiatric Update, American College of Psychiatrists, Medical Information Systems, Port Washington, NY, 1992.

Speaker, Managing psychiatric disorders in primary care. (videotape) Teleconference Educational Network, Annenberg Center for Health Sciences at Eisenhower, Rancho Mirage, CA, 1997-98.

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National, International Academic Presentations

The internship experience: prospects and problems (with LS Zegans, WH Sledge). American Psychiatric Association 1977 Annual Meeting, Toronto, Canada.

Medical Grand Rounds, University of Virginia School of Medicine, Charlottesville, VA, 1978.

Teaching psychiatry to primary care physicians, Association for Academic Psychiatry 1980 Annual Meeting, San Antonio, TX.

Course director, Psychiatric liaison to surgical services, American Psychiatric Association 1980 Annual Meeting, San Francisco, CA

Featured speaker, Symposium on the geriatric patients, University of Missouri School of Medicine at Kansas City, 1980.

Course faculty, Psychiatric problems in CCUs, American psychiatric Association 1981 Annual Meeting, New Orleans, LA.

Underrecognition of patients' psychosocial problems by internists (wht A Stoudemire, WD Mitchell). American Psychosomatic Society 1982 Annual Meeting, Denver, CO.

Psychotropic drugs in the elderly. Geriatric Medicine Update. University of New Mexico School of Medicine, Department of Medicine, Albuquerque, NM, 1982.

Pharmacologic treatment of cognitive impairment. Clinical Issues in Geriatric Research, Education, and Clinical Center at VAMC, UCLA. Sepulveda, CA, 1982.

Geriatric psychopharmacology. Seattle Chapter. Washington State Psychiatric Society. Seattle, WA, 1982.

Diagnosis and treatment of cognitive impairment. Western Gerontological Society 1982 Annual Meeting, San Diego, CA.

Teaching psychiatry to internists. Association for Academic Psychiatry 1982 Annual Meeting, Bethesda, MD.

Senile dementia or depression. (with E Busse, S Schneck, F McGlone), American College of Physicians Meeting, Colorado Springs, CO, 1982.

Underrecognition of distress level psychosocial problems by internists. (with A Stoudemire, WD Mitchell, RL Grant), American psychiatric Association 1982 Annual Meeting, Toronto, Canada.

Psychiatry Grand Rounds, University of Hawaii School of Medicine, Honolulu, 1982.

Psychiatry Grand Rounds, University of Washington School of Medicine, Seattle, WA, 1982.

Family physicians' perceptions of psychosocial problems. (with A Stoudemire, WD Mitchell, RL Grant), American psychiatric Association 1983 Annual Meeting, New York City.

Effects of a psychiatric liaison program on internists' ability to assess psychosocial problems (with A Stoudemire, WD Mitchell), American Psychosomatic Society 1983 Annual Meeting, New York City.

Psychiatric drugs in the elderly. New Mexico Family Physicians 1983 Annual Meeting, Ruidoso, NM.

Grand Rounds, Missouri Institute of Psychiatry, University of Missouri School of Medicine, 1983.

Psychiatry Grand Rounds, St. Louis University, 1983.

Medical Grand Rounds, University of North Carolina School of Medicine, Chapel Hill, NC, 1983.

The psychiatric education of the general internist, Association for Academic Psychiatry symposium, Association of American Medical Colleges 1983 annual Meeting, Washington, DC.

Course director, Psychotropic drug use in the elderly, American Psychiatric Association 1984 Annual Meeting, Lost Angeles, CA. (updated at 1985 Annual Meeting, Dallas, TX, and 1986 Annual Meeting, Washington, DC)

Scientific exhibit, Diagnosis and management of the older patient with mental decline, American Psychiatric Association 1984 Annual Meeting, Los Angeles, CA.

Discussant, paper session, New initiatives in consultation-liaison psychiatry. American Psychiatric Association 1984 Annual Meeting, Los Angeles, CA.

Panel Moderator, cost and cost-effectiveness in the DGR era: What can be done? American Psychiatric Association Institute of Hospital and Community Psychiatry 1984 Annual Meeting, Denver, CO.

Local moderator, 50 city videoconference, Management of anxiety in the primary care setting: Medical challenge or social dilemma. Professional Postgraduate Services, Upjohn Company and Hershey Medical Center, Pennsylvania State University, 1985.

Regional moderator, Clinical perspectives on anxiety, agitation, and insomnia symposium. Wyeth/Biomedical Information Corp., New York, 1985.

Discussion group presenter, Analytically oriented treatment for the elderly. American Psychoanalytic Association 1985 Annual Meeting, Denver, CO.

Underconsultation for alcoholics on medical wards. (with WD Mitchell, SR Craig), American Psychiatric Association 1986 Annual Meeting, Washington, DC.

New Directions in Biological Psychiatry Symposium, San diego, CA, 1986.

Primary care physicians' perceptions of psychiatric problems in the elderly as compared to younger adult patients (with WD Mitchell, RM House). Academy of Psychosomatic Medicine 1986 Annual Meeting, New York City.

Distinguished Psychiatrist Series, "Clinical consultation with Troy L. Thompson II, M.D., on dementia," American Psychiatric Association 1987 Annual Meeting, Chicago, IL

Psychiatry's role in primary care graduate medical education (with RJ Goldberg, TN Wise), American Psychiatric Association 1987 Annual Meeting, Chicago, IL.

Discussant, paper session, Issues in consultation-liaison psychiatry. American Psychiatric Association 1987 Annual Meeting, Chicago, IL.

Co-chair, Psychiatric education for medical practice symposium, sponsored by Association for Academic Psychiatry. American Psychiatric Association 1987 Annual Meeting, Chicago, IL.

Enhancing compliance in chronic medical illnesses. Behavioral Medicine and Disability Prevention component workshop. (APA Committee on Rehabilitation, Consultation-Liaison Psychiatry and Primary Care Education and Task Force on SSI, SSDI). American Psychiatric Association 1988 Annual Meeting, Montreal, Canada.

What makes psychiatry different? APA Committee on Interprofessional Affairs component workshop. American psychiatric Association 1988 Annual Meeting, Montreal, Canada.

Chairperson, The Mind/Body Interface paper session. American Psychiatric Association 1988 Annual Meeting, Montreal, Canada.

Moderator, Medical Colleagues Interactive Workshop. American Psychiatric Association, Minneapolis, MN, 1988.

Current Issues in Geriatric Psychiatry conference. Department of Psychiatry. State University of New York, Buffalo, NY, 1988, 1989, 1990, 1992 and 1996.

Psychiatry Grand Rounds, Medical College of Pennsylvania, 1988.

Psychiatry Grand Rounds, Institute of Pennsylvania Hospital, 1988.

Psychiatry Grand Rounds, Hahnemann Medical School, 1988.

Interviewing and treating depressed patients. American Association of Family Physicians 1988 Annual Meeting, New Orleans, and 1989 Annual Meeting, Los Angeles.

Psychiatry Grand Rounds, Temple University School of Medicine, 1989.

Leadership in an Academic Department (with L. Rittlemeyer, R Whitman). Association for Academic Psychiatry 1989 annual Meeting, Atlanta, GA.

Workshop for new academicians: What do chairmen want? (with F Guggenheim, J Houpt, and R Whitman). Association for Academic Psychiatry 1989 Annual Meeting, Atlanta, GA

Discussant, paper session, Psychiatric aspects of medical illness. American Psychiatric Association 1989 Annual Meeting, San Francisco, CA.

Psychiatry Grand Rounds, New York Medical College, 1989.

Psychiatry Grand Rounds, University of Pennsylvania, 1989.

Psychiatry Grand Rounds, Pennsylvania Hospital, 1989.

Treating depressed medically ill and elderly patients. American Psychiatric Association Institute of Hospital and Community Psychiatry 1989 Annual Meeting, Philadelphia, PA.

Critical administrative incidents in departments of psychiatry (with L. Rittlemeyer, R Whitman, F Guggenheim, J Houpt). Association for Academic Psychiatry 1990 Annual Meeting, Seattle, WA.

Chairperson, Consultation/liaison psychiatry section, Annual Review of Psychiatry. American Psychiatric Association 1990 Annual Meeting, New York, NY.

Psychiatric consultation to organ transplant services (with RE House and PT Trzepacz). Annual Review of Psychiatry, American Psychiatric Association 1990 Annual Meeting, New York, NY.

Getting started in academic psychiatry workshop, American Psychiatric Association 1990 Annual Meeting, New York, NY.

Chairperson, paper session, Psychosocial characteristics of organ transplantation. American Psychiatric Association 1990 annual Meeting, New York, NY.

Joint meeting of European Psychoanalytic Federation and American Psychoanalytic Association, Cork, Ireland, 1990.

Psychiatric Division, Puerto Rico Medical Association 1990 Annual Meeting, San Juan, PR.

Moderator, Innovations in Consultation-liaison Psychiatry paper session, Academy of Psychosomatic Medicine 1990 Annual Meeting, Phoenix, AZ.

Recent advances in the uses of clonazepam. American Psychiatric Association Institute of Hospital and Comminity Psychiatry 1990 Annual Meeting, Denver, CO.

The DART Program: Depression: Awareness, Recognition and Treatment. American Psychiatric Association Institute of Hospital and Community Psychiatry 1990 Annual Meeting, Denver, CO.

Psychiatric drug use in the medically ill. American Psychiatric Association Institute of Hospital and Community Psychiatry 1990 Annual Meeting, Denver, CO.

Faculty expert, APA Committee of Residents and Fellows session, American Psychiatric Association 1991 Annual Meeting, New Orleans, LA.

Psychiatry Grand Rounds, Pacific Presbyterian Medical Center, San Francisco, CA, 1991.

The Promotions Committee Workshop, Association for Academic Psychiatry 1991 Annual Meeting, Tampa, FL.

Mentoring Workshop, Association for Academic Psychiatry 1991 Annual Meeting, Tampa, FL.

Florida Hospital 5th Annual Symposium on Psychiatric Medicine, Orlando, FL, 1991, and 6th Annual Symposium, 1992.

1990 Roving Symposium, Academy of Medicine of New Jersey.

Royal Australian and New Zealand College of Psychiatrists meeting, Queensland, and Department of Psychiatry, Royal Brisbane Hospital, University of Queensland, Australia, 1991.

Recognition and treatment of depression. American psychiatric Association Institute of Hospital and Community Psychiatry 1991 Annual Meeting, Los Angeles, CA.

Moderator, Symposium on Clinical Research in Consultation Psychiatry. Academy of Psychosomatic Medicine 1991 Annual Meeting, Atlanta, GA.

Writing a consultation-liaison grant: The mechanics and a mock review. Academy of Psychosomatic Medicine 1991 Annual Meeting, Atlanta, GA.

Official representative of Academy of Psychosomatic Medicine, Seventh Annual Rosalynn Carter Symposium on Mental Health Policy. Physical and mental health: Closing the Gaps, Atlanta, GA, 1991.

Continuous clinical case conference: Management of a geriatric patient with complications, including psychotherapy, pharmacotherapy, and medical management. American Psychiatric Association 1992 Annual Meeting, Washington, DC.

Creative practical solutions for balancing career and family. Association for Academic Psychiatry 1992 Annual Meeting. San Antonio, TX.

Psychiatry Grand Rounds, Medical University of South Carolina, 1992.

Panel Discussant. Problems and prospects for subspecialization in psychiatry (with MJ Martin, M Sabshin, SC Scheiber, and A Stoudemire). Academy of Psychosomatic Medicine 1992 Annual Meeting, San Diego, CA.

Discussant, Getting started in C-L psychiatry paper session, Academy of Psychosomatic Medicine 1992 Annual Meeting, San Diego, CA.

Psychiatry Grand Rounds, Mayo Clinic, Rochester, MN, 1992.

Psychiatry Grand Rounds, Baylor College of Medicine, Houston, TX, 1992.

Filling the empty psychiatry department Chair, Association for Academic Psychiatry 1993 Annual Meeting, Charleston, SC.

Invited discussant of Keynote Address. Association for Academic Psychiatry 1993 Annual Meeting, Charleston, SC.

Keynote speaker, Ohio Psychiatric Association 1993 Annual Meeting.

Psychiatry Grand Rounds, St. Vincent's Hospital, New York, NY, 1993.

Psychiatry Grand Rounds, SUNY, Syracuse, NY, 1993.

Why medical students select a psychiatry career paper (with JM Zaimes). American Psychiatric Association 1993 Annual Meeting, San Francisco, CA.

Development of a national network using selected mentors and supervisors. Workshop on Climbing the academic ladder: career development for the junior consultation-liaison psychiatrist. Academy of Psychosomatic medicine 1993 Annual Meeting, New Orleans, LA.

Common themes in psychosocial interventions in the medical setting. Academy of Psychosomatic Medicine 1993 Annual Meeting, New Orleans, LA.

Subspecialization status and directions. Symposium on Major issues confronting APM: Opportunities and obstacles for the future. Academy of Psychosomatic Medicine 1993 Annual Meeting, New Orleans, LA.

Psychiatry Grand Rounds, Institute of Pennsylvania Hospital, Philadelphia, 1994.

Psychiatry Grand Rounds, University of Virginia, 1994. Discussant, Psychoanalytic variables associated with the outcome of psychoanalysis of homosexual patients paper by Houston MacIntosh, M.D. American Psychoanalytic Association 1994 Annual Spring Meeting, Philadelphia, PA.

Psychotherapy of the medically-surgically ill. Symposium on The role of psychotherapy in psychiatric practice. American Psychiatric Association 1994 Annual Meeting, Philadelphia, PA.

Consultation/liaison teaching models for primary care. Symposium on Integration of training in psychiatry and primary care: Models for the future. American Psychiatric Association 1994 Annual Meeting, Philadelphia, PA.

Interfaces of psychopharmacology and psychodynamic psychotherapy, Pittsburgh Psychiatry Society and Pittsburgh Psychoanalytic Society 1994 Combined Annual Meeting, Pittsburgh, PA

The Marvin Stern Annual lecture: The shifting boundaries of the mind-body interfaces. New York University Dept. of Psychiatry, 1994.

Psychiatry Grand Rounds, North Shore University Hospital, Cornell Medical center, NY, 1995.

Symposium organizer and presenter. Administrative and managed care challenges and opportunities for C-L: Department Chairs' views. Academy of Psychosomatic Medicine 1995 Annual Meeting, Palm Springs, CA.

Discussant, Scientific session, Freud and Feminine Subjectivity, Leon Hoffman, M.D., Philadelphia, Psychoanalytic Society, 1996.

Psychiatry and Primary care: Service Education, and Research Implications. Psychiatry in the 21st Century Conference, St. Mary's Hospital, Department of psychiatry, Rochester, NY, 1996.

Psychiatry Grand Rounds, Mt. Sinai School of Medicine, New York, NY, 1996.

Psychiatry Grand Rounds, Medical College of Wisconsin, Milwaukee, WI, 1996.

Symposium chair and presenter. Management of sexual dysfunction in depression,
-Institute on Psychiatric Services 1996 Annual Meeting, Chicago, IL.
-American Psychiatric Association 1997 Annual Meeting, San Diego, Ca.
-Institute on Psychiatric Services 1997 Annual Meeting, Washington, DC.
-American Psychiatric Association 1998 Annual Meeting, Toronto, Canada

Psychiatry Grand Rounds, Baylor College of Medicine, 1997.

Psychiatry Grand Rounds, University of Kansas School of Medicine, Wichita, KS, 1997.

Chair and moderator, Neurobehavioral Disease Management Institute, Philadelphia, PA, 1997.

