Adherence to Evidence-Based Practice in Community Treatment:
Aggregate Report for
LSAA Providers and DORA Sites

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S.J. QUINNEY COLLEGE OF LAW

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Jessica Seawright, M.S.W.
Christian M. Sarver, M.S., M.S.W.
Erin B. Worwood, M.C.J.
Robert P. Butters, Ph.D.

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Utah Criminal Justice Center, University of Utah

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Introduction

Building an evidence-based criminal justice system requires a commitment from stakeholders to continually make improvements and promote collaborative work. In the past year, the Commission on Criminal and Juvenile Justice (CCJJ), the Division of Substance Abuse and Mental Health (DSAMH), and the Utah Department of Corrections (UDC)[1] have worked to improve public safety by providing insight into what it will take to successfully adhere to evidence-based principles in the treatment of participants involved in the criminal justice system. To this end, stakeholders identified thirteen substance use treatment providers throughout the state to participate in program evaluation and quality improvement processes with the Utah Criminal Justice Center (UCJC), University of Utah. This report provides a snapshot of providers' progress with respect to implementing Evidence-Based Practice (EBP) as well as recommendations for program and system-level changes to support these efforts.

Background

In January 2015, CCJJ contracted with UCJC to assess eight programs with respect to adherence to EBP; subsequent to those evaluations, UCJC was asked to provide ongoing quality improvement through technical assistance. In June 2016, an additional five programs were selected for assessment to capture all LSAAs in the state. See *Table 1* for a list of participating DORA Sites and Non-DORA Treatment Providers and *Appendix A* for complete program descriptions.

The purpose of this report is three-fold: 1) to summarize the aggregate program assessment findings from the thirteen program assessments conducted throughout the state of Utah in 2015-2017; 2) to summarize the aggregate findings on supervision at each site; and 3) to summarize the barriers to the program assessment, quality improvement, and technical assistance processes. The final section of this report highlights key findings and provides recommendations for next steps.

Table 1. Participating Providers

Provider Name	Counties Served
DORA Sites	
DORA Treatment *and* Supervision	
Odyssey House	Salt Lake
Utah County Department of Drug and Alcohol Prevention and Treatment	Utah
Weber Human Services	Weber/Morgan
Davis Behavioral Health	Davis
DORA Treatment Only	
Bear River Health Department	Cache/Rich/Box Elder
Valley Behavioral Health - Tooele	Tooele
Four Corners Community Behavioral Health, Inc.	Carbon/Emery/Grand
Southwest Behavioral Health Center	Beaver/ Garfield/Iron/Kane/Washington
Non-DORA Treatment Providers	
Valley Behavioral Health - Summit	Summit
Wasatch County Family Clinic	Wasatch
Northeastern Counseling Center	Daggett/Duchesne/Uintah
Central Utah Counseling Center	Juab/Millard/Paiute/San Pete/Sevier/Wayne
San Juan Counseling Center	San Juan

[1] CCJJ, DSAMH, and UDC will be referred to as stakeholders throughout the rest of the report.

Brief Overview of Methods

Correctional Program Checklist On-site Assessments

Programs were assessed using the Correctional Program Checklist (CPC), which was developed by the University of Cincinnati, to assess how closely correctional programs adhere to known principles of effective interventions. Programs that adhere more closely to such principles demonstrate an increased impact on offender recidivism (see *Appendix B* for more detail). Site visits were conducted with each of the 13 providers. The assessment team included 2-4 researchers from UCJC, each of whom scored the CPC independently. Each assessment consisted of structured interviews with staff members, supervisors, administrators, program participants, and treatment providers. Additional data were gathered via the examination of representative client files (open and closed) and the review of relevant program materials (e.g., treatment manuals, course syllabi, ethical guidelines, and staff surveys). Data from the various sources were used to calculate a consensus CPC score for each program. The UCJC team then developed a comprehensive report detailing the program's strengths and weaknesses with respect to the CPC. A full report of findings and recommendations was provided to each program's leadership team. Program directors were invited to submit revisions to the draft report, after which a feedback meeting was conducted with program staff to explain the results, discuss revisions, and answer any questions.

Quality Improvement

Following the feedback meeting, UCJC staff worked directly with each provider to develop a quality improvement plan (QIP). While developing the QIP, program leadership were encouraged to select a few domains to target for improvement and to outline specific goals and action steps. UCJC staff checked in monthly unless otherwise requested by program directors. These check-ins allowed UCJC staff to update the QIP and provide specific resources and information to support the programs.

Technical Assistance

Some of the resources provided directly to the programs included: contacting outside researchers, designing and facilitating surveys, providing trainings, and giving feedback on proposed goals. UCJC staff also provided more generalized assistance to all programs, including in-person trainings, quarterly newsletters, development of an online training site to assist with staff development, and the hosting of an annual criminal justice conference. The purpose of the general technical assistance was to increase competency in evidence-based practice across the state and to f collaboration amongst criminal justice stakeholders. The newsletter and online training site were specifically developed for program staff, while the in-person trainings and conferences were open to all criminal justice stakeholders. *Table 2* describes program participation in general technical assistance offerings.

