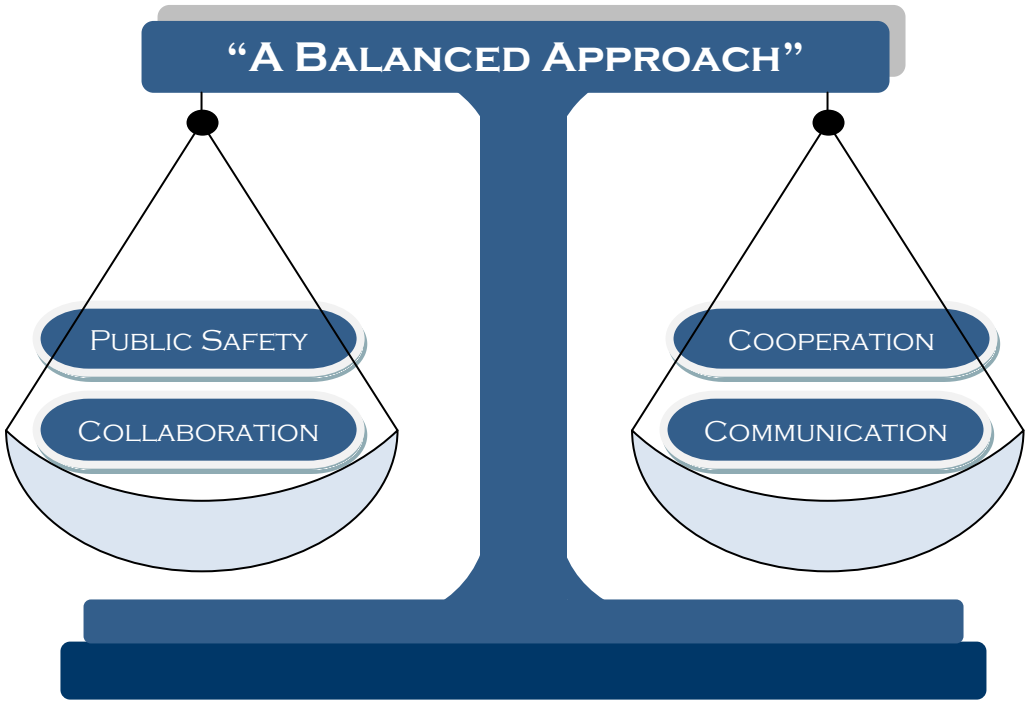
Department of Corrections

Community Corrections



Status Report

July 1, 2012 – June 30, 2013

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COMMONWEALTH of VIRGINIA

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This is a status report on the **Statewide Community Based Corrections System** as required by the 2013 Appropriations Act, Chapter 806, Item 385-A.

Prisoner Reentry services, expansion of Evidence Based Practices (EBP), and sex offender supervision and monitoring remain at the forefront of our activities. This year, however, has generated significant accomplishments including:

- Increased Sexually Violent Predator (SVP) conditional release supervision
- Ongoing partnerships to reduce outstanding absconder warrants and DNA samples
- Expanding use of an automated risk/needs assessment instrument (COMPAS)
- Continuing to increase the use of Evidence Based Practices (EBP)
- Increasing use of the Offender Management System (VirginiaCORIS)
- Recidivism rate for 2013 improved to 23.4%
- Expansion of the GPS Program has increased by 41% from the previous year
- Partnering with sentencing commission on immediate sanction program
- Expansion of VASAVOR program
- Expansion of the use of voice recognition telephonic monitoring for low risk cases in the community
- Update of Continuity of Operations Plans (COOP) for all units
- Continued use of the National Computerized Interstate Compact Offender Tracking System (ICOTS)
- Extensive collaboration with other agencies on the above issues

Workload continues to expand and we are confronted with offenders re-entering communities from prison with significant barriers to housing, jobs, and supportive services. Additionally, sex offenders, mentally disordered offenders, illegal aliens, and substance abusers require extensive and intensive services and monitoring.

Despite these major challenges, our central mission to "supervise and assist" offenders to live pro-socially and our fundamental **"Balanced Approach"** supervision principles have **not** changed.

We will continue to:

- Identify offenders' risks and needs and give priority to those offenders who pose the greatest risk to public safety
- Develop and implement supervision plans that address identified risks and needs
- Exhaust every available evidence based service to respond to individual needs to reduce the risk of recidivism
- Quickly and assertively respond to compliance and non-compliance with proportionate incentives and sanctions

We will continue our efforts to seek adequate resources, emphasize "Evidence Based Practices" in our services, focus on "value added" activities, collaborate with other agencies, reduce barriers, enhance our offender management system, and incorporate newly validated methods to achieve our mission.

When an offender's documented, habitual non-compliance or overt actions threaten public safety, we will act decisively exercising our arrest authority and advising the Court or Parole Board of recommended actions and sanctions.

Our work is important and vital to the public safety of the Commonwealth. We need to effectively manage caseloads while seeking to reduce recidivism.

Harold W. Clarke

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COMMUNITY CORRECTIONS

REFERRAL GUIDE – NON-RESIDENTIAL OPTIONS

State Probation and Parole

- Code Section 53.1-145
- Felons with suspended sentences to incarceration
- Placed on probation, parole, postrelease supervision or conditional pardon
- Available in all localities
- ***Services*:**
  - ⇒ Substance Abuse Screening and Assessment
  - ⇒ Case supervision
  - ⇒ Surveillance
  - ⇒ Home Visits
  - ⇒ Investigations
  - ⇒ Arrest Record Checks
  - ⇒ Urinalysis
  - ⇒ Referral to or direct provision of treatment services
  - ⇒ Capacity to transfer supervision to other localities or states

Intensive Supervision (ISP)

- Code Section 53.1-145
- Felons with violent or predatory sexual backgrounds
- Diversion, Detention, and Youthful Offender graduates
- Members of hate groups
- Offenders exhibiting delinquent behavior
- Accepted by local screening
- Limited caseload capacity
- Available in all jurisdictions
- ***Services***:
  - ⇒ Increased surveillance
  - ⇒ More frequent offender contacts
  - ⇒ Frequent record checks
  - ⇒ Urinalysis
  - ⇒ Referral to or provision of treatment services
  - ⇒ Capacity to transfer supervision to other states

Electronic Monitoring (EM)

- Code Section 53.1-131.2
- Same as ISP type offenders
- Must have stable residence
- Requires basic telephone service
- Home Electronic Monitoring (HEM)
- Voice Recognition (Self Reporting)
- Global Positioning by Satellite (GPS)
- Length of stay - up to 90 days is preferred
- ***Services*:**
  - ⇒ Computerized random checks and GPS tracking data
  - ⇒ Telephonic check-in
  - ⇒ Supplements and complements regular and intensive supervision services

Drug Treatment Courts

- Targets felon drug offenders
- Interactive with sentencing Judge
- Offenders must be non-violent with no mental health problems
- Intensive outpatient treatment
- Length of stay ranges from 12-24 months
- Ongoing judicial oversight
- Immediate and definite sanctions upon relapse or non-compliance with rules of programs
- Located in: Charlottesville, Chesapeake, Fredericksburg, Hampton, Henrico, Newport News, Norfolk, Portsmouth, Richmond, Roanoke, Suffolk, and Tazewell
- Conducted in partnership with localities
- ***Services***:
  - ⇒ Intensive supervision
  - ⇒ Continual drug testing
  - ⇒ Intensive substance abuse counseling
  - ⇒ Incentives for compliance
  - ⇒ System of sanctions

Note: Additional Courts require Supreme Court approval. Services reduced due to budget cuts.

