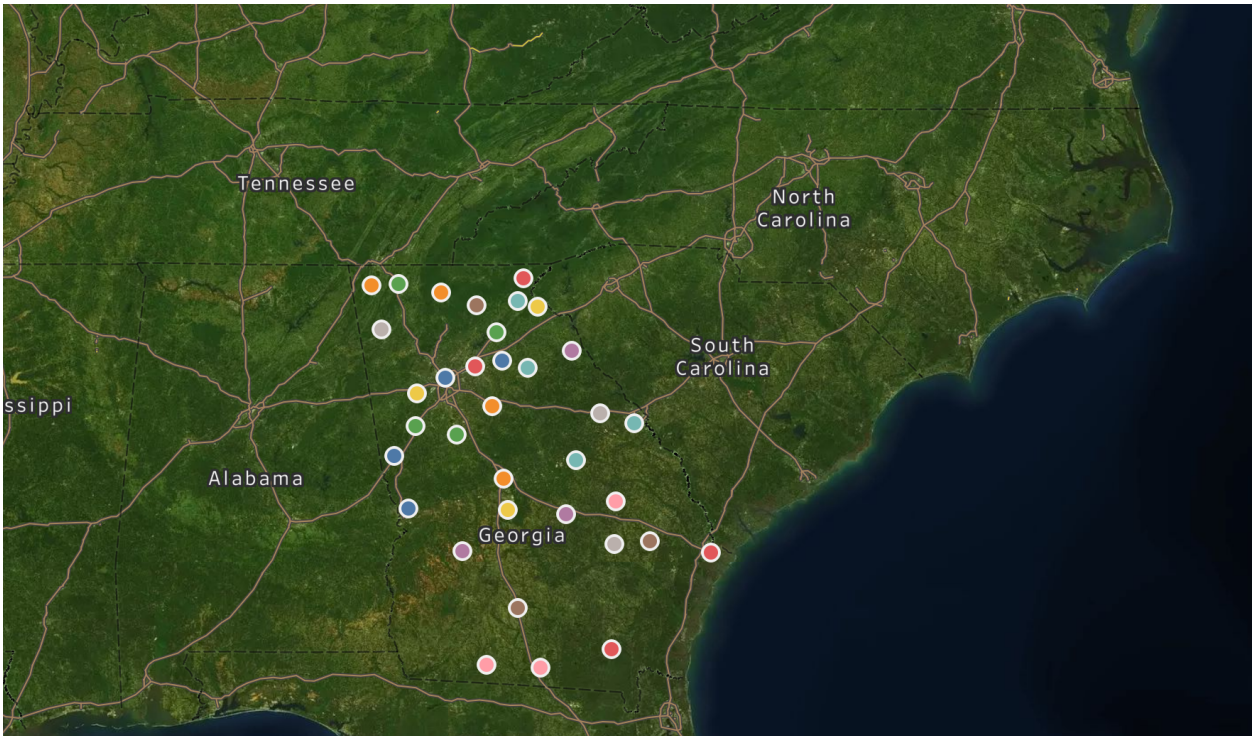
State of Georgia DRC Program Assessment Tool (DRC-PAT): Instrument development and assessment of outcomes



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Executive summary

Since 2002, the Georgia Department of Community Supervision (DCS) have provided evidence-based behavioral health services through Day Reporting Centers (DRCs) and Grant Funded Day Reporting Centers (GDRCs) throughout the state, which includes the provision of probation/parole supervision, cognitive behavioral therapy to reduce recidivism (Moral Reconation Therapy), substance use treatment and psychosocial interventions including GED training, vocational education, and family reunification services. Given the scope of services provided, there is a need to develop an instrument to consistently assess quality assurance of DRCs and GDRCs throughout the state, to ensure services are available, and delivered in an appropriate manner.

For this reason, DCS began a partnership with the University of Georgia School of Social work, with the goal to establish an internal instrument to assess program quality across all DRCs and GDRCs. This project contained multiple steps, which included (1) a review of empirical evidence for existing instruments, (2) instrument construction and development, (3) pilot testing of the new assessment instrument, (4) instrument validation, and (5) instrument demonstration.

Additionally, since the previous evaluation conducted throughout the state in 2008, GDRCs have been implemented, which are intended to serve primarily rural areas with limited community-based resources. To date, no evaluation on GDRCs outcomes has been done, and it is unknown whether there are any differences in outcomes between DRCs and GDRCs. The final step of this project examined outcomes of DRCs and GDRCs in the State of Georgia using existing data provided by the Georgia Department of Community Supervision. This report is divided into three distinct sections. They are Part 1: Introduction, Background and Context; Part II: Implementing the Evaluation and Administering the DRC-PAT; and Part III: Findings, Conclusions and Recommendations

The existing instrument used to assess DRCs and GDRCs, the Georgia Program Inventory Assessment Tool, does not capture the community supervision model currently used by the Georgia DCS. To address this problem, the UGA evaluation team began a revision of this instrument with the goal to reduce the length of the assessment process, include language to reflect community-supervision based settings, and reduce the overall subjectivity of the evaluation tool. This revision process included input from DCS administrators, staff and officers. After all revisions were mutually agreed upon by both DCS and the UGA evaluation team, and a pilot test at 4 sites throughout the state was conducted, a new program tool was produced, titled the DRC Program Assessment Tool (DRC-PAT). The DRC-PAT is a multidimensional tool, that assesses 13 areas of program operations among DRCs and GDRCs. The DRC-PAT was implemented at 35 sites across the state (15 DRCs, 20 GDRCs).

The average total score among all DRCs and GDRCs in the state of Georgia was 83.6%. The statewide average of the DRC-PAT total score for DRCs was 88.3%. The statewide average of the DRC-PAT total score for GDRCs was 80.1%. Mean scores from the subscales of the DRC-PAT identified areas of strengths, areas of low scores, and areas of inconsistencies across DRCs and GDRCs. Areas of strengths include Leadership, Staff characteristics, Program resources, Program support, Substance use programming, Cognitive behavioral programming,

Mental health services, Workforce services, and Aftercare services. Areas of low scores included Case management and Education Services. Areas of inconsistencies include Case management, Assessment, and Family services. An examination of the validity and reliability of the DRC-PAT showed that the agreement between site evaluators (reliability) was good to excellent. Additionally, by using a collaborative process to develop the DRC-PAT, face and content validity emerged. The DRC-PAT also showed strong predictive validity. When examining outcomes among participants at each DRC/GDRC, higher scores on the DRC-PAT were significantly associated with fewer probation revocations, fewer new felony charges, and fewer positive drug tests.

When examining differences between DRCs and GDRCs, differences emerged between total DRC-PAT score, and the subscales of Education services, Family services and Aftercare services. Uniformly, GDRCs reported lower total scores, as well as lower scores on each of the subscales. However, there were far more similarities in scores between DRCs and GDRCs than differences. When examining participant outcomes between DRCs and GDRCs, DRC participants experienced a higher amount of prior convictions and prior prison sentences. No other differences emerged between DRCs and GDRCs, including among the outcomes of positive drug tests, revocations, new felony charges, and reincarceration after beginning community supervision.

The results from this project suggest the DRC-PAT is a concise and clear instrument available for assessing DRCs and GDRCs in the state of Georgia. Second, there is high confidence that the DRC-PAT shortens the overall assessment process time with little to no increase in the risk for evaluator error and instrumentation bias. Third, low scores and areas of inconsistencies identified through the statewide DRC-PAT assessment offers a roadmap for program improvements among both DRCs and GDRCs. Last, there were no differences in major outcomes between persons who attended DRCs compared to persons who attended GDRCs.

Prior to offering recommendations, it is essential to acknowledge the strengths of DRCs and GDRCs in the state of Georgia. The core missions of DRCs and GDRCs – to provide attendees with opportunities to change criminal thinking and behavior through a combination of counseling, educational programming, and close supervision to address substance use and mental health is being met. Also, while there were instances where leadership was less engaged with the day-to-day operations of the program, or where staff shortages were reported as an issue to the operation of the program, areas of leadership and staff were scored very well. DRCs and GDCRs are composed with dedicated leadership and staff, including the care and treatment staff, the officers, the leadership, and administrators.

Recommendations from this project are threefold. First, in order to address low and/or inconsistent scores on the DRC-PAT, it is imperative that DCS **expands and formalizes community partnerships with the goal to enhance services.** Many GDRCs (and several DRCs) relied exclusively on local school, colleges and technical colleges for the provision of educational services, yet lack important mechanisms to track the progress of DRC/GDRC participants who were receiving these services. Additionally, DRCs and GDRCs should consider provision of services to family members of DRCs/GDRCs participants as an essential component of effective community supervision and work to expand their capacities to do so.

Second, in order to improve DRC-PAT evaluation scores, DCS should work to **refine the assessment and case management processes, to ensure quality and consistency.** While DCS is currently implementing policies associated with the assessment process, there were numerous instances where required assessment documents and case plans were absent, and instances where level of services were not matched to participant risk. While the assessment and case management process is considered a dynamic element for entry and sustained participation in DRCs/GDRCs, there must a verifiable way to document what is happening to participants as they enter DRCs/GDRCs, as well as a way to establish the appropriate level of service provision once they are admitted.

Last, to improve the quality of GDRCs, DCS should **define strategies for improving education, workforce, and aftercare services, specifically at GDRCs**. Results from the DRC-PAT showed that GDRCs scored significantly lower in these areas (education, workforce, and aftercare). To address these areas, it will likely require statewide strategies for ensuring these services are available and delivered with quality to participants at GDRCs. This may include implementation of dedicated employment liaisons/supervisors at each GDRC and establishing a process for aftercare services that require a transition case plan to aftercare, a list of goals and recommendation for each participant entering aftercare, and a specialized case plan for persons entering aftercare who have existing mental health problems.

These recommendations represent the collective agreement of the UGA evaluation team for what are the most pressing issues facing DCS in the delivery of services at DRCs and GDRCs. Efforts to address these recommendations are worthwhile, as they represent an important element in improving the overall health and wellness for all persons in the State of Georgia. The School of Social Work at the University of Georgia stands ready to assist DCS and any other group willing to undertake these efforts.

Part 1: Introduction, Background and Context

Overview of DRC's

Day Reporting Centers (DRCs) are a type of program intended to reduce recidivism by keeping offenders in their community, provide monitoring, and offer accessible social services (Zhou, Kulick, Dalton, & Collins, 2014). DRCs also provide opportunities for probationers and parolees to address criminal thinking and behavior (Government's office of crime control and prevention, 2019) through offering rehabilitative/ transitional programs (Wong, Bouchard, Lee & Gushue, 2019). These centers initially were designed for inmates who were in prison and approaching their parole or discharge date in order to be released earlier. However, DRCs have since transitioned to admitting offenders from pretrial confinement or probation (Parent, Byrne, Tsarfaty et al, 1995).

The first day reporting programs in the United States were opened in Massachusetts and Connecticut in 1986. Over the past three decades, DRCs have gained in popularity throughout the nation. These centers may be operated publicly by the judicial system city government or privately, by nonprofit agencies (Parent, Byrne, Tsarfaty et al, 1995). A distinguishing and consistent feature of the DRC model is that participants are permitted to live in their home, but report to DRCs for daily for supervision (Hyatt & Ostermann, 2019). DRCs often provide facilities in a single, physical location (Craddock, 2004).

In general, DRCs are designed to pursue three primary objectives: (1) provide increased surveillance for those offenders who have problems to abide by their supervision conditions; (2) provide an easy accessibility to treatment, rehabilitative, or transitional services; and (3) provide an alternative to incarceration thereby reducing prison/jail overcrowding. DRC is a generic term for programs that also may be called day treatment centers, day incarceration centers, restorative justice centers, community resource centers, and the like (Craddock, 2004).

DRCs are highly structured programs and have strict requirements for scheduling and attendance (Hyatt & Ostermann, 2019). DRCs may have differences in eligibility criteria including the offender's gender, legal status, treatment needs, mental health history, residential stability, and prior criminal history (Diggs & Pieper, 1994; Parent, Byrne, Tsarfaty, et al, 1995). DRC participants often receive counseling services (e.g., individual cognitive-behavioral therapy and group therapy) and enroll in a specific training classes to improve their abilities (e.g. education, vocational education, job training, etc.) (Hyatt & Ostermann, 2019; Wong, Bouchard, Lee & Gushue, 2019). They also typically receive alcohol and drug education, life-skills training, substance use and/or mental health treatment, anger management counseling, housing guidance, and community service (Diggs & Pieper, 1994; Wong, Bouchard, Lee & Gushue, 2019; Zhou, Kulick, Dalton, & Collins, 2014).

DRCs are designed to open six days per week and supervision includes on-site contacts and off-site monitoring. This monitoring includes mandatory check-in times, a rigid daily schedule or itinerary, curfews, random drug testing, mandatory training, attendance, community service, and enforced conduct rules (Hyatt & Ostermann, 2019). Treatment and supervision levels are matched by the risk level of participants (Zhou, Kulick, Dalton, & Collins, 2014).

Supervision levels gradually decrease for participants who show positive behaviors. These changes can serve as an intensive reward for participants (Parent, Byrne, Tsarfaty, et al, 1995).

Overall, DRCs are a community-based intermediate sanction and are considered as a secondary preventive method which their goal is to reduce recidivism among offenders as well as the costs and duration of maintaining offenders at incarcerations. Their programs primarily focus on improving substance use problems and developing life-skills of offenders through employing restrictive supervision and a punishments-rewards system.