Managed care paradigm shifts and C-L opportunities. (with DG Folks, JJ Silverman). American Psychiatric Association 1997 Annual Meeting, San Diego, CA.

Psychiatric disorders in primary care. Primary care and psychiatry symposium. American Psychiatric Association 1997 Annual Meeting, San Diego, CA.

Successful management of a consultation-liaison psychiatry service workshop. American Psychiatric Association 1997 Annual Meeting, San Diego, CA.

Will future psychiatrists by psychotherapists? Pros and cons. American Psychiatric Association Institute on Psychiatric Services 1997 Annual Meeting, Washington, DC.

Psychiatry Grand Rounds, University of Virginia, 1997.

Psychiatry Grand Rounds, Bowman Gray, 1997.

Managing Psychiatric Disorders in Primary Care, Annenberg Center for Health Sciences at Eisenhower, National Teleconference Educational Network, October-March, 1998.

Psychiatry Grand Rounds, Johns Hopkins, 1998.

OB/GYN Grand Rounds, Johns Hopkins, 1998.

Psychiatry Grand Rounds, Brown University, 1998.

Psychiatry Grand Rounds, University of Buffalo, 1998.

Psychiatry Grand Rounds, Hahnemann/Allegheny, 1998.

Psychiatry Grand Rounds, Medical College of Wisconsin, 1998.

Psychiatry Grand Rounds, University of Nebraska, 1999.

Psychiatry Grand Rounds, St. Lukes Medical Center, New York City, 1999.

Psychiatry Grand Rounds, Beth Israel Hospital, New York City, 1999.

Psychiatry Grand Rounds, University of Oregon Health Sciences Center, 1999

Psychiatry Grand Rounds, Detroit Hospital/Wayne State University, 1999.

Psychiatry Grand Rounds, University of Medicine and Dentistry of New Jersey, 1999.

Speaker, Symposium on Women's Health, Georgetown University Medical Center, 1999

Psychiatry Grand Rounds, University of West Virginia, 2000.

Chair, Psychiatric issues in medically ill patients. American Psychiatric Association 200 Annual Meeting, Chicago, IL.

Symposium organizer and presenter. Psychological rehabilitation advances for the SPMI. American Psychiatric Association 2000 Annual Meeting, Chicago, IL.

Invited presenter. Early career psychiatrists workshop. ABPN Examiners and ABPN Examinees. American Psychiatric Association 2000 Annual Meeting, Chicago, IL.

Symposium organizer and presenter, APA Psychosocial Rehabilitation Committee Report. American Psychiatric Association Institute on Psychiatric Services 2000 Annual Meeting, Philadelphia, PA.

Invited lecturer. Evaluation of sexual dysfunction by psychiatrists. American Psychiatric Association Institute on Psychiatric Services 2000 Annual Meeting, Philadelphia, PA.

Media

1977- Interviewed on over 20 TV and radio (including National Public Radio, Larry King) programs on topics including aging, geriatric psychiatry, Alzheimer's Disease, depression, seasonal affective disorders, sleep disorders and phobias.

Rev. 10/2009

ROBERT MARTIN CCS Chief Information Officer

SUMMARY STATEMENT

Over 31 years of Information Technology experience, including 18 years leadership experience within the healthcare industry. Particular expertise in operations, systems integration, software development, and networking.

EDUCATION

Bachelor of Science, Computer Science, Michigan State University, 1983

PROFESSIONAL EXPERIENCE

Chief Information Officer – Correct Care Solutions; Nashville, TN
As CIO responsible for all technology systems throughout the company, including software development, data center operations, technology implementations, telecommunications and networking. Implement infrastructure improvements resulting in increased system availability, increased user productivity, and below industry average technology costs. Responsible for the development of ERMA, CCS's proprietary electronic records management application suite of components and tools. Has led the company in implementing HIPAA and Department of Labor compliance programs. *2003-Present*

Director of Information Technology – Health Cost Solutions; Hendersonville, TN
Responsible for all aspects of information technology including claims processing systems, Taft Hartley systems, X12 HIPAA transaction processing, software development and infrastructure. Implemented strategies to shorten claims processing cycle, reduce costs and increase accuracy. *1999-2007*

Vice President, Information Technology ─ National Business Products; Nashville, TN
Responsible for creating and managing technology products. Responsible for creating a "variable imaging" department which collected medical billing information from several hundred providers nationwide, then produced and mailed over 2 million patient statements per month. Achievement led National Business Products to be named one of the fastest growing companies in Tennessee three years in a row as an industry pioneer in print/mail technology. *1996-1999*

Director of Healthcare Information Systems – First Data Corporation/Nationwide Credit; Nashville, TN
Responsible for information technology for the Healthcare Division of the nation's largest collection agency. Twice named to the First Data's President Circle for achievements of driving down technology costs while increasing use, productivity, and satisfaction. Worked on the acquisition and integration teams leading the technology integration during three separate mergers. *1992-1996*

Director of Operations – Nasco Data Systems; Nashville, TN
Responsible for Operations and Information Technology for large IBM value added reseller. Led the company's development of a nationwide services and systems integration services resulting in 300% growth over three years. *1988-1992*

April 2012

Safety News Flash

INSIDE THIS ISSUE:

Personal Protective Equipment

Dress Code Change

How to Comply

Mandatory Compliance Date

Recognizing Hazards

Possible Hazards

Controlling Hazards

Slip Resistant Shoes

In 2009, the U.S. Bureau of Labor Statistics collected data that indicated hospital settings were among the highest at risk for slip, trip, and fall incidents. That means we at Correct Care Solutions must therefore protect ourselves using personal protective equipment (PPE) and hazard recognition and control.

Personal Protective Equipment

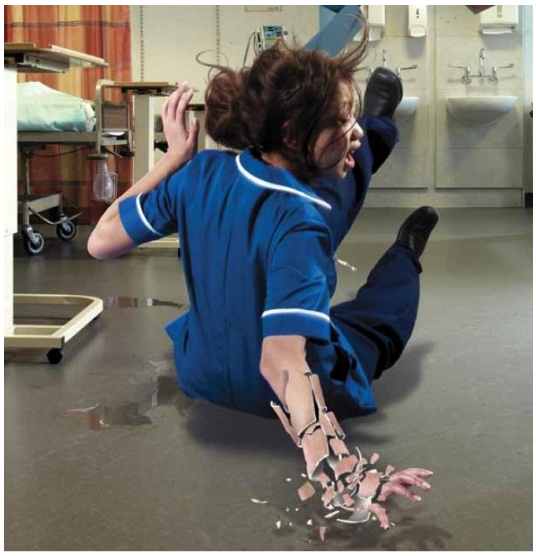
Personal protective equipment, such as slip resistant shoes, is the best way to protect against unknown hazards. As stated above, a significant danger in our workplace are walking surface hazards creating slip, trip, and fall incidents. We may not be able to control every hazard that we face throughout the day, but we can certainly do our best to utilize resources when given the opportunity. Wearing slip resistant shoes will reduce the chances of you 'falling' victim to hazardous walking surfaces.

Dress Code Change

The dress code for CCS clinical sites will be altered to comply with the new PPE policy of the company. It will affect all employees and subcontractors who are on the floor inside facilities, including Home and Regional Office employees when on visiting sites.

The following footwear will be banned from facilities after the date of mandatory compliance:

- Open backed shoes (Mules/Clogs)
- Open toed shoes or shoes with holes
- High heel shoes
- Leather soled shoes
- Flip flops



How to Comply

CCS has decided to team with SR Max as a distributor to order your slip resistant shoes. The catalogue has numerous pages of slip resistant shoes in a wide range of styles and prices, some as low as $30! If you choose this route, get with your HSA to order the shoes, sign up for payroll deduction, and the shoes will be delivered to your facility after payment is complete.

If you prefer to "try before you buy," you can buy slip-resistant shoes from a local shoe store or check our Vendor List on the next page.

Mandatory Compliance Date

EFFECTIVE OCTOBER 1, 2012

All site employees must be wearing the slip resistant shoes no later than October 1, 2012. It will be a mandatory requirement for ALL employees and subcontractors who are on the floor inside facilities. If you plan on visiting the facilities, you must wear slip resistant shoes as well.

Recognizing Hazards

Slip resistant shoes will provide assistance in protecting against hazardous floor conditions. But wouldn't it be better if we just eliminated the hazards?

The workplace can be made unsafe for walking by many sources, such as water leaks, extension cords, or spilled materials. Anticipate where some of these conditions may take place (drainage areas, faucets, under air conditioners). Keep an eye on those areas when you walk through the facility.

If you discover a hazardous condition, evaluate the best way to quickly and effectively fix the problem, if possible. Fixing the problem when it is discovered reduces the risk of having another employee injured by the hazard. After you notice a hazardous condition, be sure to let your fellow employees know as well. If you see something, say something.

Possible Hazards Controlled by Slip Resistant Shoes

- Spilled drinks
- Leaking pipes
- Waxed floors
- Ice/snow
- Sloped surfaces
- Poor housekeeping

Controlling Hazards

After the hazards are recognized, we have to do our best to eliminate or control those hazards.

- Clean up spills immediately after they occur or notify the proper contact at your facility. Notify those in the area of a slick condition.
- If available and allowed, use "Caution – Slippery Floor" signs until the hazard can be corrected.
- Clear walkways of clutter
- Communicate between shifts any hazards that were unable to be controlled.
- Keep a clean and organized workspace.
- Open doors slowly

GIVE AND GET!

A FREE PAIR OF SLIP RESISTANT SHOES!

From April 1-30, commit to give at least $3 per paycheck to Dare to Care for the next 12 months, and get a free pair of slip resistant shoes!

To get your FREE pair of slip resistant shoes, pick up a Dare to Care enrollment form from your HSA or AA. Make sure to include your email address on your application so we can follow-up with you about your shoes.

*If you currently contribute at least $3 or more to Dare to Care on a weekly basis, you are eligible to receive FREE shoes as well. Please fill-out a new enrollment form to receive your shoes

DARE TO CARE

Have questions, or want more information? Send us an e-mail:
daretocare@correctcaresolutions.com

CCS CORRECT CARE SOLUTIONS

You must submit your enrollment form by April 30th to receive your free pair of shoes

SHOE VENDOR LIST

Famous Footwear
www.famousfootwear.com
Healthy Feet Store
www.healthyfeetstore.com
Lehigh Safety Shoes
www.lehighsafetyshoes.com
Payless
www.payless.com
Sears
www.sears.com
Shoes For Crews
www.shoesforcrews.com
Sketchers
www.sketchers.com
Slip Grips
www.slipgrips.com
SRMAX
www.srmax.com
SureGrip Footwear
www.suregripfootwear.com
Walmart
www.walmart.com
Work Shoe City
www.workshoecity.com
Zappos
www.zappos.com

CCS CORRECT CARE SOLUTIONS

March 2012

Safety News Flash

INSIDE THIS ISSUE:

Flu Symptoms

Actions to Protect Yourself

Weekly Influenza Surveillance Report

Fight the Flu

Every year influenza or the "flu", significantly affects employees and employers. According to the CDC flu costs businesses approximately $10.4 billion in costs for hospitalization and outpatient visits annually.

- The flu vaccine protects against the three viruses that research suggests will be most common each year.
- The 2011-2012 vaccine will protect against influenza A H3Na virus, Influenza B virus, and the Influenza A H1N1.
- It is recommended that everyone 6 months and older get vaccinated.

Flu Symptoms

Flu is a serious contagious disease that can lead to hospitalization and even death.

Flu-like symptoms include:

- Fever
- Cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Chills
- Fatigue

Other symptoms can include vomiting and diarrhea. You can also be infected with the flu and have respiratory symptoms without a fever.

Actions to Protect Yourself

Take time to get a flu vaccine.

- CDC recommends a yearly flu vaccine.
- Vaccination of a high risk person is especially important to reduce the risk of severe flu illness.

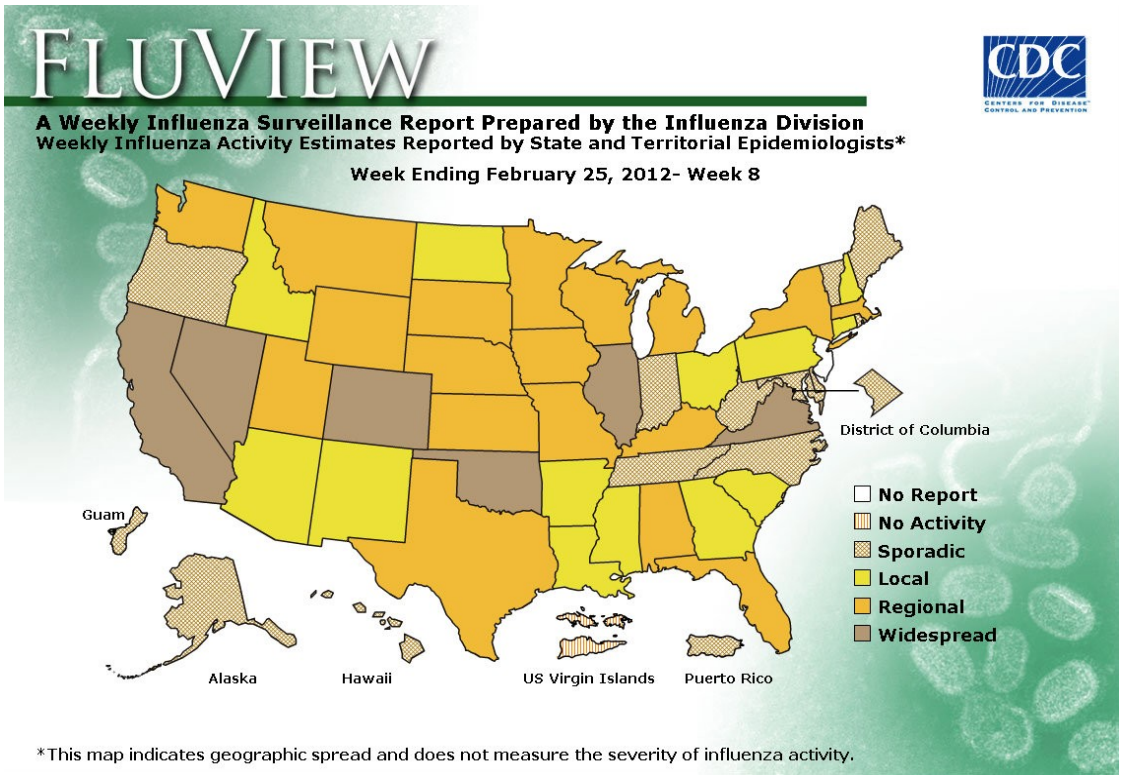
- Those of high risk include: young children, pregnant women, people with chronic health conditions like asthma, diabetes or heart and lung disease and people 65 years and older.
- Vaccination is very important for health care workers and others who live with and care for high risk individuals to keep from spreading flu to those individuals.

Take everyday preventive actions to stop the spread of germs.

- Cover your nose and mouth with tissue when you cough or sneeze. Throw the tissue in the trash after use.
- Wash your hands often with soap and water. Use an alcohol-based hand rub if soap and water are not available.
- Avoid touching your eyes, nose and mouth. Germs spread this way.
- Try to avoid close contact with sick people.
- If you are sick with flu-like illness, CDC recommends that you stay home for at least 24 hours after your fever is gone except to get medical care or for other necessities.
- While sick, limit contact with others as much as possible to keep from infecting them.

Take flu antiviral drugs if your doctor prescribes them.