COMMUNITY CORRECTIONS
REFERRAL GUIDE - RESIDENTIAL OPTIONS

Community Residential Program

- Code Section 53.1-179
- No pattern of violence
- Mentally and physically able to participate
- Requires greater substance abuse treatment intervention
- Lacks stable residence or needs transition from incarceration
- Must meet facility criteria
- Up to 162 contractual bed spaces in 8 facilities are funded
- Available statewide
- Length of stay - 90 days
- ***Services***:
  - ⇒ Food and Shelter
  - ⇒ Urinalysis
  - ⇒ Basic life skills
  - ⇒ Substance abuse education/treatment
  - ⇒ Individual/group counseling
  - ⇒ Job placement
- Facilities are located in: Charlottesville, Lebanon, Harrisonburg, Richmond, and Roanoke

Youthful Offender Program

- Code Section 19.2-311
- Chesapeake - *Men*
  Goochland - *Women*
- Available to all Courts
- Committed offense prior to Age 21
- Did not commit Class 1 Felony or assaultive misdemeanor
- Capable of being rehabilitated
- Evaluated locally and accepted by DOC prior to sentencing
- Four (4) year term plus suspended time
- Immediately parole eligible
- Term can be four (4) years plus revocation of suspended time upon violation
- Medium security with fence
- ***Services:***
  - ⇒ Remedial education
  - ⇒ Therapeutic Community
  - ⇒ Substance abuse education
  - ⇒ Life skills
  - ⇒ Military regimen
  - ⇒ AA/NA
  - ⇒ Vocational training
    - Auto mechanics/repair
    - Carpentry/plumbing
    - Printing
- Intensive Supervision for at least 1½ years upon release

Diversion Center Incarceration Program

- Code Section 19.2-316.3
- Non-violent felons as per Code Section 19.2-316.1
- *Women* -
  Chesterfield (80 beds)
- *Men* -
  Harrisonburg (108 beds)
  Stafford (104 beds)
  White Post (128 beds)
- Mentally/physically able to do activities of daily living and participate in rigorous activity(production work in private sector)
- Must be accepted by DOC prior to sentencing
- Must be a condition of probation or parole in lieu of incarceration
- Available to all Courts and Parole Board
- Length of stay – 24 weeks
- Minimum security
- ***Services***:
  - ⇒ GED Preparation and Testing
  - ⇒ Career Readiness Certification (CRC)
  - ⇒ Ready to Work
  - ⇒ Substance Abuse Education and Services
  - ⇒ AA and NA
  - ⇒ PREA
  - ⇒ ServSafe Certification
  - ⇒ Thinking for a Change
  - ⇒ Anger Management
  - ⇒ Employment in private sector
  - ⇒ Community Service Projects
  - ⇒ Home Plans
  - ⇒ Faith-based Volunteers
- Intensive Supervision upon release

Detention Center Incarceration Program

- Code Section 19.2-316.2
- Non-violent felons as per Code Section 19.2-316.1
- *Women* -
  Chesterfield (40 beds)
- *Men* -
  Appalachian (106 beds)
  Southampton (108 beds)
- Physically/mentally able to work
- Must be accepted prior to sentencing
- Must be a condition of probation or parole in lieu of incarceration
- Length of stay - 5 to 7 months
- Minimum security with fence
- Available to all Courts and Parole Board
- ***Services:***
  - ⇒ Military style regimen
  - ⇒ Remedial education
  - ⇒ Life skills
  - ⇒ Substance abuse education
  - ⇒ Work on public projects
- Intensive Supervision upon release

Critical Issues

The Department of Corrections (DOC) is engaged in organizational development to support long term public safety outcomes for offenders. The DOC, as with other correctional agencies across the nation, has been successful at creating public safety through incapacitation and other controls. External controls such as conditions of probation supervision only work as long as the control is in place. Once the external control is removed, offenders may revert back to criminal habits. To better improve long term public safety, the DOC is in the midst of strategic, adaptive organizational culture change, using evidence based practices to support offender change before release and while on probation supervision. Evidence based practices requires strategic use of offender risk and needs assessments, case supervision plans, motivational communication techniques and cognitive behavioral programming to support positive offender behavior change.

The VADOC has an impressive record of public safety. Among the 38 states that report felon recidivism as re-incarceration within three years of release, Virginia ranks as the 2nd lowest with a recidivism rate of 23.4%. Although Virginia can be proud of this rate, it also means that over the three year measured period, approximately 8,000 offenders recidivate, either because they have committed new crimes or because they have failed to comply with conditions of probation or parole supervision. This number represents new victims created, higher taxpayer costs associated with law enforcement and re-incarceration, and countless negative social impacts. The DOC must therefore continue to apply practices that are demonstrated by science to reduce recidivism.

As the DOC fulfills its mission, there are many challenges in community corrections. Key challenges also provide opportunities for continual improvement. Some of the challenges that are most significant for DOC are:

- Implementing evidence based practices in all operating units with fidelity
- Providing effective supervision with finite Probation and Parole Officer resources
- Growing and changing offender demographics including non-English speaking offenders
- Testing and treating drug and alcohol involved offenders
- Recruiting, training, and retaining top quality staff
- Using technology to best advantage
- Managing violent, sexual, high risk, and high needs offenders including security threat groups
- Developing transitional services for offenders re-entering communities
- Expanding the array of effective Evidence Based sentencing options and sanctions
- Increasing community awareness of and collaboration on public safety issues
- Evaluating and assessing programs and services to ensure effectiveness
- Promoting staff safety practices including critical incident management
- Measuring achievement and outcomes for continual process improvement

Public safety through risk control remains a top priority for the DOC, and DOC is also working to improve its organizational practices to create long term risk reduction through applying ever evolving correctional science.

Goals

The Department of Corrections has been reorganized to promote a unified approach to improving public safety with a new organizational structure that combines the former Division of Operations (prisons) and the former Division of Community Corrections into one unified division under the direction of the Chief of Corrections Operations. Dispensing with the separation of the former divisions and merging them into one operating unit provides for more efficient resource utilization, enhanced communication, and effective implementation of the Governor's initiatives.

The goals of the reorganization are:

1. To effectively implement of the Governor's Reentry Initiative.

2. To implement Evidenced Based Practices within community corrections and facilities with fidelity according to the research.

3. To create "oneness" in the organization that provides continuity of reentry services for offenders through the entire continuum of correctional supervision, from the first day of incarceration to the last day of community supervision and beyond.