Brief Summary of DRC Outcomes

There is no central definition for a DRC nor similarity in the kinds of programs and dosages of treatment. Comparisons of outcomes from one DRC to another DRC (within a state and nationally) are problematic due to the inability to account for uncontrolled variables, variances in program delivery and resources, and data gathering. The purpose of DRCs generally speaking are similar among most states and jurisdictions. That is, DRCs provide community corrections, are connected to graduated and sanctioned supervision for probationers and parolees, provide psychosocial rehabilitation regarding substance use and mental illness as well as opportunities to further education, vocational training and employment. Policy makers and criminal justice professionals believe DRCs to be less punitive and thusly, reduce incarceration days locally and statewide, which results in cost savings. In short, DRCs aim to reintegrate participants into the community as productive citizens who will not reoffend or violate within a community supervision model (Bahn & Davis, 1998).

For the most part, DRC outcome studies are measured according to recidivism rates among graduated and non-graduated participants and/or another group of probationers/parolees not associated with a DRC (Wong, Bouchard, Lee, Gushue, 2019). For example, some studies compare recidivism rates among DRC participants to a group of felons who may receive non-DRC related services, such as supervision only. Most outcome studies specify their operational definition of recidivism as a violation, arrest, a conviction or incarceration which may occur within a specified range of time post release from a DRC. Another significant pool of evaluation studies examine not recidivism of participants, but graduation versus non-graduation as an outcome (Spence & Haas, 2015). The indicated questions concerning outcomes are many, such as, do DRCs work better than other forms of sanctions, corrections, probation, and parole to reduce recidivism, if so, then what works well in DRCs and what are the predictive variables that account for positive outcomes? Overall, there are not always highly favorable results in the outcomes of DRCs to reduce recidivism, but there is some confidence in what accounts for a successful completion of a DRC program (Wong et al, 2019).

A timely and first of its kind article examining and analyzing all academic and grey literature having to do with the outcomes and effects of DRCs on reducing recidivism was published in May 2019 (Wong et al, 2019). This impressive piece of work culled down DRC outcome related articles to about 30 evaluations from which the authors determined outcomes and other kinds of activities associated with describing and /or measuring recidivism. The authors, when the literature was pooled and analyzed, concluded that DRCs have a deterring effect on convictions, but do not reduce recidivism when operationally defined as re-arrest and incarceration. DRCs do seem to perform more effectively when implemented at the front end.

The authors state they could not make any further recommendations with regard to best practices due to large variances among DRC's, reporting methods and participant characteristics found in the examined literature.

Another recent article (Fretz, 2019) provides an overview of research articles on DRC outcomes. Fretz reviews studies with rigorous methodology and his selection of articles is purposive to reflect the highest quality studies available. Fretz makes the conclusion that DRC's are not effective in reducing recidivism, but states DRCs have a helpful place in the continuum of supervision and psychosocial rehabilitation. Of note, according to Fretz, is that there are not enough adequate, robust studies to answer fully whether or not DRCs help to reduce recidivism. Of further importance is generally that studies which have very minimal rigor in design, small sample size and shallow analysis usually conclude that DRCs have a positive effect on recidivism. On the other side of a continuum, studies which are published in peer reviewed journals, contain large sample sizes, utilize randomized control trials or similar conclude that DRCs have no effect on recidivism. This is not to undermine or devalue the purpose and contributions DRC provides to community corrections as espoused by constituents.

Some researchers (Spence & Haas, 2015) suggest using the measure of graduation versus incomplete graduation as a more reliable and accurate measure of what DRC's do. They argue that recidivism among graduates is a more direct measure of DRC effectiveness than measuring recidivism among non-graduates. There is evidence to show that graduates recidivate less than non-graduates. Spence and Hass go as far to state that some DRC administrators may use employment, educational and training attainments, stable housing and successive drug free screens as measures for positive outcomes. So, then what does really work in DRC's with regard to a successful graduation? Some of the literature suggests the following could be predictive variables: length of stay in the DRC, older age of the participant, well applied and updated RNR, timely and resound sanctions, effective case management assessments, and employment (Spence & Haas, 2015).

To the evaluators' knowledge, there has been only one published report in an academic journal dealing with program success or outcomes in our Georgia DRC's. (McGregor, Brown, Yan, Mitchell, Robinson, DeGroot & Braithwaite, 2016.) This piece looked at three DRC's (one urban and two semi-urban) with regard to program success compared among substance users and those with co-occurring disorders. The researchers concluded that those with only substance use disorders were more likely to graduate from a DRC than those with both substance use disorder and a mental health disorder. However, the authors conclude that their evaluation demonstrated minimal significance as the final sample size was only 15% of the initially enrolled participants in the study due to participant attrition (McGregor et al, 2016).

To begin planning for possible outcome studies related to recidivism in Georgia DCS DRC, it is necessary to reference Georgia law. The original legislation written and passed by the Georgia Legislature which established the Department of Community Services defines recidivism as "returning to prison or jail within three years of being placed on probation or being discharged or released from a department or jail facility" (O.C.G.A.§ 42-3-2 B, 2016). This predetermined outcome for GA DRC's must serve as at least one outcome measure, when such

an evaluation is indicated. Additional quantitative outcome measures and or predictors for successful graduation are worth considering as well.

DRC's in the State of Georgia

Despite the declining U.S. correctional population within last two decades, high rate of prison population and excessive offender management costs have been a chief concern in the USA over the past half century. Since 2002, the Georgia Department of Corrections and Department of Community Supervision (DCS) have provided evidence-based behavioral health services through Day Reporting Centers (DRCs) and Grant Funded Day Reporting Centers (GDRCs) throughout the state. DRCs and GDRCs provide community corrections and psychosocial rehabilitation regarding substance use and mental illness as well as opportunities to further education, vocational training and employment for probationers and parolees through rigorous surveillance. Later, GDRCs were emerged to provide programming to areas not able to support a traditional, physical DRC, due to its rural location and absence of community-based resources. While DRC programs have been shown to be efficacious in the state, the current need is quality assurance, or consistent delivery of a high-quality service in every aspect. The last formal evaluation of DRCs in the Georgia state completed in 2008 (VanVoorhis, Groot & Ritchey, 2010), using the Georgia Program Assessment Inventory (GPAI).

However, the time involved in the use of the GPAI, paired with the emergence of GDRCs and a desire to examine GDRC outcomes has warranted the pressing need for a follow-up evaluation on program outcomes and a new valid and reliable assessment instrument for both DRC and GDRCs. To meet the needs expressed by the Georgia DCS, this project developed an instrument for ongoing internal assessment of Day Reporting Centers/Grant Funded Day Reporting Centers and used this instrument plus existing data to evaluate outcomes at all DRCs and GDRCs throughout the state of Georgia.

The Contexts for Evaluation

Day Reporting Centers (DRCs) are community-based nonresidential facilities where offenders are supervised and receive services during the day but are permitted to return to their own homes in the evening. Nationally, DRCs are a popular alternative to incarceration in prison or jails, largely due to their cost effectiveness and the reduction of both prison crowding and rates of recidivism for clients who complete the program (Barton & Roy, 2005; Spence & Hass, 2014; Parent, Byrne, Tsarfaty, et al., 1995; Craddock, 2004). DRCs in Georgia began in 2001. The creation of DRCs in Georgia was the result of a partnership between the Georgia Department of Corrections and the State Board of Pardons and Paroles. The initial DRCs provided intensive supervision and treatment for those who failed in traditional supervision, either probation or parole. Since their inception, an additional model of Day Reporting Centers has been implemented in Georgia, Grant Funded Day Reporting Centers (GDRCs). GDRCs provide programming to areas not able to support a traditional, physical DRC, due to its rural location and absence of community-based resources. To date, there has been no evaluation done on GDRCs, to examine whether they are as effective as traditional DRCs.

Additionally, there is a need for new instrumentation to assess quality assurance among DRCs and GDRCs in Georgia. A prior evaluation conducted among DRCs in Georgia (VanVoorhis, Groot & Ritchey, 2010) showed a reduction in recidivism rates for medium and

high risk offenders participating in DRCs compared to those only on probation/supervision, and culminated in the implementation of the Georgia Program Assessment Inventory (GPAI), which has since been used to assess quality assurance (consistent delivery of a high-quality service). However, the time involved in the use of the GPAI, paired with the emergence of GDRCs and a desire to examine GDRCs outcomes has warranted the need for a follow-up evaluation on program outcomes and a new valid and reliable assessment instrument for both DRC and GDRCs.

The need for an internal program assessment instrument

As the State of Georgia Department of Community Supervision (DCS) continues to monitor assessment and intervention models consistent with an evidence-based practice approach (Andrews & Bonta, 2006; Gendreau, 1996; Lipsey, 1992), there is a current need to ensure that all programs are delivered in a manner that produces an impact on clients served. While DRC programs have been shown to be efficacious in the state, the current need for the DCS is quality assurance, or consistent delivery of a high-quality service in every aspect. To ensure quality assurance is happening, a program assessment instrument is needed that is valid, reliable, and easy to use for internal DCS administration and staff. The current internal program assessment instrument, the GPAI, which has been used since 2008, has worked well for quality assurance/program assessment. But given the change in programming since 2008, including the emergence of GDRCs and the expressed desire for a less cumbersome assessment instrument, the need for a new internal program assessment instrument is high.

Need for outcomes among Georgia Day Reporting Centers/Grant Funded Day Reporting Centers

Current research in the outcomes associated with participation in DRCs highlight the importance of program matching and program completion as key components of reductions in recidivism rates (Barton & Roy, 2005; Craddock, 2004; Diggs & Piper 1994; Lowenkampl, Pealer, Latessa & Smith, 2006; Marciniak 1999; Rhyne, 2005; Roy & Grimes, 2002; Sperber, Latessa & Markarios, 2013). A prior evaluation of DRCs conducted in the State of Georgia in 2008 underscored these factors, as DRC clients who were assessed as high/medium risk and completed DRC programming showed lower recidivism rates at both 12 and 24 months compared to a matched sample of individuals on probation/community supervision (VanVoorhis, Groot & Ritchey, 2010). However, given the near ten-year gap in evaluation of outcomes, as well as the implementation of GDRCs in Georgia, there is a pressing need to re-examine outcomes associated with both DRCs and GDRCs. There are additional questions associated with the cost-effectiveness of DRCs and GDRCs that require examination. Fortunately, the Georgia Department of Corrections has data available to examine both outcomes and cost. Using this data, the evaluation team has examined these questions.To meet the needs identified above, this evaluation examined DRC and GDRCs outcomes and create a streamlined internal program assessment instrument that has been validated and determined reliable for future use.

Part II: Implementing the Evaluation and Administering the DRC-PAT

Developing the DRC Program Assessment Tool (DRC-PAT)

The existing instrument used to assess Day Reporting Centers (DRC) and Grant Funded Day Reporting Centers (GDRC) was titled the Georgia Program Inventory Assessment Tool. This instrument, developed in 2010, was modeled from a corrections-based approach and as such, does not capture the community supervision model currently used among the Georgia Department of Community Supervision. The main objectives in the revision of the GPAI were to:

1. Reduce the overall length of the assessment process.
2. Update the language used in the assessment tool to include community-supervision based settings.
3. Reduce the overall subjectivity of the evaluation tool.

The revision process of the GPAI included input from all members of the evaluation team, as well as DCS administrators, staff and officers. The initial revisions were proposed by the evaluation team. These revisions were reviewed, edited and approved by DCS administrators and staff. These initial revisions targeted the overall length of the instrument (e.g. the elimination of redundancy, clarity in scoring, identification of documentation necessary to score the instrument, etc.).

Following this initial review, DCS administrators and staff, in partnership with the evaluation team, made a second round of revisions that focused on the language used in the assessment tool to describe community-supervision based settings. These changes (e.g. dropping the term "Warden" in favor of Chief, etc.) were agreed upon by all members and a initial draft of the new program tool, titled the DRC Program Assessment Tool (DRC-PAT) was created.

Through this review method, the DRC-PAT reduced the overall length of the assessment tool, applied concise language & reduced subjectivity. Compared to the GPAI, the DRC-PAT reduced the total number of items by 20%. Questions in the DRC-PAT were revised to emphasize specific locations for supporting documents needed to answer DRC-PAT questions answer can be found, address supervision settings instead of corrections settings, and collapsed all questions to binary yes/no scoring options, in order to reduce overall subjectivity of the older assessment tool.

Pilot study

Following the development of the DRC-PAT, pilot testing was conducted. Pilot testing of the DRC-PAT included site visits to four programs in Georgia (2 DRCs, 2 GDRCs). Each site visit in the pilot test was attended by four evaluators and several DCS administrative and staff observers. Prior to the site visit, each site received a formal letter of the site visit notice with instructions that each site a) identify which staff members from each program would be present for the evaluation, b) identify which staff members would be responsible for answer questions in each section of the DRC-PAT, and c) Which files each site must prepare and present for the visit (5 randomly selected case plans for centers with less than 50 participants, 10 randomly selected case files for centers with over 50 participants).

Results from the pilot study showed overall scale reliabilities in the DRC-PAT to be between .57 and 1.0. Additionally, the intraclass correlation coefficients (ICCs), which are a measure of overall evaluator agreement were all within a 10% range of each other. Results from the pilot study, albeit with a small sample, showed acceptable reliability in both measurement and rater agreement. Following the pilot study, the evaluation team and DCS administrators and staff returned to review the DRC-PAT one final time, applying the lessons learned and the feedback received from DCS officers during the pilot study.