- If you get the flu, antiviral drugs can treat your illness.
- Antiviral drugs are different from antibiotics. They are prescription medicines (pills, liquid, or an inhaled powder) and are not available over-the-counter.
- Antiviral drugs can make illness milder and shorten the time you are sick. They may also prevent flu complications.
- It's very important that antiviral drugs be used early (within the first 2 days of symptoms) to treat people who are very sick (such as those who are hospitalized) or those who are sick with flu symptoms and who are at increased risk of severe flu illness, such as pregnant women, young children, people 65 and older and people with certain chronic health conditions.



CCS CORRECT CARE SOLUTIONS

February 2012

Safety News Flash

INSIDE THIS ISSUE:

OSHA Unveils I2P2

Correct Care Solutions' Injury and Illness Prevention Program

Is There Evidence that Injury and Illness Prevention Programs Help Save Money?

How Does the Injury and Illness Prevention Program Work?

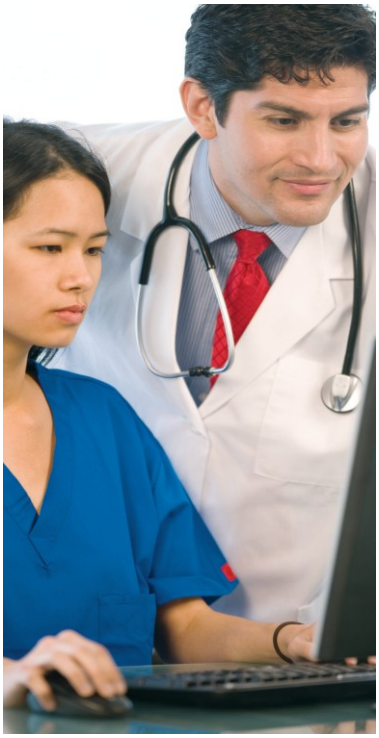
INJURY AND ILLNESS PREVENTION PROGRAM

OSHA Unveils I2P2

OSHA unveiled this past year the new I2P2 webpage. I2P2 stands for Injury and Illness Prevention Program. The program requires employers to develop a program to help identify and fix hazards in the workplace. OSHA recently released a white paper supporting its position on Injury and Illness Prevention Programs.

This program is a proactive process to help employers and employees fix hazards before someone is hurt. They are very effective in reducing injuries, illnesses and fatalities.

The Bureau of Labor and Statistics estimated in 2009 3.3 million serious work-related injuries and about 4,300 fatalities. According to the Liberty Mutual Workplace Safety Index in 2008 disabling workplace injuries and illnesses cost $53.42 billion in U.S. workers compensation costs. That is over one billion per week. An enhanced focus is needed to bring the number down.



Correct Care Solutions' Injury and Illness Prevention Program

With the start of the July 2009 Stanislaus County contract in California, CCS rolled out its first Injury and Illness prevention program. The I2P2 is mandatory in the state of California. In an effort to identify and prevent hazards the program was rolled out to all sites in 2010. All policies and forms can be found on CCSMGR/Legal and Risk Management/ Department Documents/Injury and Illness Prevention Program.

Is There Evidence that Injury and Illness Prevention Programs help Save Money?

OSHA reviewed injury and illness prevention programs in eight states. The states were Alaska, California, Colorado, Hawaii, Massachusetts, North Dakota, Texas and Washington. The success of these programs lowered the incidents by 9 percent to 60 percent.

How Does the Injury and Illness Prevention Program Work?

The program has six elements that focus on identifying hazards and developing a plan for prevention and control of hazards.

The program is based on a common set of key elements.

- Management leadership
- Employee participation
- Hazard identification
- Hazard prevention
- Control, education and training
- Program evaluation and improvement

Management Leadership

The management accepts the ultimate responsibility and the overall implementation of the working plan, compliance and training of staff to perform their work in a safe and healthful manner.

Employee Participation

Every employee is responsible for their own safety and the safety of those on their team. Employee participation makes an important contribution to the injury and illness prevention program. Encouraging employees to offer ideas and to see their ideas being taken seriously has a significant impact on the program.

Hazard Identification and Prevention

It is the intent to eliminate all hazards and unsafe conditions and work practices. Unsafe or unhealthy work conditions or work practices should be corrected in an efficient timely manner, as determined by the severity of the hazard.

Control, Education and Training

Effective dissemination of safety information is an essential element of a successful I2P2. It is necessary to provide employee training on safe work practices and specific instructions related to hazards unique to each employee's job.

Program Evaluation and Improvement

Program evaluation helps to ensure that the workplace safety program complies with state requirements and is well tailored to reducing risks and claims in the workplace.

Charles Harrington, who is the chairman and CEO of Parsons Corp, said the following.

"Establishing safety as a value rather than a priority tells our employees and our customers that safety is built into our culture, not something we do to merely comply with regulations."

December 2011

ICE AND SNOW TAKE IT SLOW

WEAR PROPER FOOTWEAR

TAKE YOUR TIME

WATCH WHERE STEPPING AND GO S-L-OW-L-Y

DON'T TAKE SHORTCUTS

WALK IN DESIGNATED WALKWAYS

WIPE YOUR FEET WHEN ENTERING BUILDINGS

FOR BALANCE:

POINT YOUR FEET SLIGHTLY OUTWARD WHEN WALKING

EXTEND ARMS OUTWARD

KEEP HANDS OUT OF POCKETS

CCS
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January 2012

Safety News Flash

INSIDE THIS ISSUE:

Definition

Statistics

Examples of Workplace Violence

Warning Signs

Continuum of Violence

What to Watch For

Triggers of Workplace Violence

Avoiding Victimization

Workplace Violence

Definition

Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the work setting.

Statistics in Workplace Violence

According to the U.S. Department of Justice in 2009 there were 572,000 nonfatal violent crimes (rape/sexual assault, robbery and aggravated and simple assaults).

The rate of violent crimes against employed persons has declined since 1993. There were an estimated 4 violent crimes per 1,000 employed persons age 16 or older in 2009 compared to 6 per 1,000 employees in 2002. The rate in 1993 was 16 per 1,000 employees. The rate of nonfatal workplace violent crimes has declined in 2002 to 2009 by 35% and a 62% decline from 1993 to 2002.

Examples of Workplace Violence

- Verbal threats to inflict bodily harm
- Attempt to cause physical harm
- Verbal harassment, abusive or offensive language, gestures or other discourteous conduct towards supervisors, employees and others
- Disorderly conduct such as shouting, throwing or pushing objects, punching walls and slamming doors
- Making false and malicious or unfounded statements against coworkers, supervisors, or subordinates which tend to damage their reputations or undermine their authority
- Inappropriate remarks, such as delusional statements
- Fascination with guns or other weapons, bringing weapons into the workplace

Warning Signs

- History of violence
- Mental illness
- Romantic obsession
- Bullying
- Conflicts, blaming
- Increased frustration with one's circumstances
- Fascination with weapons
- Desperation, suicidal thoughts
- Threats of revenge
- Substance abuse
- Extreme changes
- Absence of emotional control

Continuum of Violence

Early in the process there may be:

- Refusal to cooperate with immediate supervisor
- Gossip and rumors
- Arguing with coworkers
- Swearing
- Unwanted sexual comments

As feelings escalate there may be:

- Arguments with coworkers, customers and management
- Refusal to follow company policies and procedures
- Impairing equipment and stealing property
- Verbalizing wishes to harm co-workers and /or management
- Suicidal threats
- Sending sexual , violent or inappropriate notes to coworkers and/or management
- Stalking

As behavior escalates there may be:

- Physical fights
- Threatening/committing suicide
- Destruction of property
- Committing murder, physical or sexual assault, and /or arson
- Threatening to use /using weapons to harm others

What to Watch For

Observe unusual behavior which is a change from the normal routine.

Moderate Changes

- Recent behavior changes
- Alienation
- Excessive bitterness
- Mental health, substance abuse issues
- Irrationality, grandiosity
- Externalizing responsibility for behavior
- Raised in an abusive family
- Recent self-esteem loss

Significant Changes

- Grudge over loss or threat of loss
- Recent loss of significant other
- Emotional mood swings
- Fascination with violence
- Self-destructive behavior
- Fascination with pornography
- Severe intoxication
- Fear of losing control
- Rages
- Abusive to opposite sex
- Post-traumatic stress from combat

Triggers of Workplace Violence

- Domestic disputes
- Job stress
- Harassment
- Job performance counseling or disciplinary action
- Racial, ethnic, cultural, gender or lifestyle conflicts
- Terminations

Avoiding Victimization

- Be alert
- Be aware of your surroundings at all times
- Be careful how you say and do things
- Use the buddy system
- Park in well lighted areas
- Always let someone know where you are
- Understand and comply with workplace violence prevention and other safety and security measures
- Participate in employee suggestions covering safety and security concerns
- Report any incidents of potential or actual violence, safety and security issues as soon as possible to supervisor
- Report any concerns to the CCS Employee Hotline 866-673-6176
- CCS has an Employee Assistance Program (EAP) for those who are facing challenges big and small. They can be reached at 800-538-3543 or www.cignabehavioral.com/CGI.

CCS EMPLOYEE ASSISTANCE PROGRAM (EAP)

800-538-3543

CCS EMPLOYEE HOTLINE

866-673-6176

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Key North Program

Howard R. Young Correctional Institution

(200 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.7 Clinical Supervisor: 1.0 Counselors: 3.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.7 Clinical Supervisor: 1.0 Counselors: 5.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 4.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.7 Clinical Supervisor: 1.0 Counselors: 5.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 4.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.7 Clinical Supervisor: 1.0 Counselors: 5.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 4.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.7 Clinical Supervisor: 1.0 Counselors: 3.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.7
Clinical Supervisor:	2.0
Counselors:	9.0
Admin Assistant:	0.5

Appendix D

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Key Village Program

Baylor Women's Correctional Institution
(58 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 1.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0.5 Counselors: 2.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 2.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 2.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0.5 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.3
Clinical Supervisor:	0.5
Counselors:	4.0
Admin Assistant:	0.5

Appendix D

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Key South Program

Sussex Correctional Institution
(120 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 2.0 Admin Assistant: 0.7	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 3.0 Admin Assistant: 0.7	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 2.0 Admin Assistant: 0.7	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 3.0 Admin Assistant: 0.7	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.5 Counselors: 2.0 Admin Assistant: 0.7	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.3
Clinical Supervisor:	0.5
Counselors:	5.0
Admin Assistant:	0.7

Appendix D

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

CREST North-Men Program

Webb Community Correctional Center
(76 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.75 Clinical Supervisor: 0.75 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.75 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.75 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.75 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.75 Clinical Supervisor: 0.75 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.75
Clinical Supervisor:	0.75
Counselors:	6.0
Admin Assistant:	0.75

Appendix D

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Aftercare North-Men Program

Webb Community Correctional Center
(300 Beds Statewide)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.25 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.25 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.25 Clinical Supervisor: 0.25 Counselors: 2.0 Admin Assistant: 0.5	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.25 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.25 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.25
Clinical Supervisor:	0.25
Counselors:	3.0
Admin Assistant:	0.75

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

CREST North-Women Program

Hazel D. Plant Women's Treatment Facility
(68 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 1.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 1.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.3
Clinical Supervisor:	0.75
Counselors:	4.0
Admin Assistant:	0.75

Appendix D

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Aftercare North-Women Program

Hazel D. Plant Women's Treatment Facility
(300 Beds Statewide)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.2
Clinical Supervisor:	0.25
Counselors:	2.0
Admin Assistant:	0.25

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

CREST Primary Program

Central Violation of Probation
(200 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.5 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 1.0	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.5 Clinical Supervisor: 0 Counselors: 4.0 Admin Assistant: 1.0	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 4.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.5 Clinical Supervisor: 1.0 Counselors: 4.0 Admin Assistant: 1.0	Program Director: 0 Clinical Supervisor: 0 Counselors: 4.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.5 Clinical Supervisor: 0 Counselors: 4.0 Admin Assistant: 1.0	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 4.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.5 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 1.0	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.5
Clinical Supervisor:	1.0
Counselors:	8.0
Admin Assistant:	1.0

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

CREST Central Program

Morris Community Correctional Center
(56 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0.75 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0.75 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.3
Clinical Supervisor:	0.75
Counselors:	6.0
Admin Assistant:	0.75

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Aftercare Central Program

Morris Community Correctional Center
(300 Beds Statewide)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.2
Clinical Supervisor:	0.25
Counselors:	2.0
Admin Assistant:	0.25

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

CREST South Program

Sussex Community Correctional Center
(90 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0.75 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0.75 Counselors: 3.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.3 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0.75	Program Director: 0 Clinical Supervisor: 0.75 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.3
Clinical Supervisor:	0.75
Counselors:	5.0
Admin Assistant:	0.75

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Aftercare South Program

Sussex Community Correctional Center
(300 Beds Statewide)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 0 Admin Assistant: 0
Saturday 8:00 a.m. – 8:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.2
Clinical Supervisor:	0.25
Counselors:	2.0
Admin Assistant:	0.25

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

6 for 1 Program

Howard R. Young Correctional Institution
(80 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.3	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0.3	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0.3	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0.3	Program Director: 0 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.2 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.3	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.2
Clinical Supervisor:	1.0
Counselors:	4.0
Admin Assistant:	0.3

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Young Criminal Offender Program (YCOP)

Howard R. Young Correctional Institution
(40 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 1.0 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 1.0 Counselors: 2.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 1.0 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.1
Clinical Supervisor:	1.0
Counselors:	3.0
Admin Assistant:	0.2

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

Boot Camp Program

Sussex Correctional Institution
(100 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday		
Monday 8:00 a.m. – 5:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.1	
Tuesday 8:00 a.m. – 5:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.1	
Wednesday 8:00 a.m. – 5:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.1	
Thursday 8:00 a.m. – 5:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.1	
Friday 8:00 a.m. – 5:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.1	
Saturday		

Based on Treatment Staffing Plan

Program Director:	0.1
Clinical Supervisor:	0.25
Counselors:	1.0
Admin Assistant:	0.1

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

6 For 1 Program

Baylor Women's Correctional Institution
(30 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 2.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 2.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 2.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.25	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0
Saturday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.1
Clinical Supervisor:	0.25
Counselors:	3.0
Admin Assistant:	0.25

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CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

DUI Men Program

Sussex Correctional Institution
(50 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 0 Admin Assistant: 0
Saturday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.1
Clinical Supervisor:	0.25
Counselors:	1.0
Admin Assistant:	0.2

Appendix D

CCS PROPOSED STAFFING FOR SUBSTANCE ABUSE PROGRAMS

Treatment Staffing and Work Shift

DUI for Women Program

Baylor Women's Correctional Institution
(20 Beds)

Date/Time	A.M. Shift	P.M. Shift
Sunday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 0.5 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Monday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 0.5 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Tuesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 0 Admin Assistant: 0
Wednesday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Thursday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0.25 Counselors: 1.0 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0
Friday 7:00 a.m. – 8:00 p.m.	Program Director: 0.1 Clinical Supervisor: 0 Counselors: 0.5 Admin Assistant: 0.2	Program Director: 0 Clinical Supervisor: 0.25 Counselors: 0 Admin Assistant: 0
Saturday 8:00 a.m. – 5:00 p.m.	Program Director: 0 Clinical Supervisor: 0 Counselors: 0.5 Admin Assistant: 0	Program Director: 0 Clinical Supervisor: 0 Counselors: 0 Admin Assistant: 0

Based on Treatment Staffing Plan

Program Director:	0.1
Clinical Supervisor:	0.25
Counselors:	1.0
Admin Assistant:	0.2

COMMUNITY EDUCATION CENTERS

Indian Creek Correctional Center
Institutional Therapeutic Community Program

ANNUAL REPORT
Period Ending 12/31/2011

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Indian Creek Correctional Center – Institutional TC Program
Chesapeake, Virginia 23238

Data Collection Synopsis

Census

Background: Program was initiated in August 2004 with a TC bed count of 781. Bed capacity increases occurred in March 2006 (805), September 2006 (904) and December 2006 to the current capacity of 984.