4. To promote long term public safety goals by encouraging offenders to make positive changes towards law abiding behaviors; and by enabling staff to continually be challenged to learn and grow, to support each other and offenders, and to serve as positive role models for offenders.

5. Effective and efficient deployment of resources to effectively achieve public safety goals.

Evidence Based Practices in Action

Traditional correctional practice has focused on offender compliance with institutional rules and conditions of supervision. However, by embracing Evidence-Based Practice (EBP), the Virginia Department of Corrections (VADOC) is targeting those offenders who pose the greatest risk to public safety. The adoption of EBP – a system-wide change involving the realignment of business practices in accordance with rigorous scientific research – represents the Department's commitment to enhancing public safety, improving reentry services for offenders and better utilizing resources.

It is critical to implement Evidence Based Practices to achieve our goal of long term public safety through reducing criminal risk and recidivism, enhancing facility/supervision safety for staff and offenders and fostering a positive, learning culture. These targeted activities address the important concept that offender change is a critical factor that will create long term public safety when offenders are released from incarceration into their communities.

Evidence Based Practices (EBP) is utilized as a correctional strategy for decision making. This strategy is based on research findings regarding practices proven to be effective to change offender behavior. It is a strategic approach to organizational development, staff training, interaction with offenders, and treatment programming (which when done with fidelity to established models) will produce measurable and sustainable improvements in productivity and outcomes.

To facilitate the implementation and growth of EBP fidelity in prisons and community corrections we established a position to oversee statewide implementation, the Administrator of EBP Operations. Additionally statewide EBP Manager Positions were established to work with each probation district and prison to assist with implementation issues and help build staff skills.

In 2011, an EBP Steering Committee was established in community corrections to develop strategies to improve the fidelity of EBP practices. The committee was assisted by Dr. Faye Taxman from George Mason University, and developed a three year statewide implementation plan. Consistent with the EBP implementation plan, statewide policies and procedures were reviewed to ensure that they were consistent with the principles of EBP. Policies were modified as necessary to enable staff to engage in operational practices consistent with the science. In this same vein, the curricula at the VADOC Academy for Staff Development was reviewed to be sure that the lesson plans were consistent with current research. A result of this review process lead to the development of joint training sessions with Probation Officers and prison Counselors on subjects related to assessment and case planning.

The VADOC Research Department took action to establish comprehensive baseline measures of the community offender population so that outcome data could be established at desired intervals to reveal the efficacy of programming and supervision skills. Additionally, various dashboard reports are being created to provide the administration at each district a feedback loop to reveal trending in relevant practices. The Research Department is currently reviewing methods to enhance fidelity in many of the practices used in the field.

To ensure that all program vendors are providing services which are consistent with EBP, our Procurement Office has developed contracts which contain specific EBP language in each agreement with outside service providers. Additionally, fidelity audits have been conducted by VADOC staff of substance abuse and sex offender service providers.

To implement EBP in the District Offices we continued to change the culture. To begin, each staff member was surveyed to receive feedback on areas such as readiness for change, beliefs about crime and punishment, cynicism and basic EBP knowledge. Roughly, seventy percent of the staff responded and provided a clear perspective of the knowledge and beliefs of our Probation Officers and Administration.

The work with the early pilot sites taught us that it was critical for the Chiefs and Deputy Chiefs to thoroughly understand the science behind EBP if there was to be significant implantation in the units. To address this, we contracted with Ray Ferns of Restorative Correctional Services to provide a five day intensive training for Chiefs and Deputy Chiefs. During these sessions District administrators began looking closely at their units to identify where changes were needed to improve outcomes. The results from their district surveys were provided during these sessions so they could begin the process of developing EBP Implementation Plans for each District. Currently over seventy-five percent of Districts have completed a specific plan of EBP implementation.

Sound intervention skills are critical if an agency is seeking to improve offender outcomes. A review of national researchers and service providers lead us to Dr. Christopher Lowenkamp, the proprietor of Core Correctional Solutions. Dr. Lowenkamp, formerly of the University of Cincinnati and the Administrative Office of the Federal Court, developed an intervention strategy (EPICS) which combines effective communication skills with cognitive behavioral techniques that can be used by Probation Officers. The research associated with this strategy is results oriented and is supportive of the department's goal to implement more cognitive behavioral programming. In February 2013, Dr. Lowenkamp gave a day long presentation to all of the Chiefs in the state and all DOC administrative staff. In April, sixty staff members from the various districts began training to support a through rollout of this intervention strategy to the field. By January 2014, we will have developed sixty coaches, twenty-five trainers and roughly one third of our probation staff will have been trained in this critical intervention skill. This ensures sufficient internal capacity to carry on EPICS training as a long term department initiative.

Learning Teams are another critical strategy the department is utilizing in order to sustain change. The EBP Managers have developed guidelines for Learning Team sessions and for the Subject Matter Specialist (SMS) leading these sessions. Additionally, regular training sessions are held to enable SMS's to practice skills necessary to lead change within their Learning Teams.

The next step is to focus intensively on developing the coaching skills of our Deputy Chiefs and Senior Officers. We will train these critical mid-managers in Effective Offender Communication Skills, Case Planning and Assessment and prepare them to give coaching feedback to their assigned Probation Officers. This is a shift from the previous practice of case reviews without consistent feedback and enhances staff development and effective communication.

Sustaining EBP with fidelity and consistency will be a challenging yet worthwhile journey for the Department of Corrections. We are encouraged by the preliminary results showing the positive impact of EBP on successful case closing and reduced revocation rates. The Department is excited to meet its goal of reducing recidivism, cutting correctional costs, providing effective treatment to offenders and enhancing public safety.

Department of Corrections
Division of Community Corrections
FY 2013
State Funds

Program/Services	Probationers	Post Releases / Parolees	Total	Inmates	Operating Plan
Community Corrections Workload	54,900	2,265	57,165	0	$ 67,244,946
Electronic Monitoring (EM)	Districts	Districts	Districts	0	$ 3,619,879
436 GPS Units	Districts	Districts	Districts	0	See EM Total
12,043 Voice Recognition	Districts	Districts	Districts	0	See EM Total
0 Home Electronic Units	Districts	Districts	Districts	0	See EM Total
8 Community Residential Programs	14	130	144	0	$ 1,963,556
1 Diversion Center (Women)	47	0	47	0	See Men's Total
3 Diversion Centers (Men)	274	0	274	0	$ 10,864,163
1 Detention Center (Women)	49	0	49	0	See Men's Total
2 Detention Centers (Men)	209	0	209	0	$ 5,819,219

OUT-OF-STATE INTERSTATE COMPACT	**5,496**	**362**	**5,858**	**0**	**See Districts Total**

FIELD OFFICERS (Filled FTE)	**Senior Officers: 93**	**Officers: 606**	**Surveillance Officers: 60**	**Total: 759**

Treatment Services

The Division of Community Corrections privatizes many specialized services. This effort makes evidence-based services and licensed service providers more readily available across the state. Further, it supports the Governor's initiatives of increased privatization and use of women and minority vendors.