The Day Reporting Center Program Assessment Tool (DRC-PAT)

The DRC-PAT is a multidimensional tool, developed from prior assessment tools used in the state of Georgia. The DRC-PAT assesses 13 areas of program operations among DRCs and GDRCs. These areas include:

Case management (7 items)
Leadership (14 items)
Assessment (4 items)
Staff Characteristics (9 items)
Program Resources (14 items)
Substance Use Counseling (23 items)
Cognitive Behavioral Programming (24 items)
Mental Health Services (9 items)
Education Services (17 items)
Workforce/Employment Services (10 items)
Family Services (10 items)
Aftercare Services (8 items)

The DRC-PAT also outlines necessary documents to complete the evaluation. The required documents include:

Evidence facilitators are using manuals
Certificates of completion of all facilitators for relevant booster trainings
Records on class attendance
Records for program completion
Participants evaluation of programs
Availability of a structured manual, complete with lesson plans
Pre and posttests of class participation/learning for the participants
Records of certificates of achievement.
Transition case plans to aftercare
Separate case plans for participants with mental health and substance use problems
Actual referrals to appropriate community support services following graduation

See appendix A for instructions and guidelines for administering the Day Reporting Center Program Assessment Tool (DRC-PAT). Also, see appendix B for a complete version of the DRC-PAT

Statewide demonstration of the DRC-PAT

The DRC-PAT and outlined evaluation process was implemented at 35 sites across the state (15 DRCs, 20 GDRCs). Each visit consisted of two evaluators and two DCS administrators, who were needed to access electronic records needed to score the DRC-PAT (case management notes, participant risk/need scores, etc.). The average site visit lasted approximately two hours, and the total time to evaluate all 35 sites was about 5 months. The time between site visit evaluation and completion of final program report for each site was about one week. See appendix D & E for final program report documents.

Similar to the pilot study procedure outlined above, each site received a formal letter of site visit notice with instructions. These instructions requested that each site a) identify which staff members from the program would be present for the evaluation, b) identify which staff members would be responsible for answering questions in each section of the DRC-PAT, and c) which files each site must prepare and present for the visit.

DCS data

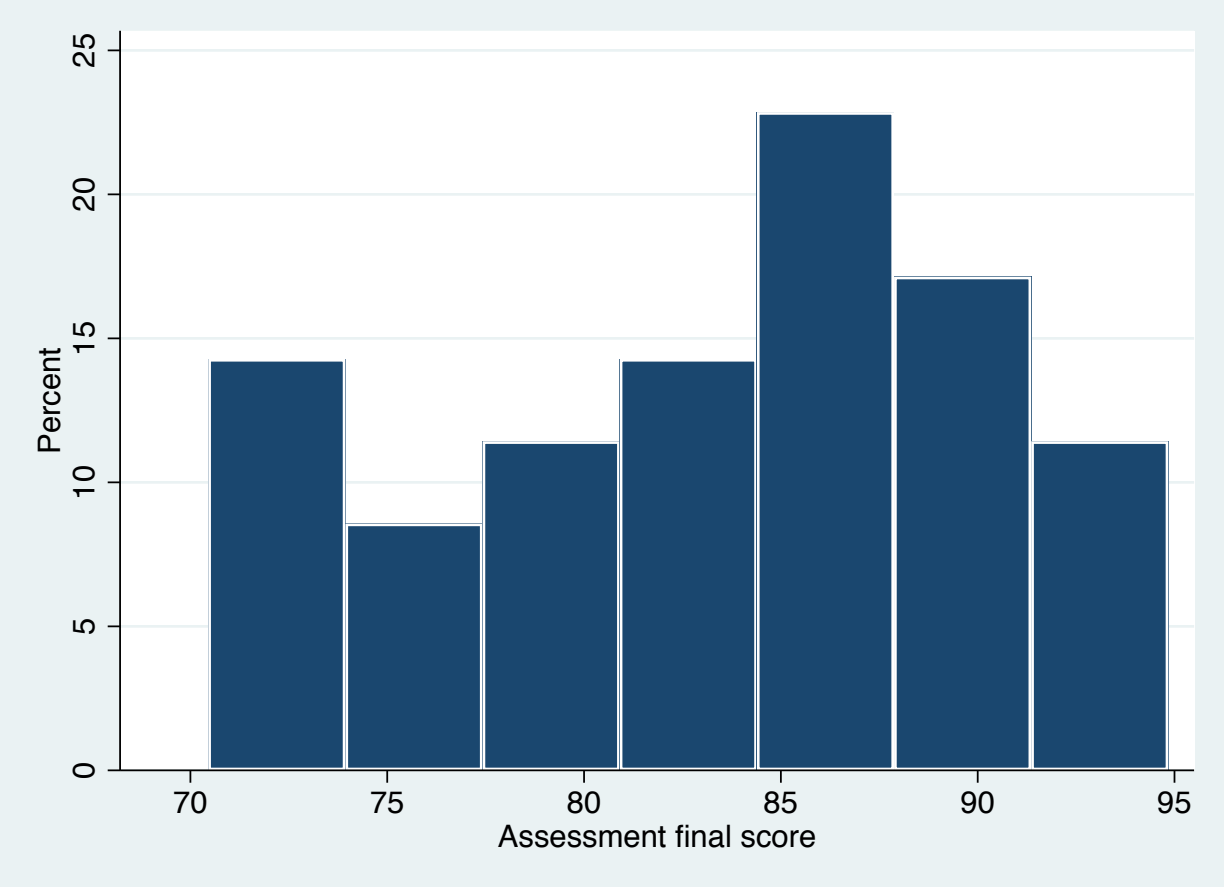
Following the statewide demonstration, efforts were made to assess the validity of the DRC-PAT through the use of administrative data supplied by DCS. This data also allowed the evaluation team to assess differences between DRCs and GDRCs, which is the second aim of this evaluation project.

The data provided is from the Georgia Reentry Portal. The cohort included all individuals who started supervision between June 1, 2018, and May 30, 2019. The follow-up time is from the start of supervision until May 30, 2019. The data does not include individuals who are being supervised outside the state or who at the start of supervision is in prison, has a detainer, or is in custody (jail). All failures (arrest, warrants, revocations, convictions) occurred after the offender's supervision start date, and between June 1, 2018, and May 30, 2019.

Part III: Findings, Conclusions and Recommendations

When examining the distribution of scores among sites, the average total score was 83.6%. The overall range scores were from 70.5% to 94.8%. Scores diverged from the statewide average by 6.9% (standard deviation). Figure 1 displays the distribution of total scores from the DRC-PAT (N=35). The statewide average of the DRC-PAT total score for DRCs was 88.3%. The statewide average of the DRC-PAT total score for GDRCs was 80.1%.

Figure 1. Statewide distribution of DRC-PAT total scores



Mean subscale scores from the DRC-PAT are presented in table 1. This table shows that the highest mean scores were observed in the mental health services (92.7%), cognitive behavioral programming (92.0%), substance use programming (92.0%), and program support (91.4%) subscales. The lowest mean scores were observed in the case management (46.5%), education services (69.4%), and family services (80.2%) subscales.

Mean subscale scores identify areas of strengths, areas of low scores, and areas of inconsistency. Areas of strengths are identified through scores that meet or exceed a subscale mean score of 80%. These areas of strengths include Leadership (87.7%), Staff characteristics (82.5%), Program resources (83.3%), Program support (91.4%), Substance use programming (92.0%), Cognitive behavioral programming (92.0%), Mental health services (92.7%), Workforce services (94.5%), and Aftercare services (86.1%).

Areas of low scores are identified through scores that are at or below a subscale mean score of 80%. Areas of low scores include Case management (46.5%) and Education Services (69.4%). Last, areas of inconsistencies across sites were identified through standard deviations of

subscale scores that are at or above 20%, which suggests a 20% or high average deviation from the subscale average score. Areas of inconsistency include Case management (Mean 46.5%, Std. Dev. 32.4%), Assessment (Mean 88.6%, Std. Dev. 22.9%), and Family services (Mean 69.4%, Std. Dev. 20.0%).

Table 1. Mean DRC-PAT subscale scores

Subscale (N=35)	Mean	Std. Dev.
Overall score	83.6%	6.9%
Case management	46.5%	32.4%
Leadership	87.7%	13.9%
Assessment	88.6%	22.9%
Staff characteristics	82.5%	8.5%
Program resources	83.3%	15.7%
Program support	91.4%	12.1%
Substance use programming	92.0%	4.8%
Cognitive behavioral programming	92.0%	5.2%
Mental health services	92.7%	10.4%
Education services	69.4%	16.6%
Workforce services	94.5%	8.2%
Family services	80.2%	20.0%
Aftercare services	86.1%	13.1%

DRC-PAT reliability

To examine the reliability of the DRC-PAT, intraclass correlation coefficients (ICCs) were examined between the two site evaluators, across each DRC-PAT subscale. The ICCs are presented in table 2. The Subscale score ICCs among evaluators were good to excellent (Cicchetti, 1994), ranging from 0.99 – 0.68. However, there were several DRC-PAT that had no variance between evaluators, suggesting 100% agreement. As such, ICCs were not possible to compute (given there was no variance). DRC-PAT subscales that had 100% agreement are noted in table 2 with an asterisk. However, while ICCs were not possible to compute, this does not mean the subscale is an unreliable section of the DRC-PAT. Rather, in this instance, the absence of an ICC can be interpreted as very high reliability, given the absence of any variability (100% total agreement) between evaluators.

Table 2. Intraclass correlations for DRC-PAT subscales

Subscale (N=35)	ICC	Alpha
Case management	.97	.79
Leadership	.92	*

Assessment	.92	.76
Staff characteristics	.99	.65
Program resources	.95	.44
Program support	.90	*
Substance use programming	.82	*
Cognitive behavioral programming	.92	*
Mental health services	.87	*
Education services	.95	.69
Workforce services	.68	*
Family services	.92	.70
Aftercare services	.95	*

DRC-PAT validity

To assess the validity of DRC-PAT, elements of face and content validity and predictive validity are presented. The evaluation did not assess for convergent, discriminant or concurrent validity. To establish face and content validity, after a thorough search through the literature on effective practices of day reporting centers and incorporation of these elements in the first draft of the DRC-PAT, the UGA evaluation team sought input and approval from DCS administration, DCS employees, and DCS staff on multiple occasions. These events led to the approval and sign-off from DCS, which is a testament to the face and content validity of the DRC-PAT instrument. In short, from this process, it is concluded that the DRC-PAT appears valid (face) and captures all relevant dimensions (content) of day reporting center programming.

To establish predictive validity (measure predicts something it should theoretically be able to predict), DCS provided the UGA evaluation team with data on program participant outcomes over an 18-month period, from June 1, 2018, and May 30, 2019, which corresponded to the timing of every statewide site visit. This data was aggregated to each DRC center and used to calculate how DRC/GDRC participants at each center experienced probation revocation, the number of new felony charges among participants at each DRC/GDRC, and the number of positive drug tests among participants at each DRC/GDRC. To determine whether higher scores on the DRC-PAT were associated with these outcomes, linear regression modeling was employed to calculate adjusted total DRC-PAT scores, based on DRC or GDRC location, participant criminal thinking scores, substance use needs, and motivation to change scores. In this analysis, adjusted scores were preferred, given the high variability across both participants and DRC/GDRC sites. Table 3 displays the relationships between DRC-PAT scores and participant outcomes.

Table 3. Associations between adjusted total DRC-PAT scores and participant outcomes

N=35	r	SE
Revocations	-.57**	.01
New felony charges	-.04**	.01
Positive drug tests	-.09**	.01

* p < .05, ** p < .01

Figure 2 Displays the relationship between DRC-PAT total score and revocations (N=35). The results from the regression model examining the relationship between DRC-PAT total score and revocations are presented in table 3. These results show that when controlling for whether the participant was attending a DRC or GDRC, as well as participant criminal thinking scores, substance use needs, and motivation to change scores, there is a significant association between higher DRC-PAT total scores and lower numbers of revocations.

Figure 2. Relationship between DRC-PAT total score and revocations

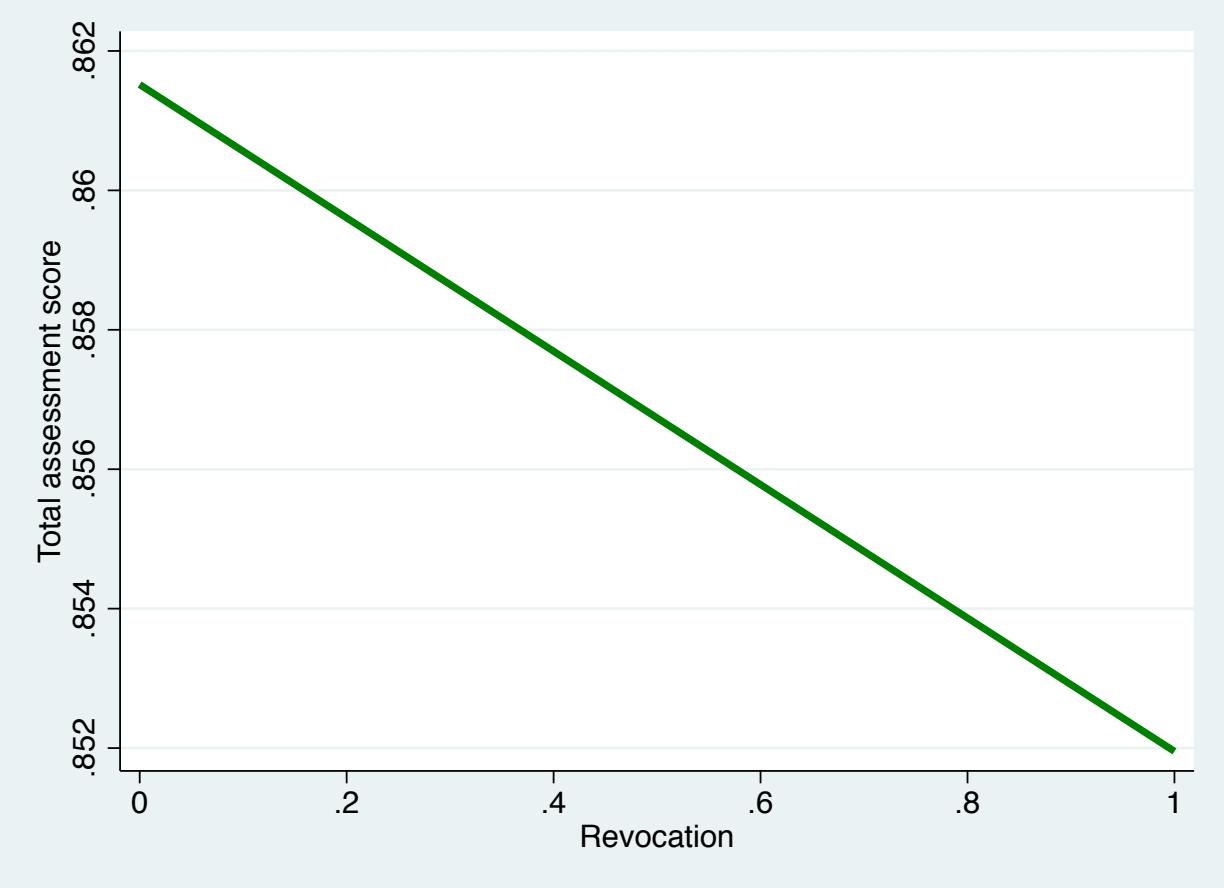


Figure 3 Displays the relationship between DRC-PAT total score and new felony charges (N=35). The results from the regression model examining the relationship between DRC-PAT total score and new felony charges are presented in table 3. These results show that when controlling for whether the participant was attending a DRC or GDRC, as well as participant criminal thinking scores, substance use needs, and motivation to change scores, there is a significant association between higher DRC-PAT total scores and lower numbers of new felony charges.