Bed Utilization Rate: Daily average rate over 100 percent in 2011.

2011 Phase Distribution

(based on end of month census):

Phase	Percent of Population	Phase Median Length of Stay (Days)
SEA – Screening, Evaluation and Assessment	1 – 6%	9
Phase 1 – Orientation	11 – 24%	34
Phase 2 – Re-socialization	41 – 59%	131
Phase 3 – Internalization and Maturation	9 – 12%	133
Phase 4 – ReEntry Curricula	16 – 19%	87

2011 Admissions – Inmate Demographics (rounded values)

Race

- 61% Black
- 33% White
- 4% Other Race
- 1% Asian
- <1% Pacific Islander/Hawaiian
- <1% Native American
- <1% Multiracial

Self Reported Substance Use

- 23% reported alcohol use only (up to and including intoxication).
- 23% reported cannabis use.
- 15% reported alcohol and 1 or more drugs.
- 14% reported *no substance use problem*.
- 9% reported heroin use.
- 9% reported cocaine use.
- 4% reported other opiates or analgesics.
- 2% reported more than 1 drug but no alcohol.
- <2% reported other drug use.

Age Ranges at Admission

- 37% Aged 25-35
- 29% Aged 35-45
- 18% Aged 45-55
- 13% Aged <25
- 3% >=55

Self Reported Education Level at Admission

- 50% GED or HS Diploma
- 30% have more than 8th grade but no GED or HS Diploma.
- 12% have college coursework.
- 5% reached between 6th-8th grade.
- 3% unreported
- < 1% less than 6th grade education.

2011 Program Outcomes

Program Discharges

- 602 discharges, all with Discharge Summary Reports and Participant Status reports submitted.
- 412 discharges with Relapse Prevention Plans developed.
- 361 TC completions of which 133 fully completed all phases.
- Additional 114 offenders did not meet TC completion criteria but were deemed successful participants.
- Program success rate of 79%.

Average Length of Stay (LOS)

- 23 months for successful institutional TC component completions.
- 7 months for unsuccessful institutional TC component discharges.
- Overall average length of stay is 18 months for all offenders discharged.

Noncompliance Discharge Rates

2004 – 7%	2007 – 26%	2010 – 14%
2005 – 11%	2008 – 18%	**2011 – 17%**
2006 – 13%	2009 – 20%	

Data Collection Synopsis

Special Programming in 2011

Intensive Treatment Unit (ITU)

- The ITU end of month census ranged from a low of 18 (September) to a high of 49 (February) offenders.
- Successful returns to the TC community ranged from 6-24 individuals each month.
- 118 Offenders were discharged from the TC through ITU during 2011.

Youthful Offenders (YO)

- 100 offenders active during 2011 were designated as Youthful Offenders.
- 42% reported cannabis as their primary drug of choice.
- 23 discharges, all were successful.

Behavioral Correction Program (BCP)

- 101 offenders active during 2011 were designated as BCP Offenders.
- 13 discharges, 4 were successful (31%).

Assessments *(gathered for milestones occurring between 1/1/2011 and 12/31/2011)*

Addiction Severity Index Summaries

- 564 interviews performed. Overall results for the assessed population indicate medium severity levels in categories of employment, alcohol/drugs and emotional needs. Low overall severity with medical, legal, family/social needs.

Intake Cognitive/Criminal Thinking Scales and Motivation to Treatment Scales

- 573 surveys of each collected.
- In 2011, risk level proportions (%) for intakes were calculated as displayed in the table to the right.

On average, 48 sets of intake surveys were collected per month. 573 treatment assessment reports were created from surveys and interviews and inserted to the clinical record.

Risk %	High	Med	Low
Irresponsibility	**24.3**	27.6	48.2
Street Values	**33.0**	20.8	46.2
Hostility	**32.5**	14.3	53.2
Problem Recognition	40.1	30.0	**29.8**
Desire for Help	28.8	19.5	**51.7**
Treatment Readiness	43.5	29.5	**27.1**

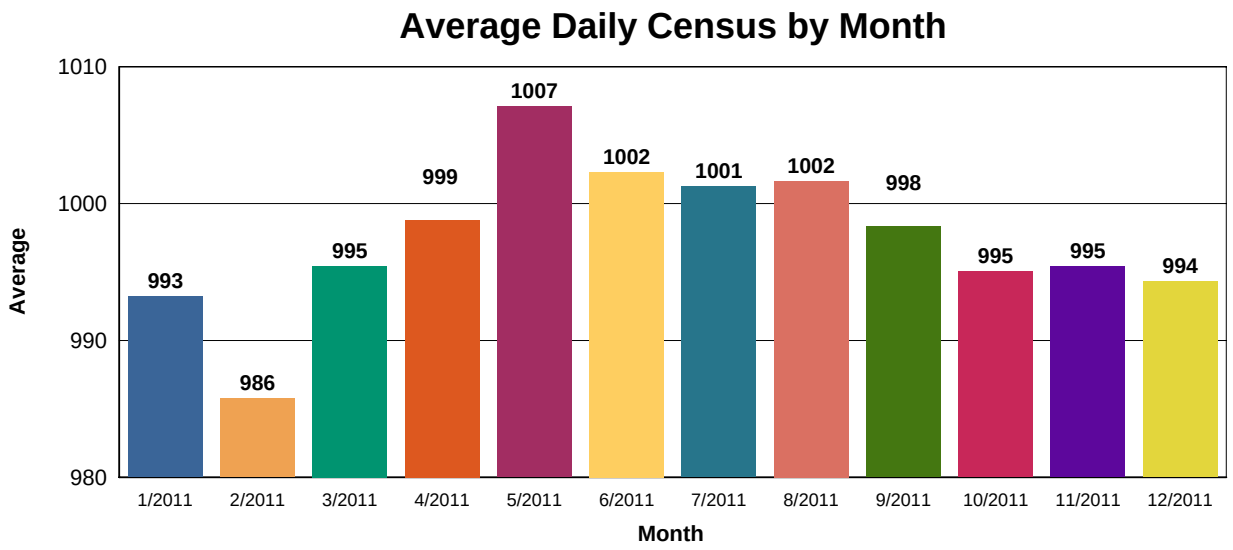
Client Evaluation of Self at Intake (CESI)

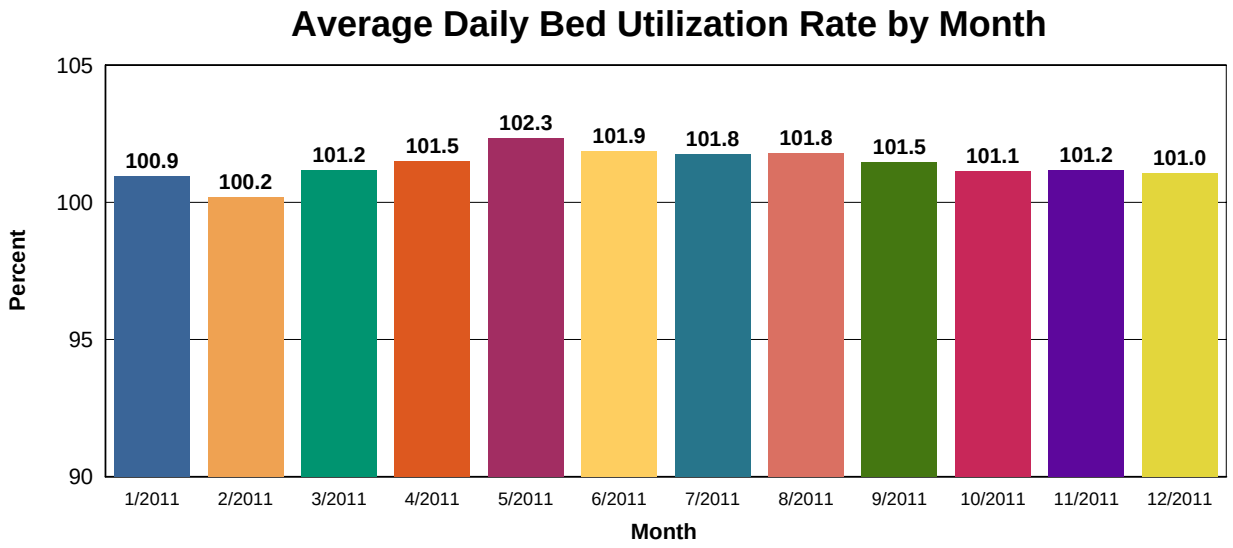
- The CESI is administered within two weeks of admission during SEA.
- In 2011, 515 ***valid*** CESI instruments have been collected from intakes.
- 80 instruments (13%) were invalidated due to response exemptions (incorrect form entry that prevented scoring) or subject refusal to participate.

Client Evaluation of Self and Treatment (CEST)

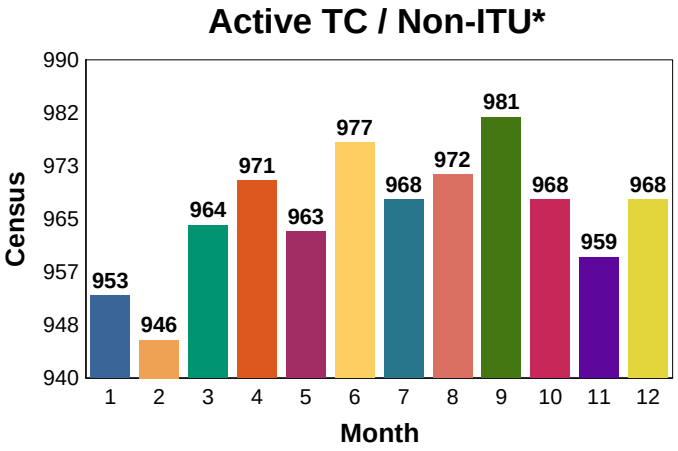
- The CEST is administered at the beginning of an offender's participation in re-entry curricula (phase 4).
- Tests are only accepted and retained in the database for comparison where an offender has successfully completed the institutional component of the TC.
- In 2011, 215 ***valid*** CEST instruments were collected from re-entry participants.
- 146 CEST instruments were not available for offenders completing the TC due to
  - Survey invalidation due to response exemptions (incorrect form entry that prevented scoring)
  - Phase IV offenders that refused to participate
  - Sudden participant discharge, prior to and preventing outcome testing.
- Comparison of the sample with correlating CESI pre-tests yielded the following pre/post test highlights:
  - 213 validated CEST surveys had corresponding CESI values.
  - 181 sets had all dimensions for comparison.
  - For those assessed to be high risk offenders at admission:
    - Criminal thinking scores improved or remained the same in 68-85% of offenders, depending upon the dimension.
    - Psychological functioning scores improved or remained the same in 76-88% of offenders, depending upon the dimension.
    - Social functioning scores improved or remained the same in 67-83% of offenders, depending upon the dimension.
    - Treatment motivation scores improved or remained the same in 61-82% of offenders, depending upon the dimension.

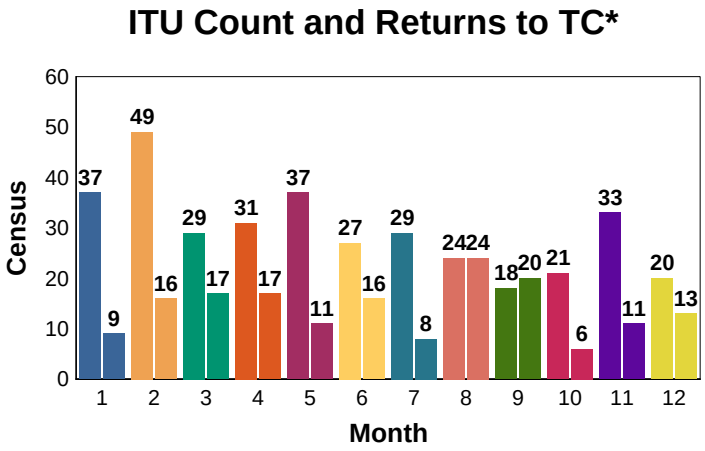
2011 Average Monthly Census and Bed Utilization Rate