In FY2013, the Division of Community Corrections allocated the amounts (state funds) below for alcohol and other drug abuse services, sex offender assessment, treatment, polygraph, and a variety of non-residential and residential treatment services.

Alcohol and Other Drug Abuse Services	**Operating Plan**
• Residential and Non-Residential General Funds	$ 2,920,203
• Urinalysis and Oral Fluid Testing	$ 468,000
Sex Offender Services	
• Assessment and Treatment	$ 1,367,100
• Polygraph	$ 299,600
Community Residential Programs	
	$ 1,963,556
Virginia Serious and Violent Offender Reentry Initiative	
	$ 579,900

Alcohol and Other Drug Services Continuum

SERVICES	PROGRAM COMPONENTS	OUTPUTS (OBJECTIVES)	OUTCOMES (GOALS)
Orientation – Introduction to group process and AOD services available. Use of COMPAS (Correctional Offender Management Profiling for Alternative Sanctions)risk/need assessment for treatment planning	**Available services/interventions in the Department, Program, Facility or Community and service delivery procedures. Programming adheres to the principles and standards of EBP (Evidence-Based Practices)**	**By utilizing MI (motivational Interviewing), participant must recognize the need for treatment. Screening and Assessment process assists person to become cognizant of substance abuse issues, the services available, and how to access these services.**	**Individual should be willing to participate in cognitive -behavioral interventions and/or treatment. Treatment goals should be achievable, time focused and easily measured. Begin to focus on making cognitive-behavioral change and develop pro-social behaviors.**
Motivational Enhancement Group – An exploration of the stages of change, the definition and development of substance abuse and addiction, the process of cognitive restructuring and cognitive skills building, abstinence, and recovery. **Minimum one and one-half (1½) hours per session for a total of thirteen (13) sessions.** **Note: A minimum of 8 to a maximum of 15 participants, < or > must be approved by Unit Head.**	**1. Introduction to the stages of change and cognitive behavioral intervention** **2. The disease model of chemical dependence** **3. The effects of addiction and AOD abuse** **4. The impact of AOD abuse and addiction on others** **5. AOD use and the relationship to criminal thinking and behavior** **6. Identify distorted thinking, beliefs, attitudes, feelings, and restructure to augment behavioral change** **7. Defense Mechanisms** **8. 12-Step/Peer Support** **9. Maintaining Abstinence** **10. STD/HIV Prevention** **11. Relapse Prevention** **12. Role Play, Thinking Reports, Journaling** **13. Discharge/Action Plan**	**Improve the participant's level of functioning, replace previously held myths and reduce the level of denial. Enhance motivation for change by enhancing self efficacy and creating cognitive dissonance.** **Demonstrate the negative impact of substance abuse, increase the participant's knowledge of addiction and need for abstinence by guiding the individual through the stages of change process.**	**Participate to successfully achieve established goals in the required time frame outlined in the individualized treatment plan.** **Initiate abstinence and/or recovery and/or participate in continued treatment. Individual to utilize learned cognitive skills to model pro-social behavior and reduce or eliminate AOD use and maladaptive behaviors.**
Outpatient Group Counseling – Managing the abstinence/recovery process. Indeterminate duration based on meeting treatment plan goals. **Generally one 1½ hour session/week for 16 weeks.** **Recommended group size 8-12.** **Note: A minimum of 8 to a maximum of 15 participants, < or > must be approved by Unit Head.**	**Conduct COMPAS and risk/needs assessment to aid in developing treatment plan. The individual will participate in an acceptable cognitive-behavioral model. Utilization of graduated incentives and sanctions as appropriate.** **Further cognitive restructuring and development of coping skills.**	**Participant plays an active role in the treatment planning process. Demonstrate progress toward achieving the individualized objectives of the treatment plan. The treatment plan shall include requirements to complete treatment, incentives and possible sanctions for failure to comply with the treatment plan.** **To have a viable relapse prevention plan in place upon discharge.**	**Participant to successfully achieve established goals in the required time frame identified in the individualized treatment plan. Demonstrate an ability to use cognitive restructuring, adaptive coping skills, and problem solving skills through thinking reports and role play. Maintain abstinence, be cognizant of issues relating to addiction and relapse, learn how family members are affected by addiction, become familiar with self-help, peer support, and agree to follow discharge plan.**
Intensive Outpatient Counseling (IOP) – process groups and/or individual counseling sessions. Referrals made for individuals requiring more intensive intervention than outpatient counseling. **Minimum of nine (9) hours of intervention per week for a minimum of twenty (20) weeks to include process groups and individual counseling as deemed clinically appropriate.** **Recommended group size is 12 participants.** **Note: A minimum of 8 to a maximum of 15 participants, < or > must be approved by Unit Head.**	**Conduct COMPAS and risk/needs assessment to aid in developing treatment plan.** **The individual will participate in an acceptable cognitive-behavioral model. Utilization of graduated incentives and sanctions as appropriate.** **Continued cognitive restructuring and enhanced development of coping skills.** **Matrix Model an Intensive Outpatient substance abuse treatment modality is integrated in the intensive reentry programs and several probation districts.**	**Participant plays an active role in the treatment planning process. Demonstrate progress toward achieving the individualized objectives of the treatment plan.** **The goal of Intensive Outpatient Counseling is to assist the offender in developing an action plan for continued abstinence and the successful completion of individual treatment goals and objectives.** **To have a viable relapse prevention plan in place upon discharge.**	**Participant to successfully achieve established goals in the required time frame identified in the individualized treatment plan. Demonstrate an ability to use cognitive restructuring, adaptive coping skills, and problem solving skills through thinking reports and role play. Maintain abstinence, be cognizant of issues relating to addiction and relapse, learn how family members are affected by addiction, become familiar with self-help, peer support, and agree to follow discharge plan.**