Figure 3. Relationship between DRC-PAT total score and new felony charges

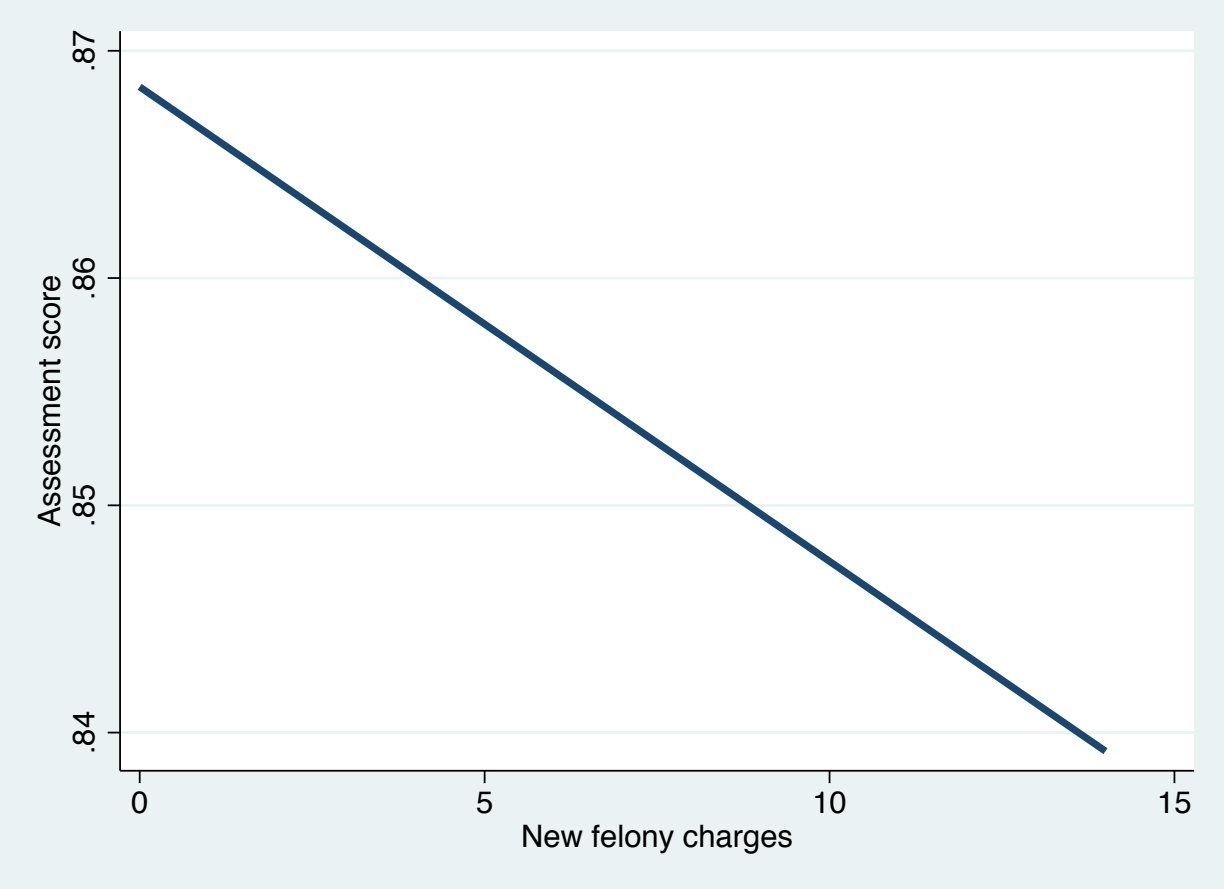
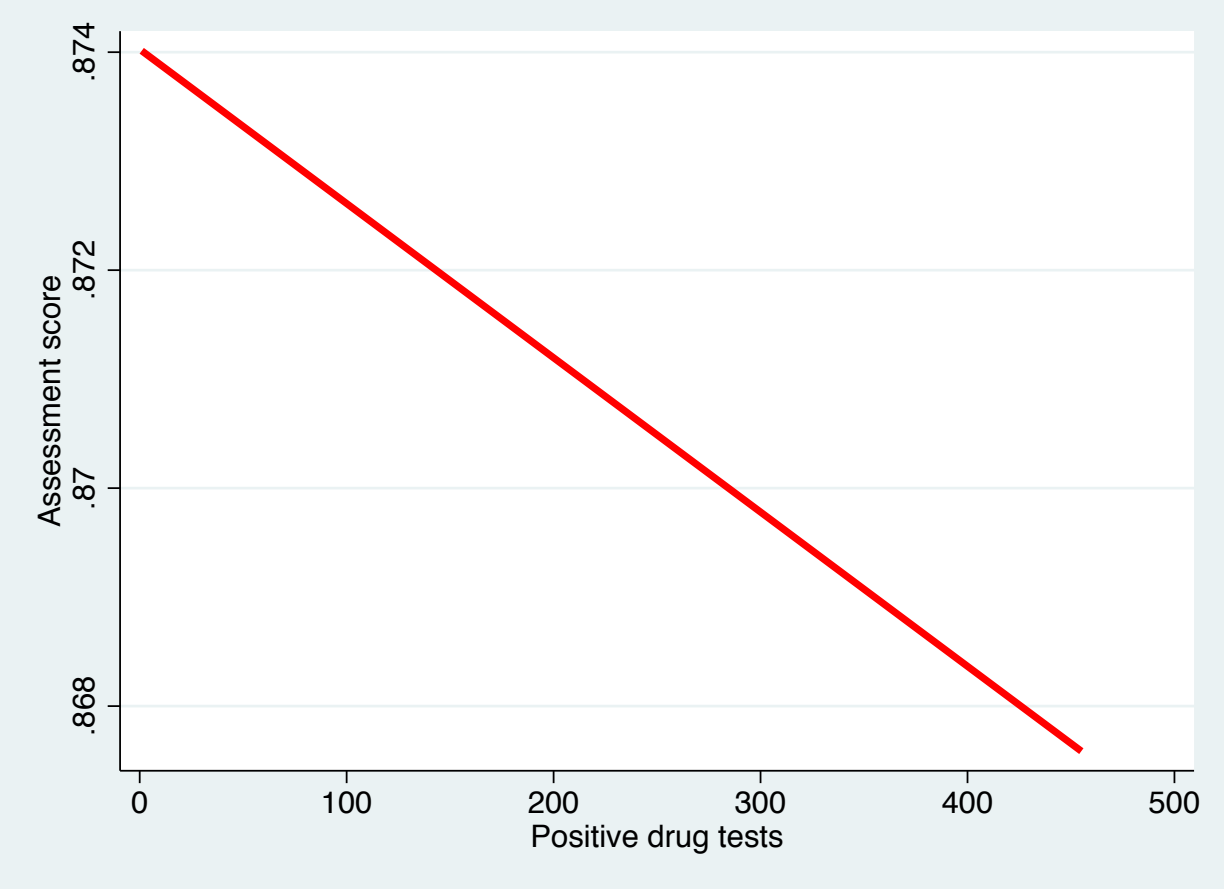


Figure 4. Displays the relationship between DRC-PAT total score and positive drug tests. The results from the regression model examining the relationship between DRC-PAT total score and positive drug tests are presented in table 3. These results show that when controlling for whether the participant was attending a DRC or GDRC, as well as participant criminal thinking scores, substance use needs, and motivation to change scores, there is a significant association between higher DRC-PAT total scores and positive drug tests.

Figure 4. Relationship between DRC-PAT total score and positive drug tests



Differences between DRCs and GDRCs on the DRC-PAT assessment

To examine differences between DRCs and GDRCs, subscale scores of the DRC-PAT were compared between these two groups. This analysis is presented in table 4. These results show that differences exist between DRCs and GDRCs. These results, taken together show a consistent pattern of DRCs scoring higher on the DRC-PAT than GDRCs. When comparing DRCs and GDRCs, a difference emerged between DRCs and GDRCs among total DRC-PAT score, where the mean score of the DRC-PAT was significantly higher at DRCs (M = 88.3%), compared to GDRCs (M = 80.1%), t (33) = 4.33, p < .01. Also, a difference emerged in the Education services subscale of the DRC-PAT, where DRCs (M = 80.8%) scored significantly higher than GDRCs (M = 60.9%), t (33) = 4.32, p < .01., A difference also emerged in the Family services subscale of the DRC-PAT, where DRCs (M = 90.7%) scored significantly higher than GDRCs (M = 72.5%), t (33) = 2.91, p < .01. Last, a difference emerged in the Aftercare services subscale of the DRC-PAT, where DRCs (M = 93.3%) scored significantly higher compared to GDRCs (80.6%), t (33) = 3.19, p < .01.

However, there were far more similarities between DRCs and GDRCs. There were no differences between DRCs and GDCRs among the Case management, Leadership, Assessment,

Staff Characteristics, Program Resources, Program support, Substance use programming, Cognitive behavioral programming, Mental health services, and Workforce services.

Table 4. DRC-PAT scores compared across DRCs and GDRCs

Subscale (N=35)	DRC Mean	GDRC Mean	t
Overall score	88.30%	80.10%	4.33**
Case management	51.4%	42.9%	0.77
Leadership	91.8%	84.6%	1.53
Assessment	95.0%	83.8%	1.46
Staff characteristics	85.5%	80.3%	1.82
Program resources	86.7%	80.7%	1.12
Program support	94.3%	89.3%	1.22
Substance use programming	93.0%	91.3%	1.07
Cognitive behavioral programming	93.6%	90.8%	1.6
Mental health services	94.8%	91.1%	1.04
Education services	80.8%	60.9%	4.32**
Workforce services	97.3%	92.5%	1.79
Family services	90.7%	72.5%	2.93**
Aftercare services	93.3%	80.6%	3.19**

*p < 05, ** p < .01

Differences between DRCs and GDRCs in participant outcomes

The final portion of the evaluation project examined whether any differences in participant outcomes exist between DRC and GDRC participants. To assess this topic, the data provided by DCS to the UGA evaluation team on participant outcomes over an 18-month period, from June 1, 2018, and May 30, 2019 was examined. Outcomes among DRC and GDRC participants included a count-based measure of positive drug tests, a binary measure of probation revocation, a count-based measure of new felony charges, and a binary measure of reincarceration after beginning community supervision. Bivariate analyses and regression-based modeling was used to assess differences between DRC and GDRC participants controlling for additional factors, including age, gender, race/ethnicity, type of crime, number of prior convictions, number of prior prison sentences, and overall sentence length. Additional control variables included participant criminal thinking scores, substance use needs, and motivation to change scores, which are part of the statewide assessment program for all persons in the criminal justice system.

Table 5 presents the bivariate differences between DRC and GDRC participants across both control variables and outcome measures. Results showed that DRC participants experienced a significantly higher amount of prior convictions (M = 1.5) compared to GDRC participants (M = 0.8), $F(1, 761) = 9.59$, $p < .01$. Additionally, DRC participants experienced a significantly higher number of prior prison sentences (M = 0.8) compared to GDRC participants (M = 0.5), $F(1, 791) = 7.25$, $p < .01$. No other significant differences emerged. There were no significant

differences between DRCs and GDRCs by age, gender, race/ethnicity, crime type, current sentence length, criminal thinking, substance use need, or motivation to change.

In terms of outcomes, no significant differences emerged at the bivariate level when examining positive drug tests, revocations, new felony charges, and reincarceration after beginning community supervision, when comparing DRCs and GDRCs. Multivariate models also showed no significant differences between DRCs and GDRCs when comparing positive drug tests, revocations, new felony charges, and reincarceration after beginning community supervision.

Table 5. Differences between DRC and GDRC participants

	Overall % or (M) N = 793	DRC % or (M) N = 666	GDRC % or (M) N = 127	X^2 or (F)
Positive drug tests	(28.6)	(29.9)	(21.4)	(1.37)
Revocation	14.2	14.6	12.3	(0.34)
New felony charges	(0.9)	(0.9)	(0.9)	(0.01)
Reincarceration after start	(0.1)	(0.1)	(0.1)	(0.69)
Age	(34.9)	(35.3)	(33.2)	(3.79)
Gender				
Male	68.1	68.9	63.8	1.29
Female	31.9	31.1	36.2	
Race				
White	66.1	65.2	70.9	1.55
Non-White	33.9	34.8	29.1	
Crime type				
Alcohol/Drug related	52.6	50.9	59.1	4.58
Nonviolent offense	32.3	32.8	29.9	
Sex crime	0.4	0.3	0.8	
Violent offense	15.1	15.9	10.2	
Prior convictions	(1.4)	(1.5)	(0.8)	(9.59**)
Prior prison sentences	(0.8)	(0.9)	(0.5)	(7.35**)
Current sentence length (days)	(2,004.1)	(2,008.3)	(1,983.4)	(0.03)
Criminal thinking	(7.4)	(7.5)	(7.2)	1.14
Substance use needs	(5.9)	(5.9)	(5.6)	(1.58)
Motivation to change	(5.2)	(5.3)	(4.6)	(3.49)

*p < .05, ** p < .01

Conclusions

The assessment process can be shortened in length and time

The construction of the new assessment tool, the DRC-PAT, aimed to accomplish the following: reduce the overall length of the assessment visit, apply concise language to the assessment process, and reduce the level of subjectivity found in prior assessment tools used. The DRC-PAT has accomplished all of these aims. In terms of length, the DRC-PAT reduced the overall number of items by 20% from the past instrument used. This reduction was achieved through a concise review of the literature on key indicators of program success for day reporting centers and constructive input from the Department of Community Supervision administrators, staff and officers.