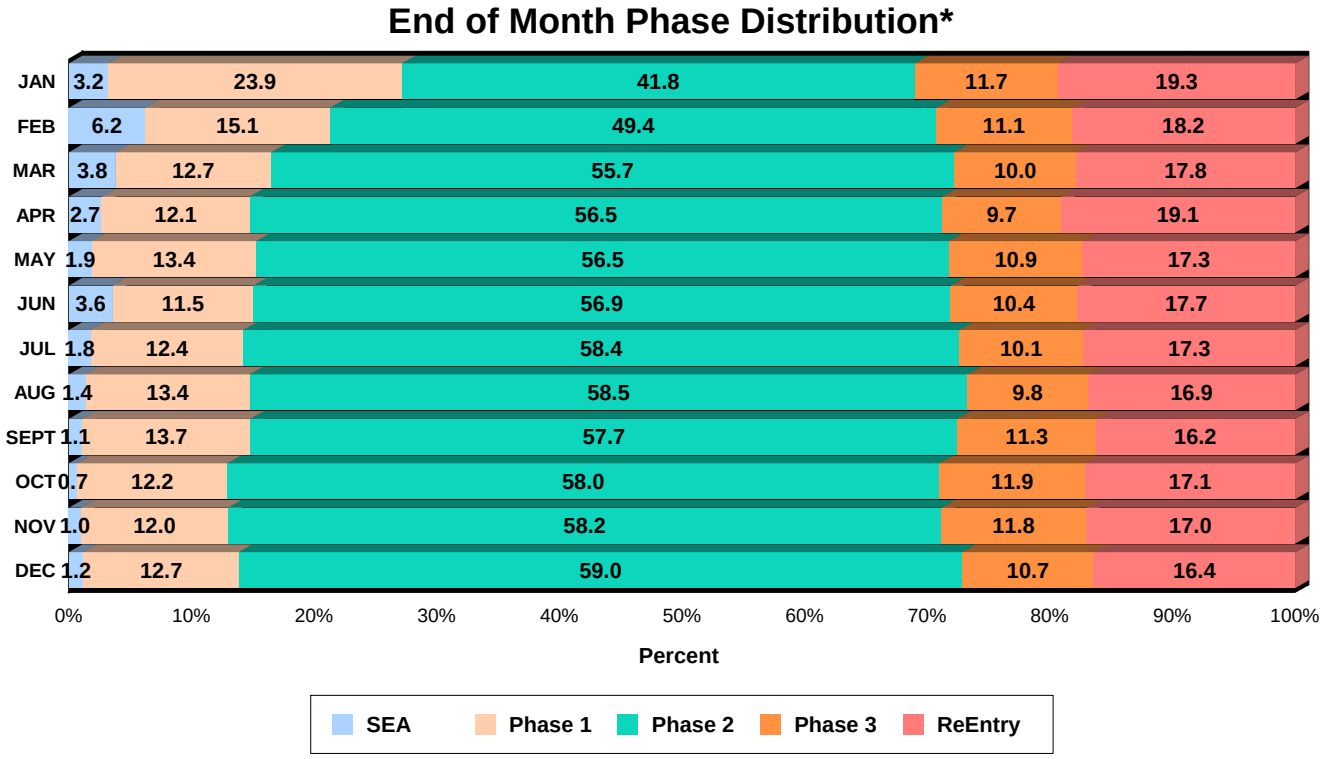


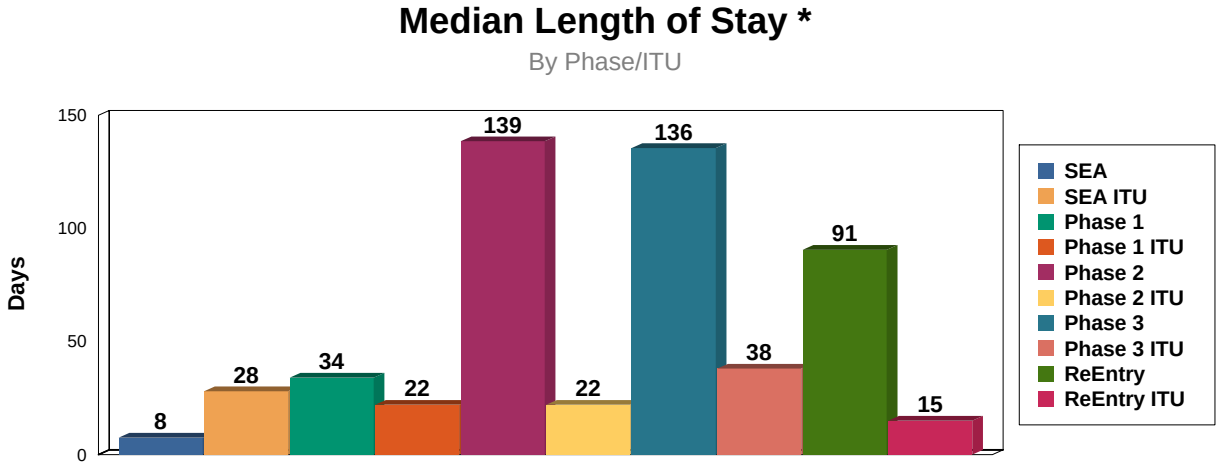


2011 End of Month Census and Phase Distributions







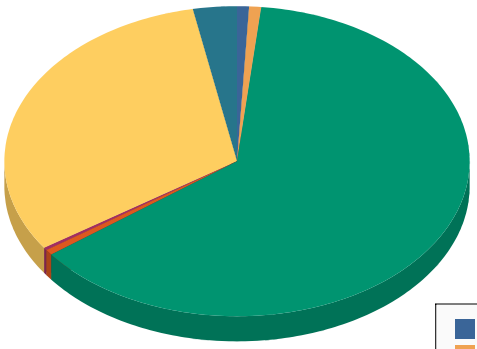


**Based on End of Month Statistics*

2011 Offender Race Distributions

Race Demographic of Current Population

12/31/2011

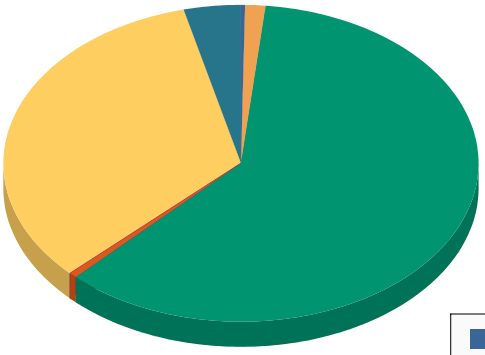


N=988

American Indian	0.7%
Asian	1.0%
Black or African American	63.0%
Multiracial	0.5%
Native Hawaiian or other Pacific Islander	0.3%
White	31.4%
Other	3.0%
Total:	100.0%

Race Demographic of 2011 Admissions

Admissions since 01/01/2011



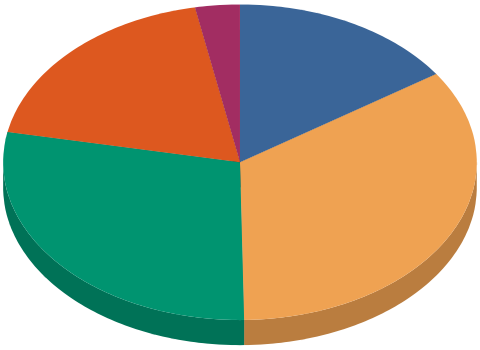
N=595

American Indian	0.2%
Asian	1.4%
Black or African American	60.8%
Multiracial	0.3%
Native Hawaiian or other Pacific Islander	0.2%
White	33.3%
Other	3.8%
Total:	100.0%

2011 Offender Age Distributions

Age Distributions of Current Population

12/31/2011

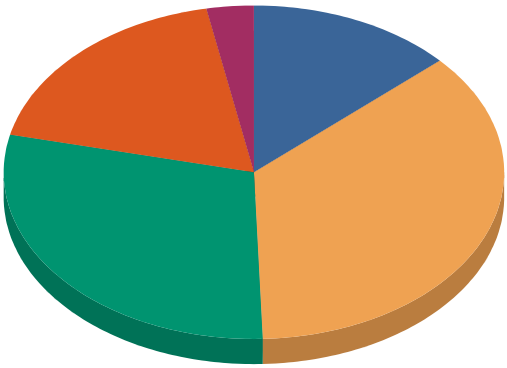


N=988

<25 Years	15.5%
25-35 Years	34.2%
35-45 Years	28.3%
45-55 Years	18.8%
>=55 Years	3.1%
Total:	100.0%

Age Distributions of 2011 Admissions

Admissions since 01/01/2011

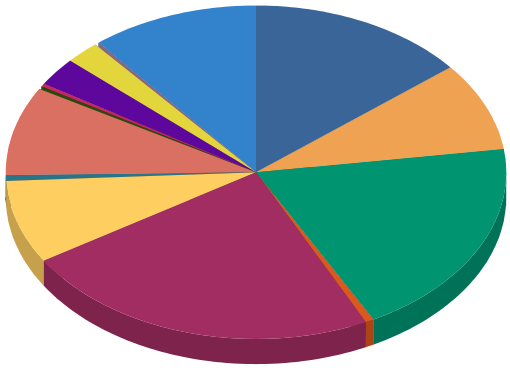


N=595

<25 Years	13.3%
25-35 Years	36.3%
35-45 Years	28.9%
45-55 Years	18.3%
>=55 Years	3.2%
Total:	100.0%

Substance Use Distributions of Current Population

12/31/2011

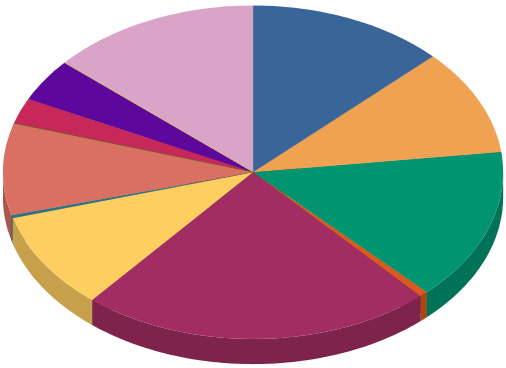


N=988

Alcohol (any use)	14.2%
Alcohol (to intoxication)	8.5%
Alcohol and one or more drugs	19.5%
Amphetamines	0.5%
Cannabis	23.4%
Cocaine	8.1%
Hallucinogens	0.5%
Heroin	8.7%
Methadone	0.1%
Methamphetamines	0.3%
More than one drug, but no alcohol	2.7%
Other opiates or analgesics	2.3%
Sedatives, hypnotics, or tranquilizers	0.1%
No problem	11.0%
Total:	100.0%

Substance Use Distributions of 2011 Admissions

Admissions since 01/01/2011



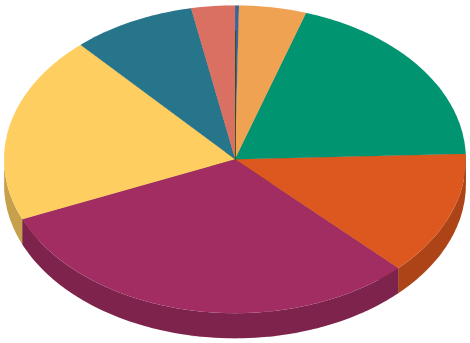
N=595

Alcohol (any use)	12.9%
Alcohol (to intoxication)	10.3%
Alcohol and one or more drugs	14.6%
Amphetamines	0.5%
Cannabis	22.8%
Cocaine	9.4%
Hallucinogens	0.5%
Heroin	8.7%
Methamphetamines	0.2%
More than one drug, but no alcohol	2.4%
Other opiates or analgesics	4.0%
Sedatives, hypnotics, or tranquilizers	0.2%
No problem	13.6%
Total:	100.0%

2011 Offender Education Level Distributions

Education Ranges of Current Population

12/31/2011

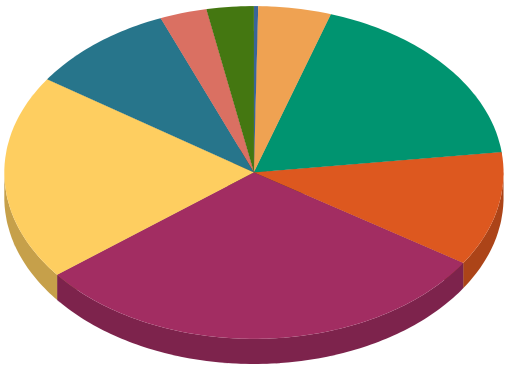


N=988

Less than 6th Grade	0.2%
6th-8th Grade	4.8%
9th-10th Grade	19.4%
11th-12th Grade	13.1%
GED	31.2%
High School Grad	19.6%
Some College	8.7%
College Graduate	2.9%
Unspecified	0.1%
Total:	100.0%

Education Ranges of 2011 Admissions

Admissions since 01/01/2011



N=595

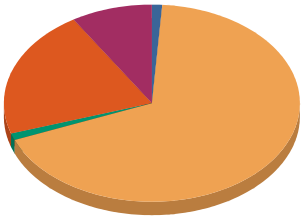
Less than 6th Grade	0.2%
6-8th grade	4.7%
9-10th grade	18.2%
11-12th Grade	11.3%
GED	30.1%
High School Grad	20.2%
Some College	9.4%
College Graduate	3.0%
Unspecified	3.0%
Total:	100.0%

2011 Special Programming Demographics -YO

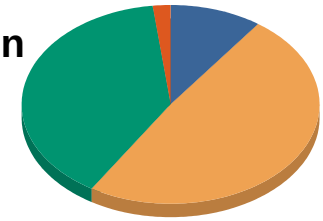
Classified as Youthful Offenders (YO)

Asian	1	1.0%
Black	68	68.0%
Native Hawaiian or other Pacific Islander	1	1.0%
White	21	21.0%
Other	9	9.0%
Total:	100	100.0%

Race Distribution



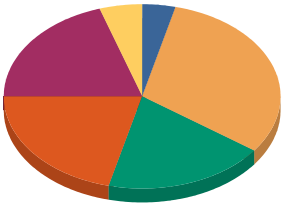
Age Distribution



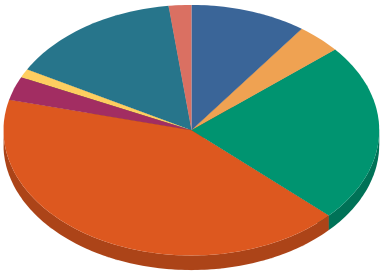
18-20 Years	10	10.0%
20-22 Years	49	49.0%
22-25 Years	39	39.0%
>=25 Years	2	2.0%
Total:	100	100.0%

Education Distribution

6-8th grade	4	4.0%
9-10th grade	31	31.0%
11-12th Grade	19	19.0%
GED	21	21.0%
High School Grad	20	20.0%
Some College	5	5.0%
Total:	100	100.0%



Substance Use Distribution



Alcohol (any use)	10	10.0%
Alcohol (to intoxication)	4	4.0%
Alcohol and one or more drugs	23	23.0%
Cannabis	42	42.0%
Cocaine	3	3.0%
More than one drug, but no alcohol	1	1.0%
No problem	15	15.0%
Other opiates or analgesics	2	2.0%
Total:	100	100.0%

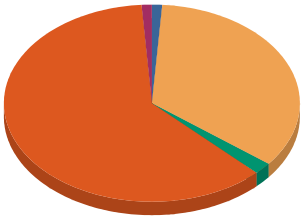
**** Counts are Offenders active at anytime during 2011.***

2011 Special Programming Demographics -BCP

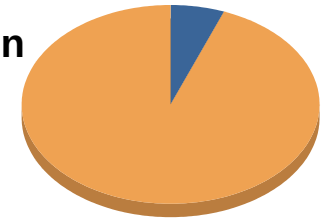
Classified as Behavior Correction Program (BCP)

American Indian	1	1.0%
Black	35	34.7%
Multiracial	2	2.0%
White	62	61.4%
Other	1	1.0%
Total:	101	100.0%

Race Distribution



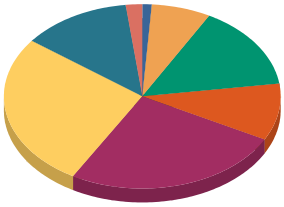
Age Distribution



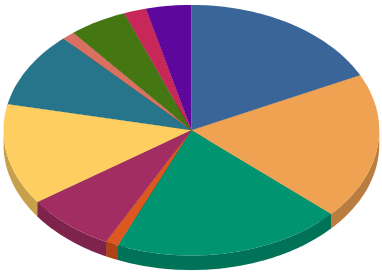
22-25 Years	6	5.9%
>=25 Years	95	94.1%
Total:	101	100.0%

Education Distribution

Less than 6th Grade	1	1.0%
6-8th grade	7	6.9%
9-10th grade	15	14.9%
11-12th Grade	10	9.9%
GED	26	25.7%
High School Grad	27	26.7%
Some College	13	12.9%
College Grad	2	2.0%
Total:	101	100.0%



Substance Use Distribution



Alcohol (any use)	18	17.8%
Alcohol (to intoxication)	19	18.8%
Alcohol and one or more drugs	20	19.8%
Amphetamines	1	1.0%
Cannabis	8	7.9%
Cocaine	13	12.9%
Heroin	10	9.9%
Methamphetamines	1	1.0%
More than one drug, but no alcohol	5	5.0%
No problem	2	2.0%
Other opiates or analgesics	4	4.0%
Total:	101	100.0%

**** Counts are Offenders active at anytime during 2011.***

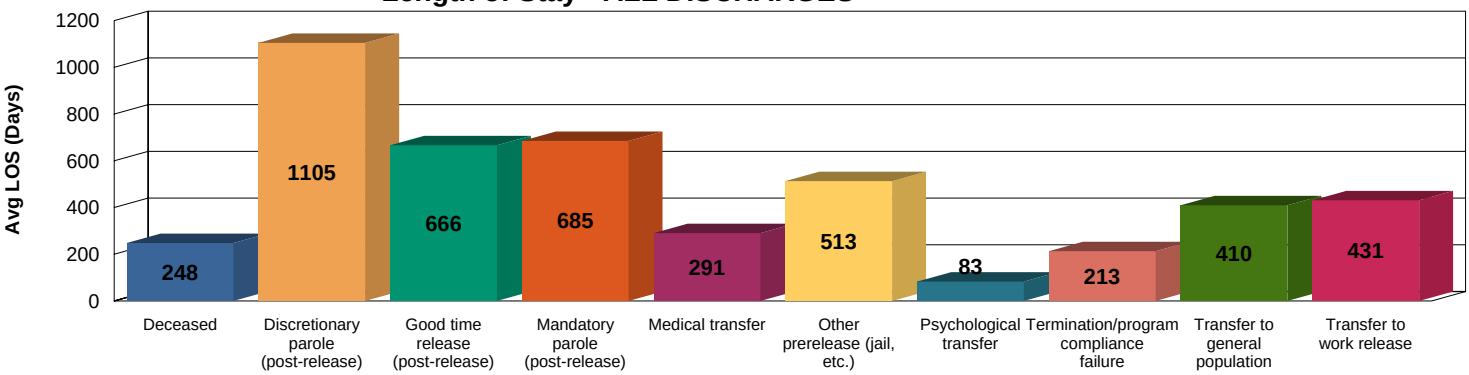
2011 Discharge Summary

Total Discharges / Discharge Plans/ Program Participant Forms for this period: 602