SERVICES	PROGRAM COMPONENTS	OUTPUTS (OBJECTIVES)	OUTCOMES (GOALS)
Family Education Group - Minimum one (1) session per week; minimum one and one-half (1 ½) hours per session for a total of twelve (12) weekly sessions. All offenders and identified family members are expected to attend the group sessions for twelve (12). Recommended group size is sixteen (16) participants. The group shall consist of both offenders and their family members. Group size shall not exceed twenty (20) participants.	**Designed to assist the offenders and their family members to be interactive and to discuss substance abuse issues related to both offenders and their family members.** **Introduction to addiction, family disease, treatment, recovery and the ensuing interpersonal dynamics.**	**Teach offenders and families to understand how the recovery process can affect relationships.** **Teach, promote and develop the basics of healthy offender/family relationships.**	**Provide offenders and family members a positive group experience with other recovering offenders and their families.** **Provide information about community resources available to offenders and their families to augment the recovery process.**
Social – Detoxification	**24-hour staff monitored non-medical detoxification. Integrate motivational enhancement, individual and/or group therapy. Case management provided and referral to medical detoxification if deemed necessary.**	**3-7 days of safe withdrawal through ongoing triage, evaluation; referral to further treatment and support.**	**Stabilize and maintain abstinence and agree to follow discharge plan. Participants shall pursue additional treatment and recovery resources and/or interventions.**
Medical – Detoxification	**24-hour staff monitored and supervised by medical/mental health care professionals. Medications to ease withdrawal are used.**	**3-7 days of medically supervised withdrawal through ongoing triage, evaluation; referral to further treatment and support.**	**Stabilize and eliminate acute withdrawal symptoms. Maintain abstinence and agree to follow discharge plan. Participants shall pursue further treatment and recovery referrals and/or interventions.**
Residential Treatment – On Site Primary Care. Length of stay based upon severity of AOD use and completing treatment plan goals.	**24-hour supervised treatment, group and individual counseling, vocational services, transition services, intensive AOD treatment, discharge planning, continuing care plan, and case management.**	**A minimum of 28 days up to 180 days contingent upon severity of AOD use in a therapeutic setting to encourage long term abstinence and recovery.**	**Participant to successfully achieve established goals in the required time frame identified in the individualized treatment plan. Participants willing to commit to discharge/aftercare and recovery plan.**
Recovery/Transitional/Halfway House Placement – Length of stay based upon meeting treatment plan goals of continued abstinence and recovery.	**24-hour monitoring, group therapy and individual counseling, 12-step, vocational, occupational educational services and peer recovery support. Discharge planning, continuing care plan, and case management.**	**2-9 months of stabilization and rehabilitation focused on continuing abstinence and long term recovery, obtaining employment and employment retention.**	**Participant to successfully achieve established goals in the required time frame. Participants willing to commit to continuing care, long term abstinence, and recovery plan.**
Peer Support Recovery Groups and Centers – available as an ancillary component of AOD services and are available post-release as a support and maintenance program. Participants are typically assigned a recovery coach or mentor to aid in their recovery from AOD use.	**Groups and Centers led by persons in recovery. Includes personal sharing, problem solving, group planning, social support to motivate ongoing behavioral change, and helping self by giving back to the community while using recovery tools.**	**Support Re-entry from the therapeutic community into society utilizing therapeutic community (TC) tools.** **Recovery coaches and mentors are utilized in the community to assist participants in their recovery and reintegration.**	**Incorporate pro-social behavior and long term recovery while living independently. Integrate and implement cognitive restructuring, adaptive coping skills, and problem solving skills on a daily basis.**
Relapse Prevention/ Continuing Care – **Minimum one (1) session/week; minimum 1½ hours per session for a total of 14 - 24 sessions.** **Recommended group size is fifteen (15) participants.**	**COMPAS risk/needs re-assessment completed.** **A cognitive-behavioral group for persons who have completed an AOD treatment program or have relapsed. Indentify relapse triggers and appropriate action plan.** **Continued cognitive restructuring and utilization of coping skills.** **Skill sets to avoid high-risk situations are regularly practiced through use of role play.**	**Remain abstinent, maintain positive peer associations, and develop an individual relapse prevention plan which integrates adaptive coping strategies and problem solving skills.** **Augment the use of cognitive behavioral based strategies to assist in identifying high-risk situations to use drugs and opportunities to develop and rehearse a positive means to cope with and manage potential high-risk situations.**	**The goal of Relapse Prevention/Aftercare is to teach and reinforce to the participant skills necessary to maintain abstinence from AOD, model pro-social behaviors, and establish long term recovery. Participants incorporate relapse prevention plan.**
Drug/Alcohol Testing	**Unannounced, random sampling throughout Continuum. Frequency determined by risk of use**	**Identify substance and/or drug of choice, deter use, encourage abstinence from AOD.**	**Maintain abstinence from AOD.**

NATIONAL INSTITUTE ON DRUG ABUSE TREATMENT PRINCIPLES

1. No single treatment works for all.
2. Treatment needs to be readily available.
3. Treatment plans must address multiple needs.
4. Treatment plans should be continually re-assessed.
5. Remain in treatment for an adequate time.
6. Medical (or social) detoxification is a first step only.
7. Group and individual counseling are critical components.
8. Medication coupled with counseling may be needed.
9. Dual diagnosed people need integrated treatment.
10. Treatment does not need to be voluntary.
11. Drug/alcohol use must be continually monitored.
12. Treatment should address infectious diseases.
13. Recovery from addiction is a long-term process often with multiple treatment episodes.

8/13

Community Corrections Facilities

The Diversion Center and Detention Center Incarceration Programs were established as a part of the "abolition of parole" legislative package in 1994. These programs were designed to offer Circuit Court judges an alternative incarceration option for non-violent felony offenders, at both initial sentencing and revocation proceedings. The Parole Board was later authorized to refer parole and post-release violators.

In FY2008, both programs extended their programs from **five (5)** to **seven (7)** month residential stay with intensive substance abuse education, life skills, and community service work. The Detention Centers have a military regimen as well. The Department of Correctional Education provides basic education and transition preparation services. The DOC Division of Operations provides health and mental health services.

In late FY2009, **four (4)** Diversion Centers and **three (3)** Detention Centers were left after budget reductions. The Chatham Diversion and White Post Detention Centers were closed. The Richmond Women's Detention Center was co-located with Chesterfield Women's Diversion Center with a net loss of **forty (40)** diversion beds.

The Centers had these results in FY2013:

- ***Capacity* – 764**
- ***Census* – 590 (6/30/13)**
- ***Admissions* – 1,377**
- ***Terminations* – 222**
- ***Graduations* – 1,201**
- ***Community Service Hours* – 157,389.1**
- ***General Education Diplomas* – 33**

Program and service enhancements were made with cognitive communities initiated at the White Post Men's Diversion Center, the Chesterfield Women's Detention and Diversion Centers. The Harrisonburg Men's Diversion Center safely continued its project to serve participants on anti-depressant medications and began use of the computerized COMPAS Risk and Needs Assessment.

Community Corrections Facility Eligibility Criteria

5-2.7 ELIGIBILITY DETERMINATION

The facilities shall receive and evaluate all referrals to the Detention Center and Diversion Center Incarceration Programs. The facility staff shall determine eligibility and suitability for each program based on established criteria and facility capabilities. Each facility should provide each District Probation and Parole Office with a copy of any specific facility criterion to ensure appropriate assignments are made. Facility staff shall make notification of acceptance/rejection and tentative facility admission date to the referring District.

See Code of Virginia Sections 19.2-316.2, 19.2-316.3, 53.1-67.7, and 53.1-67.8

Community Corrections Facilities Eligibility Criteria

In general, eligibility criteria for evaluation and intake are governed by the items below:

- Must be authorized by Circuit Courts and/or the Virginia Parole Board.
- Cannot be in addition to felony incarceration greater than 12 months.
- Must not be a violent felon offender as defined by Code Section 19.2-316.1.
- Must have no self-injury or suicidal attempts within the past 12 months.
- Potential program participants currently taking **or** who have been medically approved to stop taking prescribed mental health medications within 60 days of referral or intake will be assessed on a case-by-case basis.
- Must be physically stable, not require daily nursing care, and be able to perform the activities of daily living and program requirements.