Concerning the use of concise language, the DRC-PAT removed all prior references to corrections settings and replaced these terms, questions and topics with language consistent with community supervision. To this end, the DRC-PAT is created specifically for community correction approaches and does not rely on older, dated language that implies a correction setting.

To remove the subjectivity of the assessment process, the DRC-PAT utilized a binary scoring process for each item. Prior assessment tools relied on subjective scales to assess program operations, which may have caused issues for reliability and consistency in program assessment. Through the use of a binary scoring procedure, as well as increased clarity in the instrument guidelines for scoring questions, the DRC-PAT is a less subjective tool that will likely offer consistency in scoring programs annually.

For these reasons, there is high confidence that with using the DRC-PAT, the overall assessment process can be shortened in length and time, while at the same time offering little to no increase in the risk for evaluator error and instrumentation bias (e.g. diminished measurement reliability and validity).

Low scores and areas of inconsistencies

From scoring each program site, the DRC-PAT identified areas of strength, areas of low scores, and areas of inconsistencies. When examining areas of strength, the DRC-PAT showed relatively high scores and low inconsistency (standard deviations) for the following subscales: Leadership, Staff characteristics, Program resources/support, Substance use prog., Mental health prog., Mental health services, Workforce services & Aftercare services. These areas represent program operations where DRCs and GDRCs in Georgia, on average, are performing very well. While an analysis of DRCs and GDRCs showed a significant difference in subscales scores of Aftercare, this effect was small, and both DRCs and GDRCs showed an average Aftercare subscale score at or above 80%.

When examining lower scores, the following subscales were identified: Case management, Education services & Family services. These were the three lowest subscales of the DRC-PAT. Most problematic was the Case Management subscale, which showed an average score of 46.5%. While this low score is troubling, it is important to note that the assessment performed for 2019 was conducted during a time of transition from paper records to electronic

records. As such, there was tremendous variability in Case Management scores, and the use of specific assessment tools including a standardized treatment plan, required to be completed at each DRC/GDRC.

Areas of inconsistency identified through the use of the DRC-PAT include Case management, Assessment, and Family Services. These inconsistencies were identified through very large standard deviations, suggesting that there was a very large amount of variability across each program, despite the requirement that each program provide services within the scope of Case management, Assessment, and Family Services. Similar to the lower scores noted above for Case Management, it is possible the timing of the assessment and the transition to electronic records may have had an impact on these inconsistent scores. While concrete recommendations are outlined in the following section, it is necessary to note that future use of the DRC-PAT may serve as a baseline of comparison and shed important light on whether these low scores and inconsistencies are the result of a difficult rollout in new policies (e.g. electronic records), or an indicator of additional training.

The DRC-PAT is reliable and valid

When examining the reliability of the DRC-PAT, there are several promising results to suggest the tool is effective. First, multiple DRC-PAT items showed no variance across raters. While this is a problem for the creation of alpha coefficients, a traditional measure of subscale reliability, and can suggest that the number of programs in Georgia is too small in size to adequately determine true subscale reliability, the fact remains that there was a very, very high level of similarity across many programs, among many items included in the DRC-PAT. The conclusion that the study team takes from the high agreement is adequate subscale reliability. While future data collection efforts will be needed to fully establish the true subscale reliability of the DRC-PAT, there is sufficient evidence that the items contained within the DRC-PAT adequately capture the important dimensions of day reporting centers for the state of Georgia.

Additionally, there was very higher inter-rater agreement between evaluators at each site. This suggests that the DRC-PAT is adequate in its instructions and is capable of offering the same result independent of evaluator characteristics. While inter-rater agreements varied from site to site, the range of agreement values were from .68 to .99. These inter-rater agreement scores drive the confidence in our conclusions that the subscales contained in the DRC-PAT are reliable, and the instrument itself is reliable, meaning future evaluators, with minimal training can achieve the same results presented here.

When examining the validity for the DRC-PAT, face and content validity were achieved through the extensive input from the UGA research team, as well as DCS administration, DCS staff and DCS officers. Collectively these groups crafted an instrument that appeared to appear to capture all the necessary components of an effective day reporting center.

Additionally, an assessment of concurrent validity showed that the known differences between DRCs and GDRCs concerning community resources, in-house services, and geographic location produced significant differences in the overall scores of the DRC-PAT, as well as significant differences in Education, Family and Aftercare services – all known to have differences between them prior to the implementation of the use of the DRC-PAT.

Last, when examining predictive validity, results showed that once correcting for DRC/GDRC location, as well as individual scores for criminal thinking, substance use needs, and motivation to change, modeling showed that higher DRC-PAT scores associated with fewer revocations, fewer new felony charges, and fewer positive drug screens after starting supervision. While it is regrettable that the use of regression-based modeling approaches had to be used to assess predictive validity, due to the sheer variability among persons under community supervision in Georgia, taken together, these results demonstrate that the DRC-PAT is a valid tool for the assessment of day reporting centers in the state of Georgia.

No differences between participant outcomes among DRCs and GDRCs

Last when participant outcomes between DRCs and GDRCs were examined, we found that there were no differences in the number of revocations, new felony chargers, or positive drug tests between persons who attended DRCs compared to persons who attended GDRCs. This conclusion is based on a rigorous design: All analyses controlled for age, gender, race, type of crime, prior convictions, prior prison, sentence length, criminal thinking needs, substance use needs and motivation to change score. However, results did show that differences do exist between DRCs and GDRCs in prior convictions & prior prisons, where DRC participants were shown to have a higher number of prior convictions and higher number of prior imprisonments. Based upon the outcome data from the evaluation instrument, specific recommendations can be offered to DCS.

Recommendations

While the development and assessment of the DRC-PAT provides several concrete recommendations for improvement of DRCs and GDRCs in the state of Georgia, it would be most appropriate to first acknowledge the current strengths of DRCs and GDRCs that we observed. To begin, there is sufficient evidence to suggest that one of the core missions of DRCs and GDRCs – to provide attendees with opportunities to change criminal thinking and behavior through a combination of counseling, educational programming and close supervision to targets substance use and mental health is being met. Including all subscales of the DRC-PAT, the substance use and cognitive behavioral programming contained some of the highest scores. In essence, nearly every DRC and GDRC across the state are providing these services and providing them effectively.

Additionally, DRC-PAT subscales that assessed leadership, staff characteristics, program resources and program support were also strong. While there were instances where leadership was less engaged with the day-to-day operations of the program, or where staff shortages were reported as an issue to the operation of the program, on the whole, these areas were strong. Additional instances of DRCs and GDRCs reporting facilities insufficient in size, or reports of the broader criminal justice system not being completely informed on the principles associated with DRCs and GDRCs (e.g. Risk, needs, responsivity; Enhanced supervision programming), it is clear that nearly all DRCs and GDCRs are composed with dedicated staff who attend trainings frequently, secure external resources for their facilities and are highly knowledgeable about DCS

polices and programs. This observation extends to all staff included in DRC/GDRC operations, including the care and treatment staff, the officers, leadership and administrators.

While there are clear strengths associated with DRCs and GDRCs that were observed through the implementation of the DCS-PAT, there were also several areas for improvement across DRCs and GDRCs throughout the state. This final section outlines our recommendations, which are driven from the data obtained and crafted with input from DCS administrators and leadership on feasibility and current priorities. Recommendations from this project are threefold, and outlined below.

1. Expand and formalize community partnerships to enhance services

From the evaluation process, it was learned that many GDRCs (and several DRCs) relied exclusively on local school, colleges and technical colleges for the provision of educational services. This is a commendable effort, and consistent with the recommendation to build community partnerships. However, it was clear that these partnerships existed in an informal structure. The quality and quantity of services offered by local education providers were often unknown and there lacked important mechanisms to track the progress of DRC/GDRC participants who were receiving services from local education providers. Additionally, family services were also observed to be inconsistently delivered across DRCs and GDRCs. This is likely due to many GDRCs recent implementation of engaging events such as "family nights," or even possibly low interest in participation from families of DRC/GDRC participants. However, these reasons are outside the scope of the project and remains untested. The provision of services to family members of participants of DRCs/GDRCs is an essential component of effective community supervision in DRC/GDRC settings. Perhaps the most essential family service DRCs/GDRCs can offer is a process of informing members about DRC/GDRC programming, including what is expected of participants and what skills they may build as a participant in DRC/GDRC programming, so that family members can learn how to support and encourage DRC/GDRC participants. The development of an effective mechanism for sharing DRC/GDRC programming information to family members, so that it is delivered consistently and effectively.

2. Refine assessment and case management processes, to ensure quality and consistency

Results from the DRC-PAT suggest that both assessment and case management services were often either low scores, inconsistent scores, or in several case specific to the DRC/GDRC location, both. While it is imperative to acknowledge that DCS is currently implementing policies associated with the assessment process, there were numerous instances where required assessment documents and structured/individualized case plans were absent. Additionally, there were instances where there was no evidence that case plans were not reviewed/updated regularly, as well as instances where level of services were not matched to participant risk. For example, participants with low risk for mental health and/or substance use received similar services as participants with high risk for mental health and/or substance use. On the one hand, this may reflect poor assessment tools (such as the NGA tools) that do not reflect participant risks/needs. However, there were also several instances where DRC/GDRC locations experienced difficulty articulating how to use the NGA. The evaluation team also experienced difficulties in accessing components of the NGA, as well as accessing evidence that case plans were not reviewed/updated regularly.

3. Define strategies for improving education, workforce, and aftercare services, specifically at GDRCs

Results from the DRC-PAT, when compared between DRCs and GDRCs showed that GDRCs scored significantly lower in these areas (education, workforce, and aftercare) when compared to DRCs. To address these issues, it will likely require statewide strategies for ensuring these services are available and delivered with quality to participants at GDRCs. As mentioned above in recommendation #1, building partnerships to enhance services is one of the critical elements of this recommendation. However, there are other elements as well. For example, to improve workforce services, the appointment of a dedicated staff member who notifies participants of employment opportunities in the community may prove useful. These notification efforts must go beyond leaving newspapers or job ads around the facility, and include systematic efforts that provide helpful information to all GDRC participants and rely on a more formal approach (opposed to informal word of mouth approaches) to finding job opportunities to DRC participants, which should include serving as a liaison to major employers in the area, as well as providing specific job placement referrals to GDRC participants. To improve aftercare services at GDRCs, it will be important to establish a process where any third-party provider is able to supply each GDRC with documentation of aftercare services. This would include receipt of a transition case plan to aftercare, as well as a list of goals and recommendation for each participant entering aftercare, and a separate, specialized case plan for persons entering aftercare who have existing mental health problems. Additional efforts to address participant barriers, such as transportation, travel distance, and family issues may also serve to improve services at all DRCs/GDRCs.

While these recommendations follow directly from the project process and result, they are by no means exhaustive. These recommendations represent the collective agreement of the UGA evaluation team for what are the most pressing issues facing DCS in the delivery of services at DRCs and GDRCs. It is likely these recommendations will take sustained efforts and resources to address. We encourage DCS to cultivate these efforts and resources, as the delivery of effective services in both criminal justice contexts, as well as substance and mental health contexts in rural areas is an important factor in improving the overall health and wellness for all persons in the State of Georgia. The School of Social Work at the University of Georgia stands ready to assist DCS and any other group willing to undertake these efforts.

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Appendix A

Instructions and Guidelines for Administering the Day Reporting Center Program Assessment Tool (DRC-PAT)

Introduction and Overview of the Guide

This document describes how to use the Georgia DRC/GDRC Assessment Inventory and Interview Guide with regard to collecting data from DCS staff and assessing thirteen core features of a DRC or GDRC including evaluating the participants' case files and other DCS site related records. The overall purpose of this assessment inventory is to record, document and evaluate to what extent a DRC or GDRC complies and delivers services according to DCS policies and procedures, especially with regard to programming and case management. The guide is designed to capture the above features in a quantitative method The evaluation guide/inventory is composed of 13 major (see listing below) sections: twelve of the sections collect data by interviewing DCS staff with regard to services and other aspects, one section involves evaluators in-depth reviewing of several randomly selected case files and another section of the guide examines other records, such as records of participant attendance, records of course completions, etc. Ideally it is better to have two evaluators to help increase the reliability of the guide/inventory. Based upon the case file and records review and upon the responses from the DCS employee(s), the evaluators will make a "yes or no" decision corresponding to the item being addressed in the guide. There is space on the guide for the evaluator to make comments on each item, if deemed necessary. When the entire assessment is complete, the evaluators will compile and compare all of their scorings on a Master guide and reconcile any differences in scoring before marking the Master guide. Below are the major areas to be evaluated as exactly ordered on the interview guide. Now is the best time to become closely familiar with the entire interview guide. Doing so will help you understand better all of the instructions in this document.