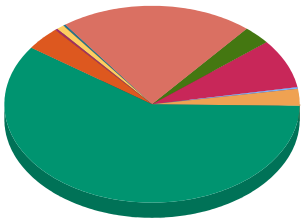
REPAC Plans Developed: 412 **Released from Custody:** 363 **ReEntry/WorkRelease:** 49

Average Length of Stay for All Discharges:	552	**Unsuccessful Discharges**	127
Average Length of Stay for TC Completions:	686	**Successful Discharges**	475
Count of TC Completions 361	**Completed All Phases** 133	**Completion Rate**	78.9%

Length of Stay - ALL DISCHARGES



Discharge Reason Percentages
ALL DISCHARGES



Deceased	1	0.2%
Discretionary parole (post-release)	17	2.8%
Good time release (post-release)	358	59.5%
Mandatory parole (post-release)	23	3.8%
Medical transfer	2	0.3%
Other prerelease (jail, etc.)	5	0.8%
Psychological transfer	2	0.3%
Termination/program compliance failure	127	21.1%
Transfer to general population	18	3.0%
Transfer to work release	49	8.1%
Total:	602	100.0%

	Successful Completion	Successful Participation	Unsuccessful	Total
Deceased	0	1	0	**1**
Discretionary parole (post-release)	15	2	0	**17**
Good time release (post-release)	311	47	0	**358**
Mandatory parole (post-release)	23	0	0	**23**
Medical transfer	0	2	0	**2**
Other prerelease (jail, etc.)	2	3	0	**5**
Psychological transfer	0	2	0	**2**
Termination/program compliance failure	0	0	127	**127**
Transfer to general population	8	10	0	**18**
Transfer to work release	2	47	0	**49**
Total	**361**	**114**	**127**	**602**

2011 Special Programming Discharges

Discharge Summary for Special Programs - Period 01/01/2011- 12/31/2011

Count of Discharges from ICCC - Segregation/ITU: 138

	Successful Participation	Unsuccessful	Total
ITU Good time release (post-release)	19	0	**19**
ITU Termination/program compliance failure	0	118	**118**
ITU Transfer to general population	1	0	**1**
Total	**20**	**118**	**138**

Successful Releases from the Segregation building were medical non-punitive placements.

Count of YO Discharges: 23

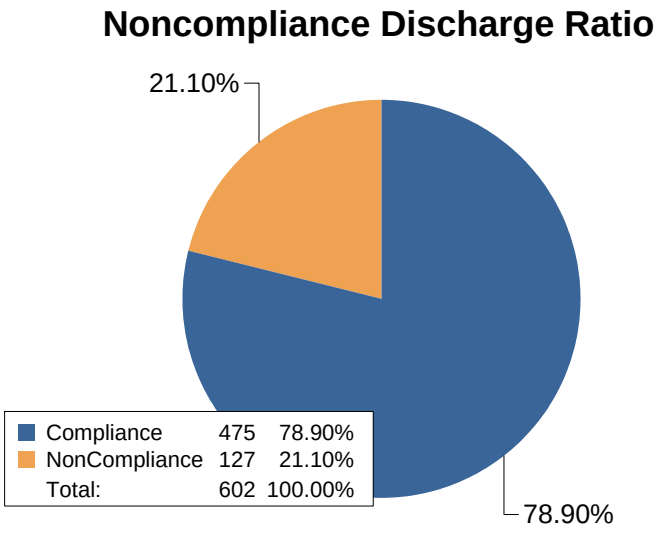
	Successful Completion	Successful Participation	Total
YO Discretionary parole (post-release)	15	2	**17**
YO Good time release (post-release)	3	0	**3**
YO Mandatory parole (post-release)	2	0	**2**
YO Other prerelease (jail, etc.)	0	1	**1**
Total	**20**	**3**	**23**

Count of BCP Discharges: 13

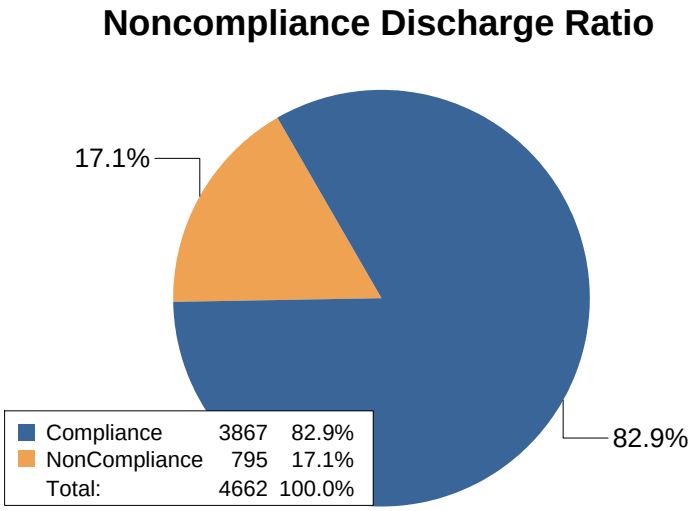
	Successful Completion	Unsuccessful	Total
BCP Termination/program compliance failure	0	9	**9**
BCP Good Time Release	4	0	**4**
Total	**4**	**9**	**13**

2011 Noncompliance Discharge Ratio

Noncompliance Discharge Ratio for 2011



Noncompliance Discharge Ratio 01/01/2004 - 12/31/2011



2011 Addiction Severity Index (ASI) Outcomes

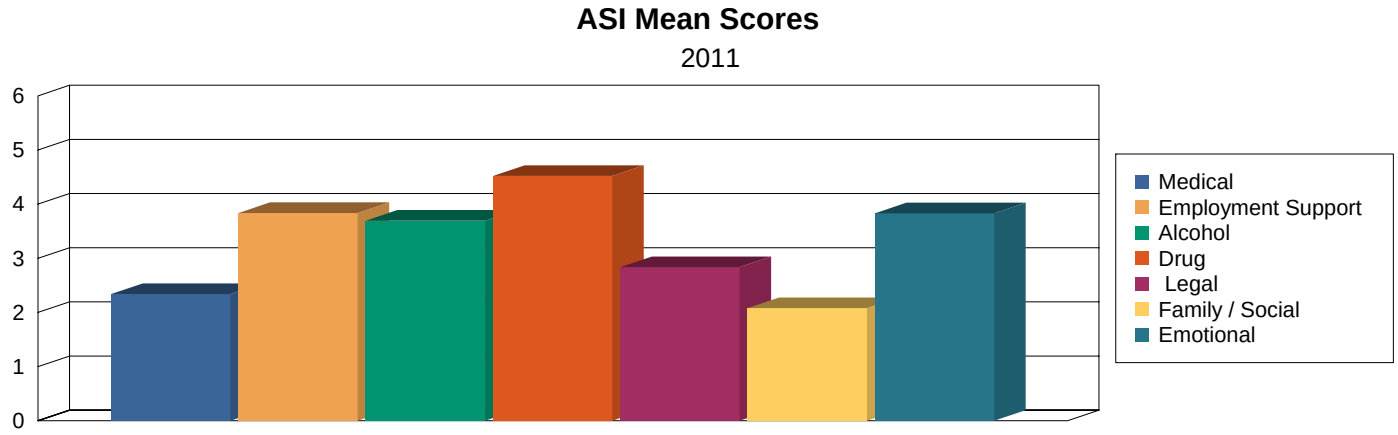
ASI Statistics for 2011

Total ASI Interviews Administered in 2011 = 564

Average Severity Profiles (Scale 0-9, Low to High Severity)

Mean Values

N	Medical	Employment	Alcohol	Drugs	Legal	Family/Social	Emotional
564	2.3 (L)	3.8 (M)	3.7 (M)	4.5 (M)	2.8 (L)	2.1 (L)	3.83 (M)



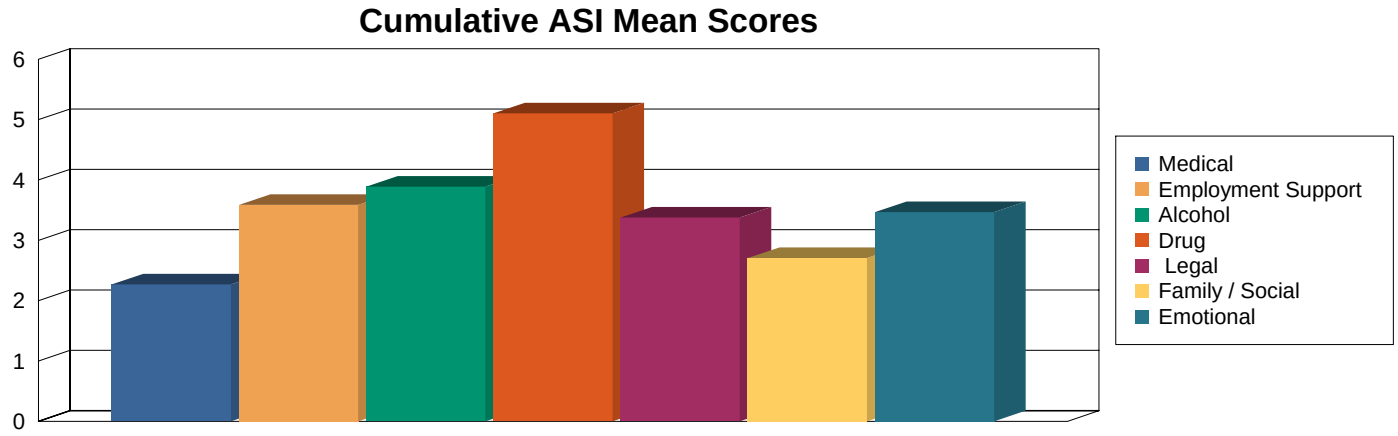
Cumulative ASI Statistics

Total ASI Interviews Administered 10/01/2004 - 12/31/2011 = 4660

Average Severity Profiles (Scale 0-9, Low to High Severity)

Mean Values

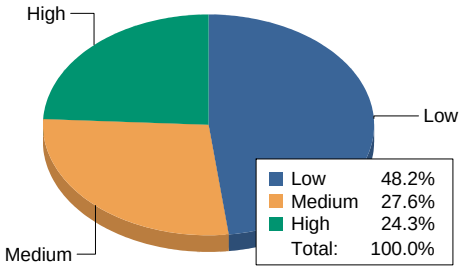
N	Medical	Employment	Alcohol	Drugs	Legal	Family/Social	Emotional
4660	2.3 (L)	3.6 (M)	3.9 (M)	5.1 (M)	3.4 (M)	2.7 (L)	3.5 (M)



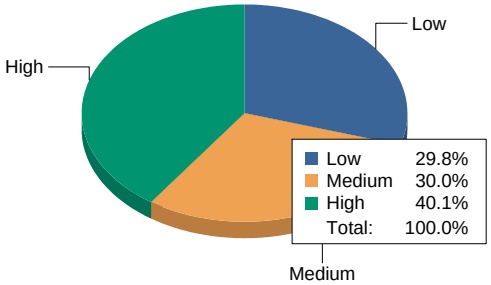
2011 Risk Levels of Admissions at Intake

N= 573

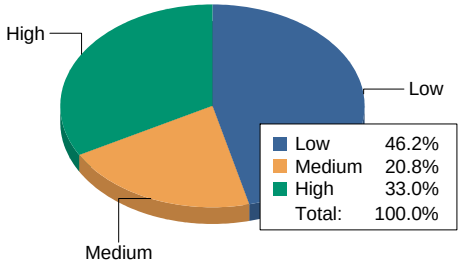
Personal Irresponsibilty



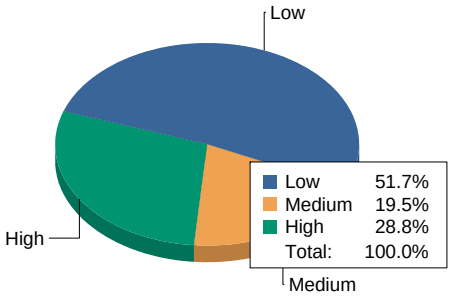
Problem Recognition



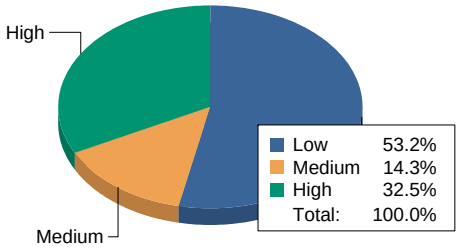
Street Values



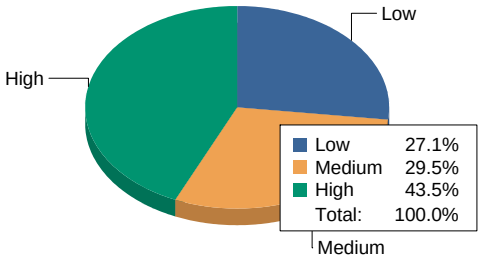
Desire for Help



Hostility



Treatment Readiness



2011 CEST Sample Tri-tile Analyses

Cumulative Baseline Scores for Demonstrating Improvement

Community Education Centers Intl.
Telephone: (508) 486-9300 Fax: (508) 303-6499

CEST Outcomes
Period Ending: 12/31/2011

Cumulative Statistics

N=1624	AX	CH	CN	CR	DH	DM	DP	EN	EP	HS	ML	PI	PM	PO	PT	RT	SC	SE	SS	SV	TN	TP	TR	TS
MEAN=	22.2	24.4	26.1	35.2	32.5	39.9	19.5	18.7	24.8	21.2	19.8	21.9	40.7	23.2	32.4	25.8	40.5	40.9	41.9	21.3	27.6	39.0	28.0	29.7
MIN	10.0	10.0	10.0	10.0	10.0	18.9	10.0	10.0	10.0	10.0	10.0	10.0	12.9	10.0	10.0	10.0	15.0	16.7	14.4	10.0	10.0	10.0	10.0	10.0
33 Percentile	20.0	22.5	23.8	33.1	30.0	37.8	16.7	15.7	22.9	18.8	17.5	20.0	38.6	21.1	30.0	22.9	38.8	38.3	40.0	20.0	24.0	37.5	25.0	25.7
67 Percentile	24.3	26.3	28.8	39.2	35.0	41.1	21.7	20.0	27.1	22.5	22.5	23.8	42.9	25.6	36.0	28.6	42.5	43.3	44.4	22.5	30.0	41.7	31.3	34.3
MAX	47.1	50.0	48.8	50.0	50.0	50.0	48.3	48.6	47.1	45.0	46.3	38.8	50.0	42.2	50.0	45.7	50.0	50.0	50.0	47.5	50.0	50.0	47.5	50.0

Motivation Tri-tiles	33 Percentile	67 Percentile
For CESI Comparison	77.1	93.3
All Dimensions	102.0	122.9

Social Functioning Tri-tiles	33 Percentile	67 Percentile
For CESI Comparison	88.2	99.6
All Dimensions	88.2	99.6