General Medical and Mental Health Questions

- What is the diagnosed malady?
- What is the commonly accepted or prescribed treatment regimen?
- Can a person with this malady who follows the treatment regimen successfully participate in required Program activities?
- What follow up care is likely to be required?

6-30-13

Sex Offender Supervision

Sex offender supervision continues to employ an enhanced supervision model for all sex offenders in the Commonwealth. A team approach is used and the team is most often comprised of a Senior Probation and Parole Officer, a Sex Offender Supervision Probation and Parole Officer, and a Surveillance Officer. All 43 probation and parole districts have incorporated the Sex Offender Supervision Practices Manual into their programs, and are active participants in the updates to that manual.

The FY2013 budget included 16 additional sex offender supervision specialist positions. Experts in the field recommend a sex offender specialist staffing ratio of 40 to 1 in order to appropriately address public safety needs. These additional positions helped move districts toward the staffing ratio. Fifteen of the positions were deployed to the field and a Sex Offender Program Coordinator position was created to manage the ever increasing demands of Global Positioning Systems (GPS).

The Code of Virginia mandates that any offender convicted of Failure to Register on or after July 1, 2006 be placed on GPS. The department has experienced steady growth in this area and at the end of June 2013 had averaged 436 on-leg units. This marks a 41% increase from on-leg units in June of 2012.

In February 2013, the Department contracted with Dr. Robin Wilson to train specialists on the scoring and use of the STABLE-2007 and the ACUTE-2007. These two instruments are sex offender risk assessments designed to be used and scored by community supervision officers. Approximately 200 officers were trained and 4 Department staff were trained as trainers, thus ensuring sustainability. Specialists began using these risk assessment tools in May. Since the original training, an additional 26 officers have been trained, along with 8 community sex offender treatment providers.

There are **18** contracts statewide providing sex offender assessment and treatment and **11** vendors providing polygraph services. A total of **$1,666,600.00** was allocated for assessment, treatment, and polygraph in all Districts. This figure does not incorporate the co-payment that was implemented for these services in FY2008.

The Sexually Violent Predator (SVP) civil commitment process continues to grow. The impact of this growth is felt by Community Corrections when these SVP's are granted conditional release. The number currently being supervised under conditional release is **100**, which is an increase of approximately **28%** from FY2012. Of that number, **33** are "pure" conditional release, meaning that they have no criminal obligation. This continues to be a high risk and high demand type of case. By statute, these cases are monitored by global positioning systems (GPS) and have demanding conditional release plans that involve collaboration with the Office of the Attorney General and the Department of Behavioral Health and Developmental Services.

Sex offenders are among the most demanding cases under supervision. The sex offender specialist staff must monitor offender behavior, verify and modify living arrangements as needed, work closely with sex offender treatment providers and polygraph examiners, and cope with victim trauma. There have been a number of legislative and procedural changes over the years that have resulted in increased demands on an Officer's case management duties. These

would include such things as GPS, SVP cases, and the Sex Offender Verification System (SOV). Training efforts are geared toward keeping the Officer up-to-date on legislative changes, technology and evidence based supervision and treatment practices. The supervision of sexual offenders is constantly evolving and Officers need to be exposed to the most current research and training.

Currently, there are about **3,529** adult probation and parole offenders who are required to register on the Sex Offender and Crimes Against Minors Registry. The Department of Corrections continues to be proactive in their supervision and monitoring of this difficult population. Probation and Parole Officers and the Virginia State Police frequently collaborate in their efforts to ensure these offenders are properly registered with the Sex Offender and Crimes Against Minors Registry.

Supervising Sex Offenders

LARGE POPULATION

- About 20,157 persons on Sex Offender and Crimes Against Minors Registry.
- About 3,529 are under Probation and Parole supervision.
- About 57,165 other felons are under Probation and Parole supervision.

SUPERVISION AND MONITORING ARE LABOR INTENSIVE

- All eligible sex offenders are registered at intake and prior to release from DOC institutions.
- Victims who request notification about sex offenders leaving prison are notified.
- Eligible sex offender registrants are monitored to determine if they have registered.
- Registry requirements are posted in District public areas.
- Department of State Police is assisted in their investigations of alleged non-registrants.
- Global Positioning by Satellite (GPS) is underway. GPS requires active staff follow-up to alerts. Voice recognition monitoring (AnyTrax) is used for selected cases.
- All active sex offenders are initially assigned to Intensive Supervision with special instructions imposed to address specific behaviors.
- Probation and Parole Districts maintain photo albums of sex offenders.

TREATMENT CAN REDUCE RISKS

- The Sex Offender Residential Treatment (SORT) Program at the Greensville Correctional Center has **86** beds. Under the clinical supervision of the Sex Offender Program Director, **16** institutions across the Commonwealth (including a female facility) offer various levels of sex offender treatment.
- Regional Peer Supervision groups including Community Corrections staff, qualified Sex Offender Treatment providers, and polygraphers meet periodically to discuss effective treatment, supervision, and monitoring practices.

Mental Health Services

In FY2012, 2155 offenders (approximately 19% of the total discharges) with mental health impairment (not including those with only substance abuse disorders) were discharged from the institutions. The overwhelming majority were released to probation or parole supervision under Community Corrections.

The Community Corrections Mental Health Services is comprised of the Mental Health Clinical Supervisor, 3 Regional (Central, Eastern, Western) Mental Health Clinicians, and a Psychology Associate Senior at Chesterfield Women's Detention and Diversion Center (CWDDC). Additional mental health support is provided by Mental Health Specialists located in the Richmond, Norfolk, and Roanoke District offices, a Clinical Counselor at Southampton Detention Center, and a Mental Health Trainer at the Academy for Staff Development.

The specific plan for Community Corrections mental health professionals is to serve as mental health and sex offender services liaison between the facility and field operations. They provide mental health services to offenders, including crisis intervention, screening, psychological assessment and evaluation, individual and brief supportive therapy, treatment planning, re-entry planning, and supervision recommendations in addition to training clinical and non-clinical staff.

To that end, the Community Corrections Regional Mental Health Clinicians and Psychology Associate Senior at CWDDC provided the following services in FY2012:

• Mental Health Discharge Summary Reviews/Discharge Planning	505
• Mental Health Consultations (case management, referrals, etc)	710
• Individual Therapy	533
• Groups	130
• Crisis Intervention	50
• CSB Contacts and Meetings	196
• Prison, Jail, Hospital, DJJ Visits and Other Staffing	195
• Sex Offender Services (Committees, Meetings, Intakes, etc)	90
• Conduct Trainings and Provide Clinical Supervision	131
• Psychological Assessments	5
• Court Hearings	6

Additional services included representing on committees, meeting with private mental health providers, and making connections in the community. Mental Health Services were provided specifically in Norfolk, Richmond, and Roanoke by the Mental Health Specialists, at Southampton Detention Center by the Clinical Counselor and by the Mental Health Clinical Supervisor across various Districts.

The Correctional Mental Health Screen (CMHS) was implemented across all Districts and Detention and Diversion Centers to screen the mental health status of offenders placed on probation supervision directly from jail or court.