Case management
Leadership
Assessment
Staff characteristics
Program resources
Program clinical/administrative supervision
Substance use counseling
Cognitive behavioral programming
Mental health services
Education services
Workforce/Employment services
Family services
Aftercare services

Preparations by the Evaluators

Become very familiar with all aspects of the guide with regard to what each question is asking and its terminology, because you may be asked to clarify the question. As a tip, one may want to have a few practice-simulation sessions with some colleagues in order to be more fluent during the actual evaluation. Make sure that your tone of voice is less interrogative but that it be

more direct, open, relational and inquisitive without sounding off putting. Preparing to evaluate case files requires competency in knowing what documents are required to be in each file. Additionally, one must have competency in knowing how to integrate required assessments (for example TCUD, ASIL, NGA, etc.) in order to make a determination about the adequacy of the case plan and the implementation of the case plan as evidenced in notes. The case review section is the most labor-intensive section calling for accurate observations and the ability to make a final score of yes or no based upon overall judgment of meeting criteria. Please note that all or parts of case materials may be located in hard copy files, the portal or Scribe. Again, it will be helpful to practice case file evaluations. One must be familiar with other documents such as booster trainings, participant attendance records and the like. Questions related to these required documents can be found inside the guide under four sections. This piece will be addressed later.

Preparations by the Site's Leadership Team

Before implementing the actual guide and inventory, the leadership team will receive a letter of notification of the assessment and requests to assemble five to ten randomly selected case files, after care files, files to related to participants' attendance, completion of MATRIX, etc., and training manuals.[All of the required files and manuals to be examined are stipulated in the assessment guide].The site DCS leadership team should have all materials set aside and well organized for examination. Additonally, the leadership team should ,when indicated, arrange for outside providers(such as teachers, mental health providers.) to be present for the interview. Other DCS personnel who provide programming and supervising services should be present for the interview to participate in their corresponding sections.

Conducting the Assessment of Case Files, the Interviewing and a Record Review

This is the substance of the assessment process and it follows the order of the sections in the interview guide. It is broken down into three main phases: the case review process, the interviewing of DCS staff and outside providers when indicated, and a review of selected records. It is more helpful when there are two evaluators who both evaluate each case file and who take turns in asking the section questions to DCS staff. Mention will be made concerning how to reconcile differences in evaluator scoring in the last section of this document. Expect the entire process to take two and a half to three and half hours to complete.

1.Conducting the Case Review.

Information for case reviews comes from many sources such as the case management plan, TCUDS, ASIL mental health assessment, NGA, intake, DAP notes, case notes, but not from the Case Supervision Plan. Some documents will be in hard copy and some will be stored electronically. Evaluators should not address case review related questions within the guide to DCS staff. Cases will have been randomly selected and will be noted on the interview guide with regard to UPI number. A member of the leadership team should be available to answer any questions or to assist in finding information or any other mechanics and only when requested by the evaluators.

This case review section is composed of two parts. The first part, number 1 on the guide, is seen in the table of the case UPI number along with seven columns of criteria related to case management and treatment planning, which must be assessed by the evaluator with a yes or no response in each cell. The scoring of a yes or a no in each cell is the data that is used collectively

to answer the seven questions on case management, which would be items a through g and which is also the second part of number 1. Please see the section 1 on case management. Please note also that items a through g call for all cases to comply. Thus, 100% compliance is required and if not, then a response of "no" should be scored for any of the items a through g.

Reviewing cases is a concentrated process as the evaluator must not only observe to see if compliance has been met by actually seeing a required case document(such as NGA, TCUDS, ASIL, Case Plan, participant signed Case Plan, notes, a DAP note(s), contacts with referral sources, etc.),but also the evaluator needs to see if the needs of participant as reflected in NGA and other assessments are mentioned in the case plan with a corresponding goal, and are also reflected in case notes. The evaluators must also assess if low risk and low need participants are placed in highly intensive services with high risk participants. Such assessment is derived through examining NGA, TCUDS, and ASIL and other documents. The needs of participants should be addressed in the case management plan. For example, if the need for education is reflected as high in NGA and/or in any other documents, then such should be present in the case management plan as a goal, such as obtaining a GED. Additionally, the evaluators need to see if the participant has other needs, such as family, which are identified and also incorporated into the case management plan or case notes. If there are needs mentioned and not addressed, then this column should receive a "no" and likewise thinking and analysis should be applied to other areas in order to reach a "yes" or a "no."

Being able to hold several pieces of case information in your mind and then being able to piece together that information to make a decision and informed judgment to the 7 items in the column is necessary. Practicing on several cases will increase accuracy, confidence and efficiency.

2.Interviewing DCS Staff

This area pertains to sections 2 through 13. Some items, essentially 2 through 6, have to do only with the leadership team. The remaining various items are addressed to other staff, such as counselors, CSO's, teachers, workforce staff, etc. Usually the leadership team assembles the staff to be interviewed and makes such known to the evaluators. The evaluators can introduce the interviewing process through saying something like this script to the group.

> DCS is interested in assessing for quality assurance about the performance and compliance of DRC's with regard to established policies and practices. The aim of DCS is to use the outcomes of the evaluations to improve service and to demonstrate accountability to all of our stakeholders. The questions we ask require a "yes" or "no" response from you. If you do not understand the question, please ask us for clarification. Likewise, if we need further information in order to know how to score your response, we will ask you to clarify or ask you to provide examples. This is not an adversarial process.

Items 2 through 6 need to be answered by the leadership team. The remaining items should be answered by staff who are assigned to services such as substance use counseling, mental health services, family services, etc.If you believe a response needs clarification or you feel you may need to "test" the veracity of the response, then the evaluator can follow up with

clarifying questions or ask for examples. The purpose here is to make sure that you can be confident in how you score an item. If a respondent is ambivalent about their response, you need to ask them to make a final decision of yes or no. If for some reason a respondent cannot answer the question, then leave that item unscored and make a note in the comment section. Once the interviewing is finished then thank the group for their cooperation and for their preparation. You may ask them how it was going through the interviewing. If they ask you for your impression of their performances, you need to politely decline and then instruct them to wait for official follow up.

3.Evaluating Other Records

This last piece of the guide and inventory work has to do with examining records pertaining to the sections of substance use counseling, cognitive behavioral programming, education services and after care services. A summary of these areas and questions can be found on page four of the instrument. The site leadership team should have required records available for each evaluator to examine in a well-organized manner. Please note that the exact questions are embedded in only four sections, as described above and are located at the end of the section, and are labeled as "DO NOT ASK." These kinds of questions the evaluator responds to and scores as a yes or no after examining records and searching for documents.If the site leadership cannot produce a record or document for the evaluator to examine and apply a question, then that question related to an absent document should be answered with a "no." It is helpful to practice examining documents required to answer the questions.

There are some specific items which need addressing.in the Aftercare section. The site should provide the evaluators with three kinds of Aftercare cases: those which have issues with substance misuse and another which have issues with mental health and one which shows evidence of a transition plan to aftercare. In other areas when the question asks for "all", then the evaluators must have the records of all facilitators to evidence booster trainings. When the questions call for evidence of completion and attendance records, then the evaluators just need to see several, not all.

Wrapping Up

At this point, the evaluators need to first take an unused interview guide and mark it as "Master" on the first page. This Master labeled interview guide will be used to mark the final scores as agreed upon by both evaluators. It is at this point in the process the evaluators discuss each item by item to determine a final score, which is then marked on the Master. When there are differences in scores, the evaluators must provide their rationale for their score, discuss their differences, then arrive at a mutually agreed upon score, which then becomes the final score marked on the Master guide. After the Master guide is completed, it and each evaluator scored interview guide need to be given to the central leadership of the State DCS.

Appendix B
The Georgia Program Assessment Tool (GPAT)

GEORGIA PROGRAM ASSESSMENT TOOL (GPAT)
INTERVIEW GUIDE 2018-2019

Date: Evaluator:

INTRODUCTION

a. Name of the program:_____
b. Percentage of:

Whites- _____ Black- _____ Hispanic- _____ Males- _____ Females- _____

c. What are the names and the titles of the individuals that were interviewed? **(ADD ADDITIONAL ROWS IF NEEDED)**

NAME	TITLE	RACE/ETHNICITY	GENDER
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

1. CASE MANAGEMENT

Case management records review sheet

Review: NGA score, T-CUDS, ASI-L for match to services/needs (NGA motivation score), case plan sheet for offender collaboration (sheet should be signed), and online case notes to ensure they are updated regularly. Any other documents (e.g. updated paper notes) should not be used in scoring).

Number	Matched to assessments?	Reviewed/ goals?	Part. Needs?	Collab. With staff/agencies?	Intensive serv. For high risk?	Low risk/less intensive?	Collab with offender?
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

a. Does a sample of records/computer files contain evidence of structured and individualized case plans that set offender goals for all files? (review 10 records for centers over 50 people, 5 records for centers less than 50 people). **If case plan is present for all offenders, mark yes.**

YES NO Comments:

---

b. Are all case files are matched to the NGA and/or additional assessment results (T-CUDS, ASI-L)? **If NGA scores, T-CUDS, ASI-L or other DCS assessments (e.g. biopsychosocial assessment) are all present for all offenders, mark yes.**

YES NO Comments:

---

c. Are all case notes reviewed and updated on a regular basis, reflecting a meeting of goals? **If portal case notes are present for treatment-specific progress (e.g. making progress in classes, mark yes)**

YES NO Comments:

---

d. Is there evidence case plans are developed for all needs of participants, e.g., housing, family reunification, employment, and on-going programming? **If NGA risk scales for education, employment or peer/family are medium/high or if other assessments indicate a risk, and case notes address these risks, mark yes.**

YES NO Comments:

---

e. Do case plans show evidence of more intensive services for medium and high-risk participants? **If mental health and/or substance use NGA risk is high, or T-CUDS and/or ASI-L scores are high, every offender should be in/completed substance use and/or mental health programs. Mark yes if this is the case.**

YES NO Comments:

---

f. Do case plans keep low risk participants out of interventions intended for higher-risk participants? (Any instances where low-risk participants are admitted by courts indicate that this question should be rated NO). **If NGA substance use and/or mental health risk is low, or T-CUDS and/or ASI-L scores are low, offender should NOT be in/should have already completed substance use and/or mental health programs. Mark yes if this is the case.**

YES NO Comments:

---

g. Is the case plan developed in collaboration with the offender? **Need to see evidence (e.g. a signature) on a case plan. Do not count for handbook signature or self-report.**

YES NO Comments:

---

2. LEADERSHIP

---

a. What changes have you made to improve program services since you have been in management? *(Leadership makes changes to improve program)*

YES NO Comments:

---

b. Tell us how you are engaged in operations that involve staffing, administrative hearings, care, treatment and programming? *(Leadership is engaged?)*

YES NO Comments:

---

c. Do you provide direct services to the participants? What are some services you provided? Do you provide these services on a consistent basis?

YES NO Comments:

---

d. Describe the treatment-related services offered by your facility. (*The leader is knowledgeable of the services being provided by the facility.* Description must be relevant to treatment and not activities.)
YES NO Comments:

---

e. Describe the services offered by outside providers. (*The leader is knowledgeable of the services being provided by outside providers.* The leader must be able to tell you what these services are in general terms and the services must be relevant to treatment and not activities.)
YES NO Comments:

---

f. Have you been introduced to the principle of RNR (Risk, Need, Responsivity)? What are some of the RNR principles?
YES NO Comments:

---

g. Do the principles of RNR inform what you do here? How? (*There is evidence the principles of RNR affect what is done here)*
YES NO Comments:

---

h. Have you been introduced to the principles of ESP? What are some of the ESP (Enhanced Supervision Programming) principles?
YES NO Comments:

---

i. Do the principles of ESP inform what you do here? How? (*There is evidence the principles of ESP affect what is done here)*
YES NO Comments:

---

j. How do you select staff who can deliver effective interventions? (*Leadership selects staff that can deliver or support effective interventions)*
YES NO Comments:

---

k. Have you received any treatment-related professional development in the past year? (Credit only if in the area of treatment, to include conferences, working on a helping degree, DCS trainings, or self-study/reading that can be well-articulated).
YES NO Comments:

---

l. Who is responsible for encouraging/enabling staff to attend trainings? How is this done? (Do not count DCS In-Service or encouragement alone.) *(Leadership actively supports program staff's securing of additional training)*
YES NO Comments:

---

m. What goals did you set forth from the previous site evaluation? Have any been accomplished? What is their status? (Not applicable for 2018 evaluation)
YES NO Comments:

n. How do you arrange opportunities for you and your staff to celebrate success? *(Leadership arranges opportunities for staff to celebrate success)*

YES NO Comments:

3. ASSESSMENT

a. Can you show me how the NGA tool is used?

YES NO Comments:

b. Does the program administer the following assessments for risk factors/criminogenic needs other than the NGA? Check all that apply:

☐ Mental health ☐ ASI-L ☐ TCUDS ☐ Other (specify tests) _____

c. Does the assessment or some other information gathering process secure information about (check all that apply):

☐ Criminal History (source)-_____ ☐ Education (source)- _____ ☐ Housing (source)- _____

☐ Employment/Vocational (source)- _____ ☐ Vocational training (source)- _____ ☐ Parenting/Childcare (source)- _____

☐ Emotional control/Anger (source)- _____ ☐ Mental health (source)- _____ ☐ Financial assets/Debts (source)- _____

☐ Substance use (source)- _____ ☐ Family (source)- _____ ☐ Benefits/Entitlements (source)- _____

d. Are assessment results discussed with participants?