Psychological Tri-tiles	33 Percentile	67 Percentile
For CESI Comparison	171.5	190.2
All Dimensions	171.5	190.2

Criminal ThinkingTri-tiles	33 Percentile	67 Percentile
For CESI Comparison	146.2	166.1
All Dimensions	146.2	166.1

Treatment Needs/Motivation Scales
DH= Desire for Help
EP = External Pressures
TN= Treatment Needs
TR= Treatment Readiness

Psychological Functioning
AX= Anxiety
DM= Decision Making
DP= Depression
PM= Self Efficacy
SE= Self-Esteem

Social Functioning
HS= Hostility
RT= Risk Taking
SC= Social Consciousness

Treatment Process Domains
CR= Counselor Rapport
PT= Peer Support
SS= Social Support
TN= Treatment Needs
TP= Treatment Participation
TS= Treatment Satisfaction

Criminal Thinking
CH= Cold Heartedness
CN= Criminal Rationalization
EN= Entitlement
ML= Mollification
PI= Personal Irresponsibility
PO= Power Orientation
SV= Street Values

3/27/2012

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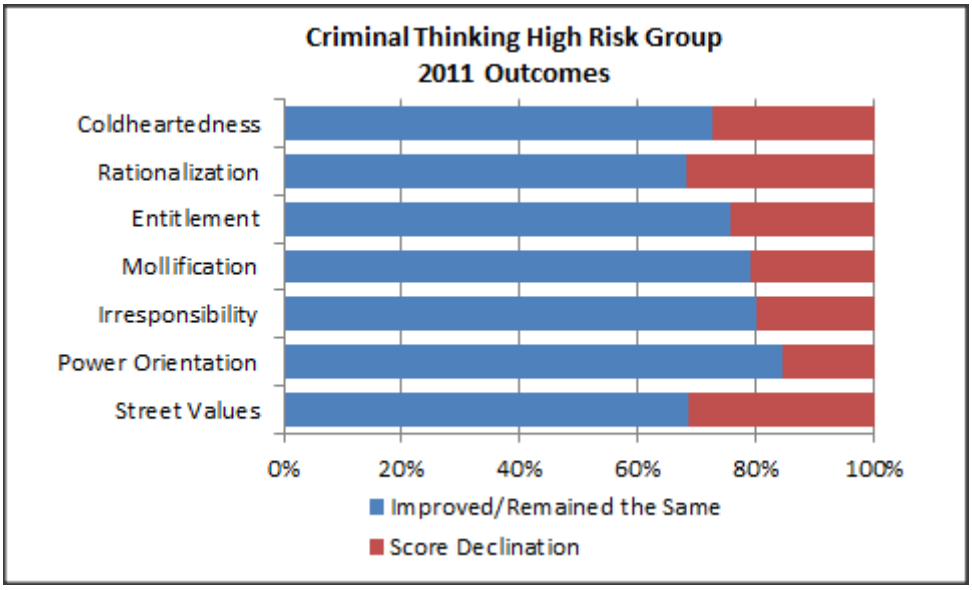
2011 CEST Criminal Thinking Outcomes

Criminal Thinking Outcomes for Successful Completions

2011	N*	Pretest Mean	Post-test Mean	Improved/Maintained Score Ct	%	Avg. Improved Score
Cold Heartedness	181	24.85	25.39	89	49%	3.69
High Risk	62	30.50	27.82	45	**73%**	4.97
Criminal Rationalization	181	26.81	27.16	98	54%	3.64
High Risk	60	33.50	31.17	41	**68%**	4.85
Entitlement	181	18.13	18.60	98	54%	3.40
High Risk	86	22.33	20.83	65	**76%**	3.53
Mollification	181	20.40	20.13	111	61%	3.31
High Risk	77	25.16	22.29	61	**79%**	4.47
Personal Irresponsibility	213	21.94	23.11	102	48%	3.48
High Risk	70	27.30	24.82	56	**80%**	4.04
Power Orientation	181	23.46	23.41	105	58%	3.46
High Risk	52	29.42	26.88	44	**85%**	3.64
Street Values	213	20.10	22.29	85	40%	2.97
High Risk	76	26.12	24.46	52	**68%**	3.92



**** Counts are Offenders with Valid Pre and Post Surveys***

Personal Irresponsibility and Street Values have higher sample sizes as dimensions from an intake evaluation sample never invalidated to meet intake assessment needs. Other dimensions are part of a separate testing administration where incomplete surveys are removed from the research data set.

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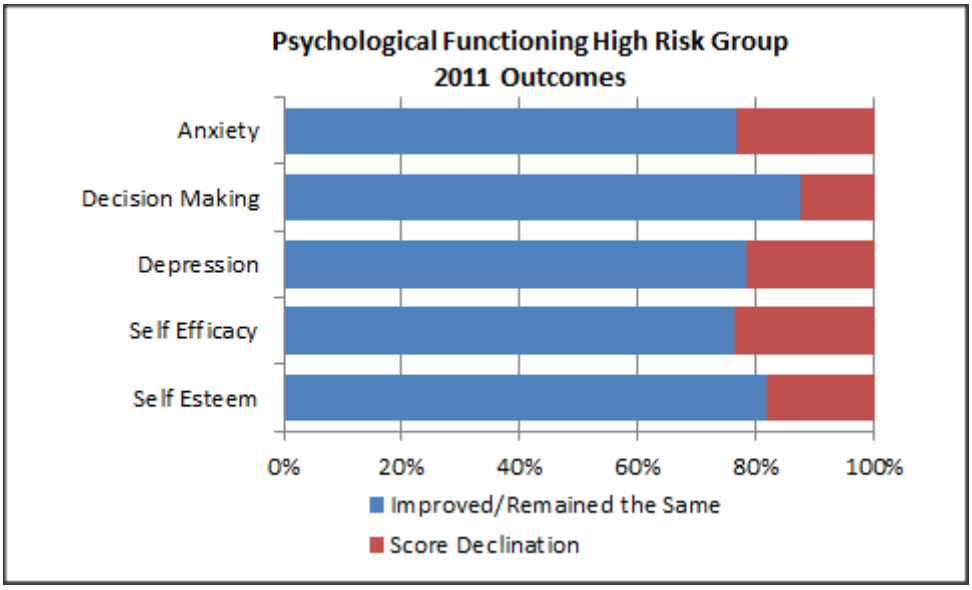
2011 CEST Psychological Functioning Outcomes

Psychological Functioning Outcomes for Successful Completions

2011		N*	Pretest Mean	Post-test Mean	Improved/Maintained Score Ct	%	Avg. Improved Score
Anxiety		181	23.15	23.24	104	57%	4.42
	High Risk	69	30.60	27.04	53	**77%**	5.93
Decision Making		181	37.43	39.64	130	72%	4.65
	High Risk	98	33.72	37.91	86	**88%**	5.19
Depression		181	20.16	20.05	107	59%	4.59
	High Risk	56	27.74	23.84	44	**79%**	6.36
Self Efficacy		181	40.02	40.24	106	59%	4.11
	High Risk	72	34.66	38.11	55	**76%**	5.56
Self Esteem		181	38.20	40.27	126	70%	5.38
	High Risk	82	32.64	37.52	67	**82%**	7.09



**** Counts are Offenders with Valid Pre and Post Surveys***

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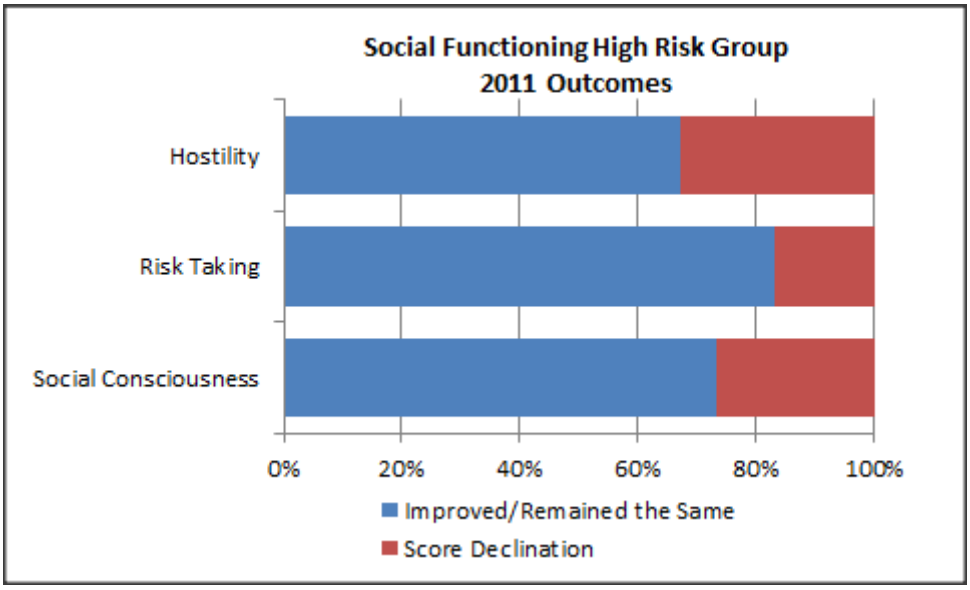
2011 CEST Social Functioning Outcomes

Social Functioning Outcomes for Successful Completions

2011		N*	Pretest Mean	Post-test Mean	Improved/Maintained Score Ct	%	Avg. Improved Score
Hostility		213	19.80	22.04	96	45%	4.31
	High Risk	82	26.25	24.66	55	**67%**	5.09
Risk Taking		181	28.37	26.76	124	69%	4.87
	High Risk	84	34.05	29.63	70	**83%**	6.00
Social Consciousness		181	38.92	39.36	110	61%	3.48
	High Risk	97	35.43	37.41	71	**73%**	4.08



**** Counts are Offenders with Valid Pre and Post Surveys***

Hostility has a higher sample size as a dimensions from an intake evaluation sample never invalidated to meet intake assessment needs. Other dimensions are part of a separate testing administration where incomplete surveys are removed from the research data set.

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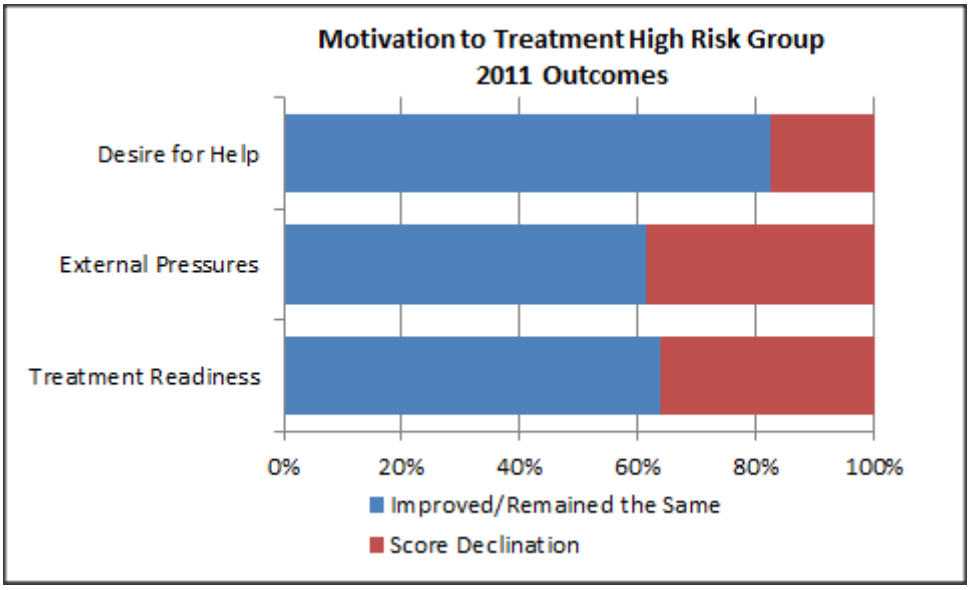
2011 CEST Motivation for Treatment Outcomes

Motivation for Treatment Outcomes for Successful Completions

2011	N*	Pretest Mean	Post-test Mean	Improved/Maintained Score Ct	%	Avg. Improved Score
Desire for Help	213	29.84	30.47	124	58%	6.16
High Risk	119	22.17	27.25	98	**82%**	6.96
External Pressures	181	27.13	24.06	60	33%	3.63
High Risk	31	19.14	20.42	19	**61%**	4.70
Treatment Readiness	213	29.13	25.23	79	37%	4.78
High Risk	80	21.03	22.86	51	**64%**	5.39



**** Counts are Offenders with Valid Pre and Post Surveys***

Desire for Help and Treatment Readiness have higher sample sizes as dimensions from an intake evaluation sample never invalidated to meet intake assessment needs. External Pressures is a dimension of a separate testing administration where incomplete surveys are removed from the research data set.

TCU FORMS/CJ-CEST -SG (09/03)