Virginia Prisoner Reentry Policy Academy

A cornerstone of Governor Robert F. McDonnell's public safety initiative is to reduce victimization, improve outcomes for offenders returning to their communities, and impact recidivism favorably by strengthening the Commonwealth's prisoner re-entry program. On May 11, 2010, the Governor signed Executive Order Number Eleven establishing the ***Virginia Prisoner and Juvenile Offender Re-entry Council*** and tasked the members with developing collaborative re-entry strategies. Under the leadership of Secretary of Public Safety, Marla Decker, and Deputy Secretary of Public Safety, Banci Tewolde, the Virginia Prisoner and Juvenile Offender Re-entry Council has connected the re-entry initiative between state agencies, local agencies, and community organizations. The Council has been charged specifically by Executive Order Number Eleven with:

- Identifying re-entry barriers and developing methods to address them;
- Improving collaboration and coordination of re-entry transition services;
- Establishing partnerships to promote jobs;
- Promoting re-entry strategies for juveniles and adults;
- Submitting a report of re-entry actions to the Governor; and
- Participating in the development of the state re-entry strategic plan.

As of May 2013, **37,131** state responsible offenders were incarcerated in the Virginia Department of Corrections (VADOC) prisons or local jails, and **57,165** offenders were supervised by VADOC in the community on probation or parole. This fiscal year (FY13), **31%** of incarcerated felons – **11,661** state responsible offenders – completed their sentences and returned to local communities from state prisons and jails. Of the offenders released in FY2013, **9,826 (84%)** offenders were released with probation or post release supervision obligations, **1,081 (9%)** offenders were directly released with no supervision, **392 (2%)** offenders were released on mandatory parole, and **233 (2%)** offenders were released on discretionary parole

In keeping with the Governor's initiative, and building on accomplishments already achieved, the VADOC rolled out the Virginia Adult Re-entry Initiative (VARI) on November 1, 2010. Under the leadership of the Director of Corrections, Harold W. Clarke, the VARI strategic plan introduces fundamental changes to the current VADOC re-entry programs, and provides a comprehensive unified strategic effort to prevent crime, minimize victimization and improve communities and public safety in the Commonwealth.

Plans continue to produce VARI phase two within the next four years.

DEPARTMENT OF CORRECTIONS

"Preparing Offenders for Release"

Institution-Based Programming

• Anger Management	• Rational/Emotive Therapies	• Agribusiness Work Opportunities
• Productive Citizenship	• Cognitive Behavioral (Thinking for a Change)	• Correctional Enterprises Work Opportunities
• Substance Abuse (Therapeutic Communities, Educational)	• Parenting/Healthy Relationships	• Volunteer/Mentoring Services
• Collaboration with Pre/Post Incarceration Services	• Sex Offender Residential Treatment (SORT)	• Religious Services
• DSS Community Re-entry Initiative	• Educational and Vocational Services	• Capital Construction Work Opportunities
• Offender Release Community Re-entry Specialists (10)	• Cognitive Communities	• Highway Labor
	– Intensive Reentry Programs	

Community-Based Programming

• **Virginia Serious and Violent Offender Reentry (VASAVOR)**	• **Community Re-entry Programs**
– Serious, Violent Offenders	– Local collaboration committees
– Home plan in Fairfax County	– Linkage to designated institutions
– Classified to Fairfax Jail	– Led by the Department of Social Services
– Home plan in Newport News	– Thinking for a Change Peer Support Group
– Classified to Newport News Jail	– HIDTA Substance Abuse Treatment Grant Program
– Substance Abuse and Mental Health Services	
– Residential Services	• **Community Residential Programs (CRP)**
– Technological Monitoring and Urinalysis	– Stable, healthy offenders. Some violent or sex offenders are eligible.
– Job Placement Services	– Probation & Parole Supervision
– Followed by Probation & Parole Supervision	– Contract Residential Facilities
	1. Alexandria 5. Lebanon (Russell County)
• **Jail Contract Work Release Beds**	2. Charlottesville 6. Richmond City (2)
– Within 12 months of Release	3. Hampton 7. Roanoke
– 350-bed capacity	4. Harrisonburg
– Contracts with local and regional jails	– 3 to 6 months length of stay
– Coordinated by Classification	– Job Placement Services
– Generally followed by Probation & Parole Supervision	– Urinalysis

Interstate Compact for Adult Offender Supervision

On June 30, 2013, there were **5,858** Virginia offenders under supervision in other states via the Interstate Compact for Adult Offender Supervision and **2,293** out-of-state cases under supervision in Virginia. Virginia currently ranks among the top five states in volume of transfers.

Since 1937, the Interstate Compact for the Supervision of Parolees and Probationers provided the sole statutory authority for regulating the transfer of adult parole and probation supervision across state boundaries. All 50 states are members of this interstate agreement, as are the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

In 1998, the National Institute of Corrections (NIC) Advisory Board directed its staff to begin pursuing a revision of the compact. Through a partnership with The Council of State Governments (CSG), NIC and CSG developed and facilitated a Drafting Team of state officials to design a revised interstate compact – one that would include a modern administrative structure, that provided for rule-making and rule-changing over time, that required the development of a modern data collection and information sharing system among the states, and one that was adequately funded to carry out its tasks.

The new Compact was enacted in June 2002 with 35 member states. In 2004, Virginia joined the Compact when Governor Mark Warner signed the Interstate Compact for Adult Offender Supervision (ICAOS) into law as approved by General Assembly.

The rules of the Compact have the force and effect of federal law and are enforceable in the federal courts. Accordingly, the demands and liability for non-compliance are significant. The "Interstate Compact Bench Book for Judges and Court Personnel" is available on the ICAOS website at www.interstatecompact.org.

The Compact established a Commission comprised of representatives from each state and a national office comprised of full-time staff. The Interstate Commission oversees the day-to-day oversight of the compact between the states. It promulgates rules to achieve the goals of the compact, ensures an opportunity for input and timely notice to victims and to jurisdictions where defined offenders are authorized to travel or to relocate across state lines and established a system of uniform data collection, provides access to information on active cases by authorized criminal justice officials, and coordinates regular reporting of Compact activities to heads of state councils, state executive, judicial, and legislative branches and criminal justice administrators. The Commission monitors compliance with the rules governing interstate movement of offenders, initiates interventions to address and correct noncompliance, and coordinates training and education regarding regulations of interstate movement of offenders.

The Compact also required the establishment of a state council that includes members of the executive, legislative and judicial branches of government, a representative of crime victims, and the Compact Administrator. Virginia's Council members are James Parks, Director, Offender Management Services, Virginia Department of Corrections, who serves as the Compact Administrator/Commissioner; Brian Swann, Sr., Deputy Secretary of Public Safety; Robert Tavenner, Director, Division of Legislative Services; The Honorable Lee A. Harris, Jr., Judge, Henrico Circuit Court; and Shelly Shuman-Johnson, Director, Henrico Victim/Witness Program.