YES NO Comments:

4. STAFF CHARACTERISTICS

a. What proportion of all program staff (counselors, supervisors, and group facilitators) has a bachelor's degree in a helping profession (nursing, psychology, sociology, social work, counseling, criminal justice, public health, or education)?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

b. What proportion of all program staff (counselors, supervisors, and group facilitators) has a master's degree in a helping profession (nursing, psychology, sociology, social work, counseling, criminal justice, public health, or education)?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

c. What proportion of all program staff (counselors, supervisors, and group facilitators) has been formally trained in Basic Counselor Training?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

---

d. What proportion of all program staff (counselors, supervisors, and group facilitators) has been formally trained in Motivational Interviewing?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

---

e. What proportion of all program staff (counselors, supervisors, and group facilitators) has been formally trained in Effective Communication?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

---

f. What proportion of program staff (counselors, supervisors, and group facilitators) receive at least 3 hours of training related to treatment topics per year?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

---

g. What proportion of management staff (Chief, Coordinating Chief, Assistant Chief, and Center Administrator) has been introduced to the principles of RNR?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

---

h. What proportion of ALL staff has been trained in Motivational Interviewing?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

---

i. What proportion of ALL staff has been trained in Enhanced Supervision Skills?

☐ 0%-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100%

5. PROGRAM RESOURCES

a. Does this facility have enough meeting space to conduct the programs and individual sessions with participants?

YES NO Comments:

---

b. Does this facility have sufficient AV equipment and materials to conduct all programs and individual sessions with participants?

YES NO Comments:

---

c. Have any changes in the budget made it difficult to run core programs?

YES NO Comments:

d. Does the program need additional staff to run core programs and required assessments? If yes, why?
YES NO Comments:

e. Have outside stakeholders in the community (e.g. judges) been introduced to RNR and ESP?
YES NO Comments:

f. Have any outside stakeholders, beyond those in the criminal justice system, provided resources to the program? If so, what?
YES NO Comments:

g. Have program staff, other than leadership, sought new resources for this program during the past year?
YES NO Comments:

6. PROGRAM CLINICAL/ADMINISTRATIVE SUPERVISION

a. Who provides clinical supervision for Care and Treatment/counseling staff? (*Are program staff supervised?*)
YES NO Comments:

b. Does the clinical supervisor(s) for staff have a professional license, certificate, or graduate degree to perform clinical supervision, or is a certified addiction counselor?
YES NO Comments:

c. Does the administrative supervisor ever review case/program/treatment plans?
YES NO Comments:

d. Does the administrative supervisor observe counseling staff to assure they are utilizing clinical skills (RNR principles, motivational interviewing skills, OARS)?
YES NO Comments:

e. Does the administrative supervisor observe counseling staff to assure that they are appropriately accessible to participants?
YES NO Comments:

f. Does the administrative supervisor observe counseling staff to assure that medium to high-risk clients receive a more intensive level of intervention than low-risk clients? When appropriate, does the administrative supervisor submit override requests when they appear to be appropriate?

YES NO Comments:

---

g. Does the administrative supervisor ever sit in on groups to observe staff facilitating groups? (How often are they reviewed? Does the supervisor review the curriculum used by outside providers? What are they looking for when they review these individuals? Probe to see if they are looking for consistency with the principles of RNR & ESP).

YES NO Comments:

---

7. SUBSTANCE USE COUNSELING

a. Does this program directly provide substance use services to participants? Include services provided by program staff as well as those provided in house but by an outside provider.

YES NO Comments:

---

b. Do available substance use programs cover different aspects of addiction, e.g., pre-programming, substance dependency, relapse prevention, etc.?

YES NO Comments:

---

c. Do participants have access to self-help groups?

YES NO Comments:

---

d. Are all substance use facilitators licensed or certified substance use counselors? (If yes, what are the certifications? Do they have any other special licensure or certifications pertaining to substance use?)

YES NO Comments:

---

e. Are participants admitted to substance use programming according to risk and need?

YES NO Comments:

---

f. Do participants receive awards and other reinforcements for program completion?

YES NO Comments:

g. Does program use graduated sanctions and follow through on sanctions? What is an example of it? (Ensure the program is using graduated sanctions such as warnings, written assignments, time-outs, etc.)

YES NO Comments:

h. Do facilitators track the drug tests of participants?

YES NO Comments:

i. Are all substance use facilitators current on mandatory substance use training?

YES NO Comments:

j. Do all substance use facilitators have a bachelor's degree in a helping profession (nursing, psychology, sociology, social work, counseling, criminal justice, public health, or education)?

YES NO Comments:

k. Is management staff supportive of substance use services? Explain.

YES NO Comments:

l. Is treatment staff supportive of substance use services? Explain.

YES NO Comments:

m. Are DCS officers supportive of substance use services? Explain.

YES NO Comments:

n. Has the program been reviewed for quality assurance within the past year?

YES NO Comments:

o. Any evidence of problems with access to groups? If so, what problems do you have?

YES NO Comments:

p. Substance use groups meeting frequency adheres to approved guidelines.

YES NO Comments:

q. Is the class size appropriate for the nature of the program? (7-20 participants)
YES NO Comments:

---

r. **DO NOT ASK – RECORD REVIEW:** Do all substance use facilitators receive booster training annually?
YES NO Comments:

---

s. **DO NOT ASK – RECORD REVIEW:** Does the program have a structured manual, complete with lesson plans? (Need to see manual)
YES NO Comments:

---

t. **DO NOT ASK – RECORD REVIEW:** Is there evidence the facilitators are using the manuals?
YES NO Comments:

---

u. **DO NOT ASK – RECORD REVIEW:** Do facilitators maintain records on attendance?
YES NO Comments:

---

v. **DO NOT ASK – RECORD REVIEW:** Do facilitators maintain records for program completion?
YES NO Comments:

---

w. **DO NOT ASK – RECORD REVIEW:** Do participants have the opportunity to evaluate the substance use programs?
YES NO Comments:

---

8. COGNITIVE BEHAVIORAL PROGRAMMING

a. Does this program directly provide cognitive behavioral programming to participants? Include services provided in house or by an outside provider.
YES NO Comments:

---

b. Does the program provide services other than MRT? If yes, mark all that apply.
☐ Getting Motivated to Change ☐ Anger Management ☐ Other program (specify)- _____

---

c. Are participants selected for cognitive behavioral programming based on the appropriate risk and need scores?
YES NO Comments:

---

d. Are participants screened according to responsivity? How?

YES NO Comments:

---

e. Are rewards for participation and completion offered? (Probe to determine if the program is using certificates of completion to reward participation)

YES NO Comments:

---

f. Do facilitators have onsite supervision by individuals trained in the curricula?

YES NO Comments:

---

g. Have facilitators been trained in the model(s) being used?

YES NO Comments:

---

h. Are all facilitators current with training requirements?

YES NO Comments:

---

i. Are facilitators selected according to treatment-relevant criteria?

YES NO Comments:

---

j. Do all cognitive behavioral programming facilitators have a bachelor's degree in a helping profession (nursing, psychology, sociology, social work, counseling, criminal justice, public health, or education)?

YES NO Comments:

---

k. Are management staff supportive of cognitive behavioral programming? Explain.

YES NO Comments:

---

l. Are treatment staff supportive of cognitive behavioral programming? Explain.

YES NO Comments:

---

m. Are DCS officers supportive of cognitive behavioral programming? Explain.

YES NO Comments:

---

n. Does cognitive behavioral programming group meeting frequency adhere to approved guidelines?

YES NO Comments:

---

o. Has the program been reviewed for quality assurance within the past year?
YES NO Comments:

---

p. Is there any evidence of problems with access to groups? If so, what problems do you have?
YES NO Comments:

---

q. Are class sizes appropriate for the nature of the program? (7-15)
YES NO Comments:

---

r. Does the program administer any type of pre and post tests for the participants?
YES NO Comments:

---

s. **DO NOT ASK – RECORD REVIEW:** Do all facilitators receive relevant booster trainings?
YES NO Comments:

---

t. **DO NOT ASK – RECORD REVIEW:** Do facilitators have access to all treatment manuals?
YES NO Comments:

---

u. **DO NOT ASK – RECORD REVIEW:** Is there evidence the facilitators are using manuals?
YES NO Comments:

---

v. **DO NOT ASK – RECORD REVIEW:** Do the facilitators maintain records for attendance?
YES NO Comments:

---

w. **DO NOT ASK – RECORD REVIEW:** Do the facilitators maintain records for program completion?
YES NO Comments:

---

x. **DO NOT ASK – RECORD REVIEW:** Do participants have an opportunity to evaluate the class?
YES NO Comments:

---

9. MENTAL HEALTH SERVICES

a. Does the program offer mental health services to participants? Include services provided in house or by an outside provider. Explain.

YES NO Comments:

b. Does in-house or outside provider offer medication and monitoring of medication?
YES NO Comments:

c. Are emergency mental health services available in-house or by an outside provider? If yes, what services are provided?
YES NO Comments:

d. Do the in-house or outside mental health services provider offer therapy or counseling? If yes, what groups are offered by mental health services? (Only count if clinical counseling under the supervision of a psychiatrist.)
YES NO Comments:

e. Do in-house or outside mental health providers report to program site staff on a regular basis of at least once per month? If yes, what is reported? When does the staff report?
YES NO Comments:

f. Are in-house or outside mental health provider staff aware of participant's mental health assessment results?
YES NO Comments:

g. Do in-house or outside mental health provider staff plan or assist for continuity of care. (Must involve actual communication with follow-up resources)
YES NO Comments:

h. Is the in-house or outside mental health provider staff responsive to DCS suggestions? (Can a counselor talk to them? Is the therapist approachable?)
YES NO Comments:

i. Any problems getting any mentally ill participants to needed services? Explain.
YES NO Comments:

10. EDUCATION SERVICES

a. Does the program offer educational services? Include services provided by outside providers.

YES NO Comments:

---

b. Have you had anyone in the program that has needed English to Students of Other Languages (ESOL)? If yes, is it available? If no, do you have a plan in place if you get participants who need ESOL?

YES NO Comments:

---

c. Have you had anyone in the program that has needed literacy education? If yes, does the program offer literacy services? If no, do you have in place if you get participants who need literacy education?

YES NO Comments:

---

d. Does the program offer GED preparation classes?

YES NO Comments:

---

e. Are Adult Basic Education (ABE) classes available?

YES NO Comments:

---

f. Does the program provide a way to secure a high school diploma?

YES NO Comments:

---

g. Are post-secondary opportunities available? How? (Classes must be able to count toward at least an associate's degree)

YES NO Comments:

---

h. Are student satisfaction surveys provided by DCS collected on a semiannual basis for instruction and curricula improvement?

YES NO Comments:

---

i. Are students enrolled according to established relevant criteria?

YES NO Comments:

---

j. Do all teachers attend training annually?

YES NO Comments:

---

k. Do students receive certificates of program completion?

YES NO Comments:

l. Is there any problem with access to educational programs? (Based on current program offerings - if 90% of current wait list cannot be served in one year then Yes)

YES NO Comments:

m. Are class sizes appropriate for the nature of the program? (e.g., LRR=15; ABE=20; GED=25)

YES NO Comments:

n. DO NOT ASK – RECORD REVIEW: Does this program administer any type of pre and post test for the participants in all education groups?

YES NO Comments:

o. DO NOT ASK – RECORD REVIEW: Does the program maintain and provide DCS with records of student attendance.

YES NO Comments:

p. DO NOT ASK – RECORD REVIEW: Program maintains and provides DCS with records of class completion.

YES NO Comments:

q. DO NOT ASK – RECORD REVIEW: Program maintains and provides DCS with records of certificates of achievement.

YES NO Comments:

11. WORKFORCE/EMPLOYMENT SERVICES

a. Do you have workforce services for participants?

YES NO Comments:

b. Are assessment services for vocational aptitude and/or work skills available?

YES NO Comments:

c. Are referrals to area tech schools in the community offered? (Referral must involve assistance with the placement and partnerships with the program.)

YES NO Comments:

d. Are opportunities being provided to participants to attend vocational classes at your program or in the community?

YES NO Comments:

e. Do participants receive certificates for completion of tech/voc classes?
YES NO Comments:

f. Does the program offer a Life Skills/Reentry curriculum? (i.e. Goals/Plans/Success curriculum)
YES NO Comments:

g. Does the program have a staff member who notifies participants of employment opportunities in the community (can't be "newspapers on a table" or "check the computer").
YES NO Comments:

h. Does the program have a staff member who serves as an employment liaison?
YES NO Comments:

i. Does the program have a staff member who provides job placement referrals (employment locating)?
YES NO Comments:

j. Are there any problems with access to employment opportunities?
YES NO Comments:

12. FAMILY SERVICES

a. Are participants' families participating in any aspect of your program?
YES NO Comments:

b. Is this program proactive in encouraging family members to visit? (works with volunteer agencies to secure transportation, sends information about special events.)
YES NO Comments:

c. Does this program work to assist family reunification services where appropriate?
YES NO Comments:

d. Does this program work to assist child reunification services where appropriate?
YES NO Comments:

---

e. Does this program provide parenting classes that address child development and child management?
YES NO Comments:

---

f. Does this program systematically inform family members of the participant's case plan? Do not give credit for in response to a phone call.
YES NO Comments:

---

g. Does the program provide orientation to family members about the nature of the interventions offered at the program? If yes, which groups have the orientations for the family members?
YES NO Comments:

---

h. Does this program educate family members, so they are able to provide support for the participant's treatment? If yes, how is the education accomplished?
YES NO Comments:

---

i. Does this program provide any services that help family members to receive services such as clothing, transportation, job services, or shelter? (There should be evidence in the aftercare plan.)
YES NO Comments:

---

j. Does the program have incentives for the family members to participate? If yes, what incentives are used?
YES NO Comments:

---

13. AFTERCARE SERVICES

a. Does the program have transition services for participants who are about to enter aftercare?
YES NO Comments:

---

b. Do the participants receive a list of goals and recommendations prior to entering aftercare?
YES NO Comments:

---

c. Does the program educate the participants about support services that are available to them upon entering aftercare?
YES NO Comments:

d. Does the program maintain referrals to outside service providers for participants? If yes, what are some typical referrals and what is the process?
YES NO Comments:

e. Does the program work with community partners to maintain aftercare planning, e.g., churches, housing, labor, social services, child care, and mental health and substance abuse agencies?
YES NO Comments:

f. Are participant benefits maintained throughout their time in aftercare e.g., Medicaid, TANF, veterans, social security, food stamps, etc.?
YES NO Comments:

g. DO NOT ASK – RECORD REVIEW: Is there evidence of a transition case plan to aftercare?
YES NO Comments:

h. DO NOT ASK – RECORD REVIEW: Do participants with mental health problems receive a separate case plan upon entrance to aftercare that provides for continuity of care?
YES NO Comments:

RECORDS TO REVIEW AT CONCLUSION OF ASSESSMENT:

Substance use counseling: (Page 9)

☐ Is there evidence the facilitators are using the manuals?
- ☐ Do all facilitators receive relevant booster trainings (View certificates of completion)?
- ☐ Do facilitators maintain records on attendance?
- ☐ Do facilitators maintain records for program completion?
- ☐ Do participants have the opportunity to evaluate the substance use programs?
- ☐ Does the program have a structured manual, complete with lesson plans?