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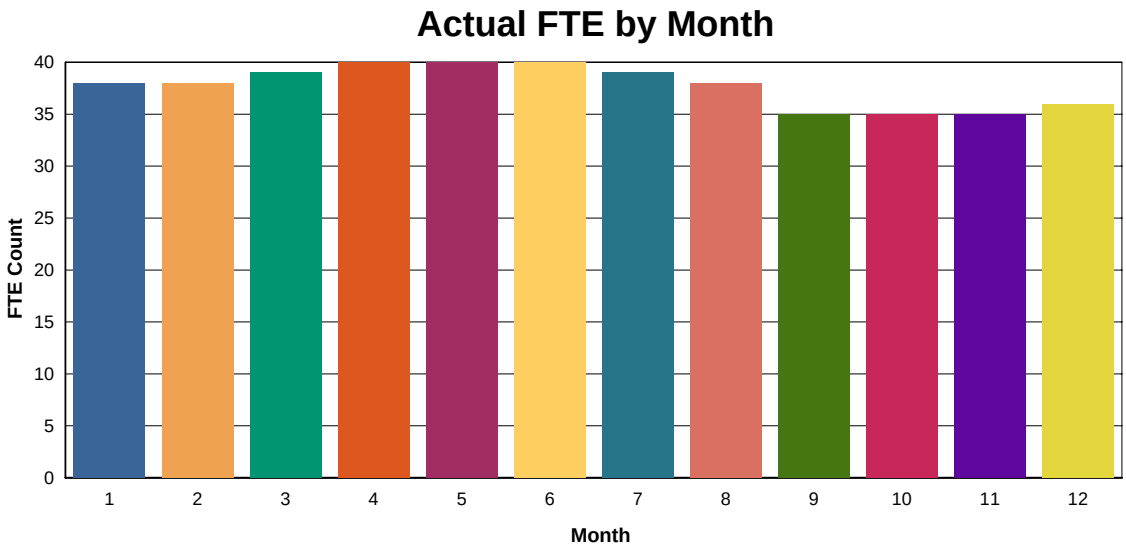
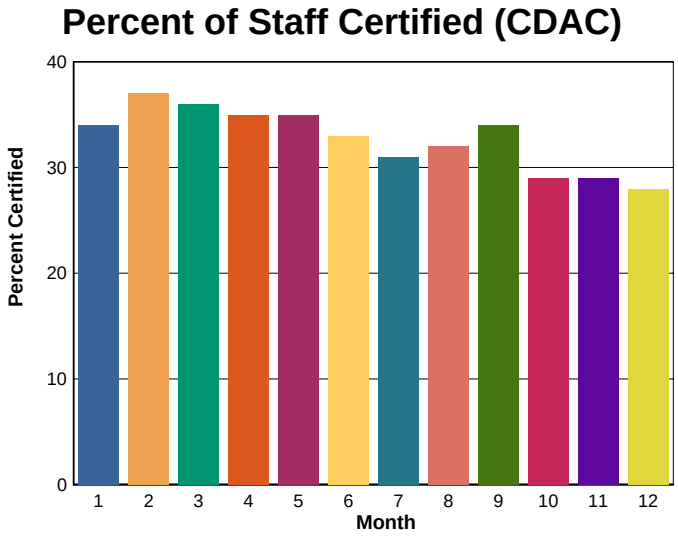
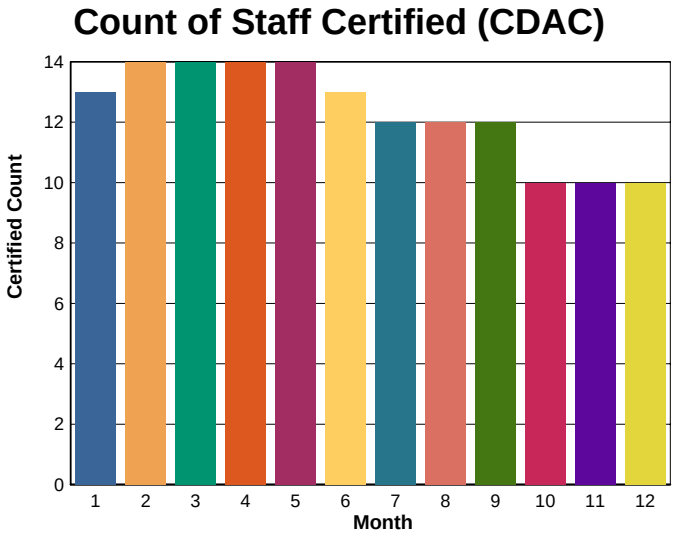
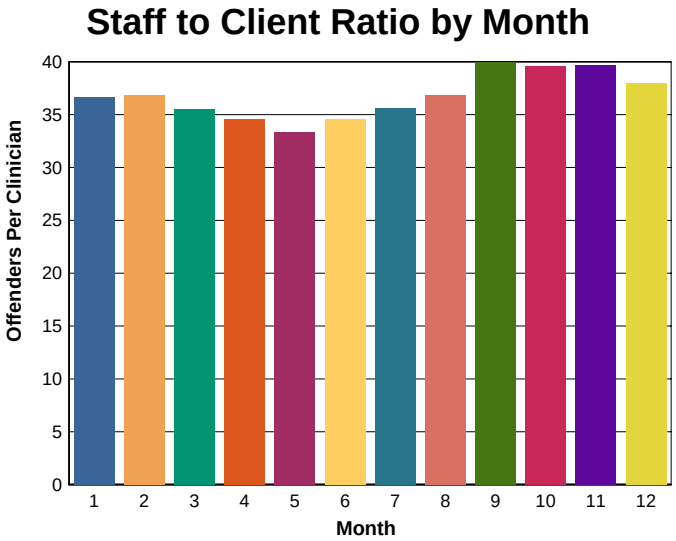
2011 Staffing Summary









Women's Health:

Center for Women/Infants (Dover) — 744-7249
Center for Women/Infants (Milford) — 430-5739
Maternity Services (Kent) — 674-4700
Women's Wellness Resource Center — 430-5540
Christiana Care Breast Center (Newark) — 623-4200
Christiana Care Women's Health System — 733-2326
Planned Parenthood of DE — 655-7296

Employment & Education:

James Groves Adult Education (GED) — 856-9035
Del. Tech. (Workforce Training Programs) — 856-5400
Vocational Rehabilitation (Sussex) — 856-5135
Vocational Rehabilitation (Kent) — 739-5478
Vocational Rehabilitation (New Castle) — 326-8930
Department of Labor (Sussex) — 856-5230
Department of Labor (Kent) — 739-5473
Delaware Job Hotline — 800-414-5748

HIV Services:

Wellness Clinic (Sussex) — 856-5135
Wellness Clinic (Smyrna) — 739-5610
Wellness Clinic (Wilmington) — 428-2538
Sussex AIDS Committee — 644-1090
People Living with AIDS (Sussex) — 628-2011
People Living with AIDS (Kent) — 697-4494
AIDS Delaware — 226-5350

Social Services:

DE Health & Social Services — 255-9433
Division Public Health (Sussex) — 856-5184
Division of Public Health (Milford) — 422-1560
Division of Public Health (Dover) — 739-4727
Food Bank of DE (Newark) — 292-1305
Whatcoat Social Service Agency — 734-0319

Other Services:

Child Abuse Hotline (24 Hour) — 800-292-9582
Gambling Hotline — 888-850-8888
DE Counsel on Gambling — 655-3261
Gay & Lesbian Hotline — 800-292-0429
Crisis Intervention Service (New Castle) — 800-652-2929
Crisis Intervention Service (Kent/Sussex) - 800-345-6785
Hepatitis C Hotline — 1-866-DEL-HEPC
Division of Public Health (Sussex) — 856-5106
Mobile Crisis Unit — 800-345-6785
Community Legal Aid (Kent) — 674-8500
Community Legal Aid (Sussex) — 856-0038
Food Stamp Information — 800-464-4357
Eating Disorders (Dover) — 734-4252
Child Protective Services (24 hrs) — 1-800-292-9582
Child Mental Health Mobile Crisis — 633-5128
DE Center for Justice — 658-7174
Salvation Army — 472-0750
Delaware Helpline — 800-464-4357

Sober Support System Phone List:

Sponsor / Mentor's Phone #

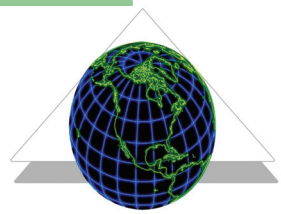
Sober Support List:

Name: _____

Phone #: _____

Name: _____

Phone #: _____



COMMUNITY EDUCATION CENTERS

Delaware's Key - Crest - Aftercare

RESIDENT RESOURCING BROCHURE

Build A Future Better Than Your Past !

COMMUNITY RESOURCES

Aftercare / TASC:

Crest North Aftercare Dept.——761-2650 (51)
Crest Central Aftercare Dept.—— 739-5387
Crest South Aftercare Dept.—— 856-5888
TASC New Castle County—— 577-2711
TASC Kent Count—— 739-1278
TASC Sussex County—— 856-5487

Probation & Parole Contacts:

Kent County —— 739-5387
Sussex County—— 854-6994 (5243)
Wilmington Office—— 577-3443
New Castle Office—— 323-6050
Delaware City Office—— 836-6344
Sussex Community Correction Center—— 856-5790
Morris Community Correction Center —— 739-4758
Plummer Community Correction Center —— 577-3039

Recovery Support Systems:

Alcoholics Anonymous (Sussex)—— 945-1411
Alcoholics Anonymous (Kent)—— 736-1567
Alcoholics Anonymous (24 hrs)—— 655-5113
Narcotics Anonymous (NA)——800-317-3222
Narcotics Anonymous (NA)——429-8175
Chemical Dependence Anonymous— 1-888-CDA-HOPE
Addiction Coalition of Delaware—— 984-2322
Children of Alcoholics—— 656-5554

Substance Abuse / Mental Health Treatment Contacts:

New Castle County:

Ellendale Detox Center——422-8338
Kirkwood Detox Center—— 691-0140
Hogar Crea/Men Wilmington)—— 654-1158
Hogar Crea/Female (Wilmington)—— 765-2362
Way Home Program (Sussex)—— 856-9870
Fellowship Health Resources—— 855-1066
Rockford Center Mental Health (Wilmington)—996-5480
Connections CSP Inc.—— 984-3388
Catholic Charities, Inc. (Wilmington) —— 655-9624
Community Mental Health —— 577-2484

Kent County:

Thresholds (Georgetown)—— 856-1835
Thresholds (Rehoboth)—— 249-4094
Sojourner's (Wilmington)—— 764-4713
Sussex County Counseling—— 854-0172
Kent County Counseling—— 735-7790
Children and Families First—— 856-2388
Catholic Charities, Inc. (Kent)—— 674-1600
Community Mental Health (Kent)—— 739-4170
People's Place—— 424-2420
Phoenix Mental Health (Dover) —— 736-6135
Brandywine Counseling —— 856-4700

Sussex County:

VA Coatsville—— 800-290-6172 x5412
VA Perrypoint—— 410-642-2411 x6221
VA Elsmere—— 994-2511 x4812/4810
VA Eligibility—— 633-5212
YMCA Resource Center (Wilmington)—— 571-6975
Catholic Charities, Inc. (Sussex)—— 856-9578
Community Mental Health (Sussex)—— 856-5490
La Esperanza Community Center ——854-9262
Community Mental Health (Milford) ——422-1395

Emergency Medical:

Fire, Police, Ambulance——911

New Castle County Medical:

Christiana Care Health Systems—— 733-1000
Newark Emergency Center—— 738-4300
Riverside (Wilmington)—— 764-6120
St. Francis Hospital (Wilmington)—— 421-4100
Veterans Affairs Hospital (Wilmington)—— 633-5500
Select Specialty Hospital —— 421-4592

Kent County Medical:

Bayhealth Medical Center —— 674-4700
Kent General Hospital —— 674-4700

Sussex County Medical:

Beebe Hospital —— 645-3300
Bayhealth Medical Center —— 422-3311
Milford Memorial Hospital —— 422-3311
Nanticoke Memorial Hospital —— 629-6611

Domestic Violence:

Battered Women's Hotline (24hrs)—— 762-6110
Crisis Intervention (24hrs) —— 800-464-HELP
Child Protective Services (24hrs) —— 800-292-9582
Kent/Sussex Hotline (24-Hours) —— 422-8058
Northern Kent Hotline (24 Hours) —— 678-3886
People's Place —— 422 8058
Sexual Assault Victims —— 800-262-9300
Suicide Prevention —— 800-652-2929
DE Coalition Against Domestic Violence1-800-701-0456
Domestic Violence Council—— 1-302-577-2684
Domestic Violence Court Advocacy (Kent) — 739-6552
Domestic Violence Court Advocacy (Sussex) -856-5843
Contact Delaware (Rape, Suicide, Crisis)—— 761-9100
Latino/a Population (M-F 8am-5:00pm)—— 228-5906
(Weekends & Holidays) —— 228-5904
Latino/a Rape Crisis Contact —— 800-262-9800

Housing Options:

New Castle County:

Chance House (Wilmington) —— 427-9080
Burton House/Men (Wilmington) —— 498-5174
Friendship House (Men Wilmington) —— 652-8278
Epiphany House (Women Children) —— 652-5713
Gateway House/Men —— 571-8885
Limen House/Men —— 652-7969
Limen House/Female ——571-1216
Men's Day Center (Wilmington) —— 652-8278
Women's Day Center (Wilmington) —— 652-8033
Sunday Breakfast Mission/ Men—— 656-8542
Salvation Army (Wilmington) —— 654-8808
Sojourner's (Wilmington) ——764-4713

Kent County:

Salvation Army —— 678-9551
Battered Women's Shelter —— 678-3886
Battered Women's Shelter —— 422-8058
House of Pride —— 677-0116
Shepherd Place —— 678-1909

Sussex County:

Men's Oxford House (Lewes)—— 644-2979
Men's Oxford House (Georgetown)—— 854-9151
Women's Oxford House (Georgetown) —— 855-5806
Men's Recovery House (Georgetown) —— 855-9435
Seaford Mission —— 629-2559
Home of the Brave (Veterans Shelter) —— 424-1681
Crisis House (Emergency Shelter) —— 856-2246
Casa Francisco (Emergency Shelter) —— 684-8707
Corinthian House (Georgetown) —— 856-5748
Tau House (Women's Housing/Program) —— 856-4363
1st State Community Action —— 856-7761
Salvation Army —— 856-7145
Battered Women's Shelter —— 422-8058

LICENSE NO. 2010102630 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

LN: 12 50050 18

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 3LM2 5MN6#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
300 W WATER ST
DOVER DE 19904-6743

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 003

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

Most licensees are also required to pay either gross receipts or excise taxes in addition to the license fee. You can file these taxes online or obtain a paper form from our website at www.revenue.delaware.gov. You must **submit all business tax returns** filed with the Division of Revenue **under the same identification number.** If you are a sole-proprietor, and have a federal employer identification number, use the employer identification number, not your social security number. Only sole proprietors with no employees are allowed to file under their social security number. Inquiries regarding your coupon booklets to pay withholding, corporate tentative, and Sub Chapter "S" estimated taxes, or to make changes to your name, address, or identification number, should be directed to the Business Master File Unit at (302) 577-8778.

1/12/12 - Sent to Site
FedEx 797941149880

INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010103165 DORM

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

LN: 12 50050 10

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 ALM2 5MN0#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
1201 COLLEGE PARK DR STE 101
DOVER DE 19904-8702

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 010

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

Most licensees are also required to pay either gross receipts or excise taxes in addition to the license fee. You can file these taxes online or obtain a paper form from our website at www.revenue.delaware.gov. You must submit all business tax returns filed with the Division of Revenue under the same identification number. If you are a sole-proprietor, and have a federal employer identification number, use the employer identification number, not your social security number. Only sole proprietors with no employees are allowed to file under their social security number. Inquiries regarding your coupon booklets to pay withholding, corporate tentative, and Sub Chapter "S" estimated taxes, or to make changes to your name, address, or identification number, should be directed to the Business Master File Unit at (302) 577-8778.

1/12/12 - Sent to Site
FedEx 7979 4112 2129

INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102629 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 19

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 2LM2 5MN8#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
23207 DUPONT BLVD
GEORGETOWN DE 19947-2664

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 002

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

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OTHER IMPORTANT INFORMATION

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pd FedEx 7794100450 6

INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102632 DDRBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

ILN: 12 50050 15

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

2012

VALIDATED

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 5LM2 5MN1#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
620 BAYLOR BLVD
NEW CASTLE DE 19720-1140

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 005

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

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INTERNET SITE

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LICENSE NO. 2010102946 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

BLN: 12 50050 14

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 9LM2 5MN3#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
660 BAYLOR BLVD
NEW CASTLE DE 19720-1140

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 009

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

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FedEx 793110791225
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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102818 DORSL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

TIN: 12 50050 17

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 7LM2 5MN7#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
875 SMYRNA LANDING RD
SMYRNA DE 19977-9653

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 007

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

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OTHER IMPORTANT INFORMATION

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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102444 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 16

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 75.00

MAILING ADDRESS

BUSINESS LICENSE

BUSINESS LOCATION

#BWNKHPS
#15AK P0D0 1LM2 5MN0#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

CORRECT CARE SOLUTIONS LLC
1181 PADDOCK RD
SMYRNA DE 19977-9679

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 001

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102634 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 12

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 6LM2 5MN9#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
1301 E 12TH ST
WILMINGTON DE 19802-5315

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 006

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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REPLACEMENT LICENSES

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OTHER IMPORTANT INFORMATION

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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102945 DDRBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 50050 13

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 8LM2 5MN5#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
200 GREENBANK RD
WILMINGTON DE 19808-4760

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 008

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

LICENSE NO. 2010102631 DDRBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

BIN: 12 50050 11

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 01/05/12

VALIDATED

2012

LICENSE FEE: $ 25.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#15AK P0D0 4LM2 5MN4#
CORRECT CARE SOLUTIONS LLC
3343 PERIMETER HILL DR STE 300
NASHVILLE TN 37211-4147

BUSINESS LOCATION

CORRECT CARE SOLUTIONS LLC
38 TODDS LN
WILMINGTON DE 19802-3210

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 32009 2573 004

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

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INTERNET SITE

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