A web-based Interstate Compact Offender Tracking System (ICOTS) was introduced for use by all the member jurisdictions in 2008. This has enabled the computerized transfer of cases and supporting documentation. Substantial oversight, field training, and technical assistance continues to be provided by the Virginia Interstate Compact Office of the Virginia Department of Corrections.

Operations Extradition/Fugitive Services Unit

The Operations Extradition/Fugitive Services Unit is comprised of a Unit Manager (Major), a Captain and seven (7) Lieutenants. This unit is responsible for locating and apprehending offenders who have absconded or are wanted by the Department of Corrections. Additionally, one Lieutenant is assigned development and implementation of the Continuity of Operations Plans (COOP) for the entire agency.

FY2013 accomplishments for this unit include:

- 463 persons wanted by this agency were arrested clearing 835 warrants.
- This unit also assisted local, state, and federal law enforcement agencies in the arrest of 551 fugitives clearing 1,388 outstanding warrants in the process.
- This unit was contacted by local, state, and federal law enforcement agencies asking for informational assistance 2,105 times.
- For FY2013 this unit successfully completed 163 out of state extraditions without incident.
- For FY2013 this unit completed over 6,177 case transfers in VirginiaCORIS.
- As one unit responsible for the entire state, this unit assigned staff the responsibility of overseeing each district ensuring that the needs of the Probation and Parole Districts are met.
- Assisted the Academy for Staff Development by supplying adjunct instructions when requested.
- Completed updates to the COOP.
- Since the reorganization of the department, this unit doubled in size and it was determined additional office space was needed in order to carry out the mission. We were able to remodel a vacant house owned by the agency allowing the unit to have the space and privacy needed to carryout sensitive investigations.

Division of Education

As a part of the Governor's Reform and Restructuring Plan for state government, the Department of Correctional Education's adult programs have been consolidated with the Department of Corrections. This consolidation was finalized on July 1, 2012. This partnership provides seamless educational, Career & Technical Education (CTE), and transitional services to adult offenders based on the combined education and re-entry efforts of the Department.

Educational Services prepare adults for success after incarceration. Academic and CTE training are means to an end – the development of basic academic skills necessary to function in society, the pursuit of higher education, and employment upon release. The agency strives to provide quality educational programs that enable incarcerated adults to become responsible, productive, tax-paying members of their communities.

Educational programs are offered statewide in:

- Diversion Centers
- Detention Centers
- Reception Centers
- Adult Correctional Centers
- Adult Correctional Field Units

Education programs are geared toward helping individuals realize their potential and become productive members of society. The public benefits from the educational programs provided to offenders because productive and taxpaying citizens make positive contributions to society and, most importantly, do not create victims through criminal acts.

Adult Programs:

- Adult Basic Education (ABE)
- General Educational Development (GED)©
- Special Education
- Apprenticeship Programs
- Library Services
- Career and Technical Education
- Career Readiness Certificates
- Job/Employability Skills Training
- Comprehensive Adult Student Assessment System CASAS
- Plaza Communitaria, (Alfabetización, Primaria, Secondaria, and Bachilleres)
- Post Secondary

In FY2013 the academic programs in major institutions averaged 1,220 hours of instruction and the CTE programs in the major institutions averaged 1,155 hours of instruction. The Academic programs in the Correctional Field Units averaged 522 hours of instruction and the three CTE programs averaged 885 hours of instruction for fiscal year 2012. In fiscal year 2012 the education programs had the following overall enrollments and completions:

Program	Enrollments	Completions
Academic ABE I-VI	7,329	1,247
Academic GED (ABE VI)	Included above	1,093
Plaza	277	100
Career & Technical Ed.	6,546	1,730
Apprenticeship	686	55

Note: A new data system was used in 2012/2013. Consequently, all numbers are subject to final verification.

Currently part-time instructors still serve Harrisonburg Men's Diversion Center and the White Post Men's Diversion Center. During the past year a part time ABE/GED© position was established at Stafford's Men's Diversion Center. ABE programs and two Career and Technical programs are offered at Appalachian Detention Center. Testing is provided at the Southampton Men's Diversion Center. In addition, we assisted in establishing a partnership between the Tazewell Probation and Parole District 49 and Adult Education for the Southwest Region to continue providing assistance for ABE instruction through the BOOK program and GED© testing for former offenders on probation or parole.

- DOC has begun the process of setting up equipment for the computerized GED© testing that becomes effective January 1, 2014. Currently the Department has identified 42 testing locations. The major facilities will have fixed systems while many of the smaller sites will have mobile systems. All site IDs have been established with Pearson VUE, the testing company, and the testing staff have all been certified to administer the GED© exam via computer.

Acknowledgements

Many staff throughout the Department of Corrections contributed information, statistical data, ideas and reports for inclusion in this report.

Among the many contributions were Susan Edson (fiscal information), D. Wayne Bennett (DOE), Michael Whipple (AOD updates), Julie Lohman (Interstate Compact), Clyde King (Operations Extradition/Fugitive Services Unit), Dr. Susan Williams (Mental Health Services), Shirley Hughes (statistical information), Scott Richeson (Prisoner Re-entry and Evidence Based Practices), Randi Lanzafama and Maria Stransky collaborated on the sex offender related research information, and Stephanie Plunkett who typed the narrative.

My appreciation is extended to all who generously offered their assistance.

Harold W. Clarke
Director

§ 1-111. DEPARTMENT OF CORRECTIONS (799)

Item 385.

	Item Details ($) First Year FY2013	Item Details ($) Second Year FY2014	Appropriations ($) First Year FY2013	Appropriations ($) Second Year FY2014
Supervision of Offender and Re-Entry Services (35100)			$ 82,984,939	$ 83,326,913
Probation and Parole Services (35106)	$ 79,101,559	$ 79,443,533		
Community Residential Programs (35108)	$ 1,963,556	$ 1,963,556		
Administrative Services (35109)	$ 1,919,824	$ 1,919,824		
Fund Sources: General	$ 81,069,607	$ 81,411,581		
Special	$ 85,000	$ 85,000		
Dedicated Special Revenue	$ 1,490,332	$ 1,490,332		
Federal Trust	$ 340,000	$ 340,000		

Authority: §§ 53.1-67.2 through 53.1-67.6 and §§ 53.1-140 through 53.1-176.3, Code of Virginia.

A. By September 1 of each year, the Department of Corrections shall provide a status report on the Statewide Community-Based Corrections System for State-Responsible Offenders to the Chairmen of the House Courts of Justice; Health, Welfare and Institutions; and Appropriations Committees and the Senate Courts of Justice; Rehabilitation and Social Services; and Finance Committees and to the Department of Planning and Budget. The report shall include a description of the department's progress in implementing evidence-based practices in probation and parole districts, and its plan to continue expanding this initiative into additional districts. The section of the status report on evidence-based practices shall include an evaluation of the effectiveness of these practices in reducing recidivism and how that effectiveness is measured.

B. Included in the appropriation for this Item is $150,000 the first year and $150,000 the second year from nongeneral funds to support the implementation of evidence-based practices in probation and parole districts. The source of the funds is the Drug Offender Assessment Fund.