Cognitive behavioral programming: (Page 11)
- ☐ Do all facilitators receive relevant booster trainings (View certificates of completion)?
- ☐ Do facilitators have access to all treatment manuals?

☐ Is there evidence the facilitators are using manuals? (Use CQIs if any ambiguity in participant response)
☐ Does the program administer any type of pre and post tests for the participants?
☐ Do the facilitators maintain records for attendance?
☐ Do the facilitators maintain records for program completion?
☐ Do participants have an opportunity to evaluate the class?

Education: (Page 14)

☐ Does the program administer any type of pre and post tests for the participants?
☐ Does the program maintain and provide DCS with records of student attendance?
☐ Program maintains and provides DCS with records of class completion.
☐ Program maintains and provides DCS with records of certificates of achievement.

Aftercare services: (Page 18)

☐ Is there evidence of a transition case plan to aftercare?
☐ Do participants with mental health problems receive a separate case plan upon entrance to aftercare that provides for continuity of care?
☐ Do participants with mental health problems receive actual referrals to appropriate community support services upon graduation?
☐ Do participants with substance use issues receive a separate case plan upon graduation that provides for continuity of care?
☐ Do participants with substance abuse issues receive actual referrals to appropriate community support services upon graduation?

Records review notes

Appendix C
Sample site visit letter

DRC Site Visit Notification

Location: **LOCATION NAME**
Chief/CA: **CHIEF/CA NAME**
Date: **SITE VISIT DATE**
Time: **SITE VISIT TIME**

Evaluation Team: **NAME ALL MEMBERS OF THE EVALUATION TEAM**

The assessment process will be expedited to the fullest extent possible, but the visit may last up to 4 hours, depending on records available, staff availability, and total interview times. Upon arrival, the evaluators will introduce themselves, contact the Chief, and begin the process of records review. The required records necessary for review are outlined below. Following records review, the evaluation team will begin their interviews, first with the Chief, then with additional staff. The requested staff and areas they should be knowledgeable of are also outlined below.

Throughout the assessment, evaluators will ask questions about DRC/GDRC programming, across the following dimensions:

- Case management
- Leadership
- Assessment
- Staff characteristics
- Program resources
- Program clinical/administrative supervision
- Substance use counseling
- Cognitive behavioral programming
- Mental health services
- Education services
- Workforce/Employment services
- Family services
- Aftercare services

After each visit, the evaluators will compile data and conduct a thorough team review. From this process, each DRC/GDRC will receive a written report from the evaluation team outlining their total assessment score, areas of strength, areas of concern and topics outside of DRC/GDRC control in a reasonable timeframe.

Questions or concerns about the assessment process should be directed through Statewide DRC Manager (**INSERT STATEWIDE MANAGER NAME AND CONTACT)**.

For each site visit, the following records and materials will be required for review. These should be available for review prior to the arrival of the evaluators.

Substance use counseling

1. A list of all substance use programs provided (by inside and outside providers)
2. Program manual for substance use services.
3. Substance use programming attendance records for past three months.
4. Substance use programming completion records for past three months.
5. Any participant evaluations done for substance use programming for past three months.
6. Certificates of completion for all counselor booster trainings

Cognitive behavioral programming

1. A list of all cognitive behavioral programs provided (by inside and outside providers)
2. Program manual for substance use services.
7. Any pre and post test data for participants in mental health programming for past three months.
8. Mental health programming attendance records for past three months.
9. Mental health programming completion records for past three months.
10. Any participant evaluations done for substance use programming for past three months.
11. Certificates of completion for all counselor booster trainings

Education services

1. Any pre and post test data for participants in education programming for past three months.
2. Education programming attendance records for past three months.
3. Education programming completion records for past three months.
4. Education services certificates of achievement for past three months

Phase 3/Aftercare services

1. Transition case plan for 3 most recent program graduates.
2. Transition case plan for 3 most recent program graduates with documented mental health problems.

For each site visit, the following staff positions will be interviewed. Each position should be familiar with the general topics listed. It is understood that the same staff member may be responsible for multiple areas. It is also suggested that if any of these areas are covered by outside entities (referrals to external agencies, external partners providing onsite services, etc.) that those providers would be present for the interviews and/or available by phone during the interview process.

1. DRC/GDRC Chief or designee - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Leadership style, services provided, staff training, staff selection, NGA tool, participant entry assessment results, and program resources

2. Programming supervisor for care and treatment counseling staff - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Program supervision, staff requirements and annual evaluation

3. Substance use programming supervisor - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Available programs, program operations, staff characteristics, staff training, and program supports

4. Mental health programming supervisor - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Available programs, program operations, staff characteristics, staff training, program supports, and availability of mental health services

5. Education programming supervisor - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Available programs, staff characteristics, and staff training

6. Workforce/Employment programming supervisor - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Available programs, staff characteristics, and staff training

7. Family services programming supervisor - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Family engagement and available services

8. Phase 3/Aftercare services programming supervisor - **(NAME OF PERSON TO ADDRESS THIS SECTION – TO BE COMPLETED BY DRC/GDRC STAFF)**

a. Interview topics include: Program operations, and case planning

Appendix D
Sample scoring report

DRC/GDRC NAME			
Area	**Percentage**	**Score**	**Max Score**
Case management	100%	7	7
Leadership	100%	13	13
Assessment	100%	4	4
Staff Characteristics	100%	45	45
Program resources	100%	7	7
Program supervision	100%	7	7
Substance use counseling	100%	23	23
Cognitive behavioral counseling	100%	24	24
Mental health services	100%	9	9
Education	100%	17	17
Workforce development	100%	10	10
Family services	100%	10	10
Aftercare services	100%	8	8
Total	**100.0%**	**184.0**	**184.0**

Appendix E
DRC/GDRC Assessment Program Site Visit Report

Name: NAME
Date of visit: DATE
Evaluators: EVALUATORS

Overview: On **DATE** the evaluation team visited the **SITE NAME** to assess program operations along 13 dimensions (listed below). These dimensions were identified from two sources: (1) DCS policy and (2) Nationwide evidence-based research on factors associated with reducing recidivism among day reporting center participants. The information below contains an overview of program operations, outlining three areas within each domain: *Strengths* (what the program is doing well/in accordance with DCS policy), *Areas for improvement* (what the program is not doing well/is out of compliance with DCS policy) and *Topics outside of DRC/GDRC control* (topics where program operations are out of compliance with DCS policy, but cannot be remedied by the specific center).

Individuals Interviewed: Name, title; Name, title;

DRC/GDRC NAME			
Area	**Percentage**	**Score**	**Max Score**
Case management	100%	7	7
Leadership	100%	13	13
Assessment	100%	4	4
Staff Characteristics	100%	45	45
Program resources	100%	7	7
Program supervision	100%	7	7
Substance use counseling	100%	23	23
Cognitive behavioral counseling	100%	24	24
Mental health services	100%	9	9
Education	100%	17	17
Workforce development	100%	10	10
Family services	100%	10	10
Aftercare services	100%	8	8
Total	**100.0%**	**184.0**	**184.0**

The above table illustrates specific scores within each section of the assessment. The total percentage is the average across each area and is scored on a 0% - 100% scale. Detailed information associated with assessment results across each area are outlined below.

1. Case Management

Strengths

- Case files include an individualized case plan with participant goals
- Case files are matched to the NGA and other assessments conducted
- Case notes are reviewed and updated on a regular basis, to reflect meeting goals
- Case plans are developed for all needs of participants
- Case plans show more intensive services for medium and high-risk participants and keep low risk participants out of interventions intended for higher-risk participants
- Case plans are developed in collaboration with the offender

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

2. Leadership

Strengths

- Leadership has made changes to improve program
- Leadership is engaged in program operations
- Leadership provides direct services to participants
- Leadership is knowledgeable of the services provided
- Leadership has been introduced to the principles of RNR and ESP, and these principles affect what is done at program
- Leadership has received treatment-related professional development in the past year
- Leadership actively supports program staff in securing additional training

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

3. Assessment

Strengths

- Staff is knowledgeable on the use of the NGA
- Required assessments (ASI-L, T-CUDS) are administered on a consistent basis
- Assessment results are discussed with participants

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

4. Staff Characteristics

Strengths

- All program staff have a bachelor's degree in a helping profession
- Most program staff have been trained in Basic Counselor Training, Motivational Interviewing, Effective Communication

- Most program staff have at least 3 hours of training related to treatment topics
- Most management staff have been introduced to the principles of RNR
- Most staff have been trained in Motivational Interviewing
- Most staff have been trained in ESP

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

5. Program Resources

Strengths

- Program has enough meeting space to conduct the programs and individual sessions with the participants
- Program has sufficient equipment and materials to run interventions
- Program has sufficient staff to run core programs
- Outside stakeholders have been introduced to the principles of RNR and ESP
- Stakeholders beyond the criminal justice system have provided resources to the program
- Program staff, other than leadership, have sought new resources for the program

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

6. Program Supervision

Strengths

- Program staff are supervised
- Clinical supervisors have a professional license, certificate or degree
- Administrative supervisor observes counseling staff to assure they are using RNR principles
- Administrative supervisor observes counseling staff to assure they are accessible to participants
- Administrative supervisor observes counseling staff to assure high-risk participants receive more intensive services than low-risk participants
- Administrative supervisor sits in on groups to observe staff facilitating groups

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

7. Substance Use Counseling

Strengths

- All substance use facilitators are licensed or certified substance use counselors
- Participants are admitted to substance use programming according to risk
- Participants receive awards or other reinforcements for program completion

- Program uses sanctions and follows through on sanctions
- Facilitators track the drug tests of participants
- All substance use facilitators are current on mandatory training
- Management, staff, and officers are supportive of substance use services
- Program has been reviewed annually for quality assurance
- Substance use groups meeting frequency adheres to approved guidelines
- Class sizes are appropriate for the nature of the programs
- Program has a structured manual that is complete with lesson plans
- Program facilitators are using manuals
- Facilitators maintain records on attendance and program completion
- Participants have the opportunity to evaluate substance use programs

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

8. Cognitive Behavioral Counseling

Strength

- Program provides cognitive behavioral programming in addition to MRT
- Participants are selected for cognitive behavioral programming based on appropriate risk, need and responsivity
- Awards for participation and completion are offered
- Facilitators have onsite supervision by individuals trained in the curricula
- All facilitators are current with mandatory training
- All facilitators have a bachelor's degree in a helping profession
- Management, staff, and officers are supportive of cognitive behavioral programming
- Cognitive behavioral programming meeting frequency adheres to approved guidelines
- Class sizes are appropriate for the nature of the programs
- Program has been reviewed annually for quality assurance
- Program administers pre- and post-tests for all participants
- Facilitators have access to all treatment manuals
- Facilitators are using the manuals
- Facilitators maintain records for program completion
- Participants have an opportunity to evaluate the classes

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

9. Mental Health Services

Strengths

- Program offers mental health services to participants

- Emergency mental health services are available to participants
- Mental health services offer therapy or counseling under the supervision of a psychiatrist
- Mental health providers report to program staff on a regular basis of at least once per month
- Mental health provider staff are aware of participant mental health assessment results
- Mental health provider staff plan or assist for continuity of care
- Mental health provider staff are responsive to DCS suggestions

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

10. Education

Strengths

- ESOL classes are available, or a plan is in place for participants who need ESOL
- Literacy Education classes are available, or a plan is in place for participants who need them
- Program provides GED preparation classes and Adult Basic Education
- Program provides a way to secure a high school diploma
- Post-secondary opportunities are available
- Student satisfaction surveys are collected on a semiannual basis
- Students are enrolled according to established criteria
- Teachers attend training annually
- Students receive certificates of program completion
- Class sizes are appropriate for the nature of the program
- Program administers pre and post tests for students
- Program maintains and provides DCS with records of student attendance and completion
- Program maintains and provides DCS with records of certificates of achievement

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

11. Workforce Development

Strengths

- Workforce opportunities are available for participants (voc./tech/life skills)
- Staff is actively involved in providing job opportunities

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

12. Family Services

Strengths

- Program encourages family participation
- Program works to assist family reunification services where appropriate
- Program works to assist child reunification services where appropriate
- Program provides parenting classes
- Program systematically informs family members of participant case plans
- Program provides an orientation to family members
- Program provides education to family members, so they are able to provide support to participants
- Program provides services that help family members
- Program provides incentives for family members to participate

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None

13. Aftercare Services

Strengths

- Program participants receive a list of goals and recommendations when entering aftercare
- Program educates participants about support services available to them when entering aftercare
- Program maintains referrals to outside providers for participants
- Program works with community partners to maintain aftercare planning
- Participant benefits are maintained throughout their time in aftercare
- Each participant has a transition case plan to aftercare
- Participants with mental health problems receive a separate case plan upon entrance to aftercare that provides for continuity of care

Areas for improvement

- None

Topics outside of DRC/GDRC control

- None