Table 2. Participation in general technical assistance offerings by programs

Technical Assistance	Percent of Programs
Quarterly Newsletters	100%
Online training site	62%
1st Beck Institute Cognitive Behavior Therapy Training	77%
2nd Beck Institute Cognitive Behavior Therapy Training	23%
1st Utah Criminal Justice Conference	38%
2nd Utah Criminal Justice Conference	62%

Aggregate Results from Program Evaluations

Background and Methods

CPC assessment scores for all 13 providers were aggregated to provide stakeholders information on the programs' overall adherence to EBP as well as to highlight areas in need of system-wide attention. A summary analysis of the CPC assessment results was conducted to identify areas where the 13 providers demonstrated strong adherence to EBP and critical areas in need of improvement to fully implement EBP.

The process for conducting and scoring the CPCs is described in the *Correctional Program Checklist (CPC)* sub-section within *Appendix B*. When most or all programs were unable to meet the evidence-based practice, system-wide recommendations are provided here. "System-wide" refers to areas that may require a review of system-wide policy and procedures, collaboration with other criminal justice stakeholders, or require additional state resources to accomplish the practice.

Results and Recommendations

The following sub-sections review the specific areas for improvement, as well as strengths, organized by the five domains of the CPC. Although there are many direct service improvements that each program can make, those are outside of the focus of this report and have been provided to individual programs in their individual program evaluation reports. Program and system strengths are noted throughout the sections, as they pertain to skills or resources that should be leveraged when addressing the areas for improvement.

Program Leadership and Development

The Program Leadership and Development domain examines the program director's qualifications and previous experience, as well as his/her current involvement with the staff and the program participants. This domain also evaluates whether empirical literature was consulted prior to initiation of programming and whether new initiatives are piloted prior to implementation. The degree of support for the program, including funding stability and from both the at-large and criminal justice communities, are evaluated.

This domain was the strongest across all 13 programs. At the time of the assessment, all programs had adequate and stable funding to implement their programs as designed and had been in operation without major programmatic changes for several years. However, at the time of assessment, many programs were still adopting standards required by the Justice Reinvestment Initiative (JRI), and the adequacy and stability of funding for additional community-based treatment for criminal justice-involved participants was still being determined and negotiated at a legislative level. Overall, the programs were valued by the community-at-large where they operated as well as by the criminal justice community. The program directors (those responsible for the day-to-day management of the treatment program) all had sufficient qualifications and experience with offender treatment. Most program directors directly supervised staff and selected their staff.

The primary areas for improvement (elaborated upon below) in this domain included: consistently providing single-sex group treatment, eliminating the barriers to conducting literature reviews as well as educating staff on their findings, and providing support and resources for program leadership that promote the level of engagement required for evidence based programming and continual staff development.

It is recommended that services should not be provided in mixed gender settings. This recommendation is particularly noteworthy because women's pathways to crime and substance abuse differ from men's (Berman, 2005; Covington, 1999; Covington & Bloom, 2007; Grella, 2008; Nelson-Zlupko, Kauffman, &

Dore, 1995; Sun, 2006). Some research (Hodgins, el-Guebaly, & Addington, 1997) indicates women have improved treatment experiences when in single-sex groups. One barrier for programs to meet this recommendation were constraints in participant numbers and resources (e.g., staff). To improve program effectiveness, individual services should be recommended for women if single-sex groups cannot be created and maintained.

To effectively reduce recidivism among criminal justice- involved populations, each program must have a core where all of its components are based on a coherent theoretical model that has empirical evidence supporting its effectiveness. All staff should also be continually exposed to the literature to the extent that they can demonstrate a thorough understanding. The barriers reported during assessment interviews for individual programs to accomplish this recommendation include changes in staffing, continual updates to the literature, difficulty in acquiring ongoing access to research databases to retrieve articles, and allotting staff time to conduct the reviews.

To support programs in meeting this recommendation, stakeholders may consider the following approaches. One option is program-based and includes allocating resources to support a staff member at each program dedicated to identifying, reviewing, and discussing such literature. This staff member should be provided with the time and resources (e.g., access to a database subscription to retrieve articles) to familiarize her or himself with the psychological theories that form the basis of the program as well as the scientific literature supporting the efficacy of interventions based on those theories. The second option is a state-based approach. Theoretical models are prioritized and investment is made in conducting comprehensive literature reviews where relevant research concerning effective treatment approaches utilized by programs, including major criminological and psychological journals, are used. More importantly, staff trainings should then be sponsored and made accessible through a variety of approaches (e.g., in-person training, online, and written) to share the results with all programs on an ongoing basis.

The education and expertise of program leadership was strong throughout the state. Therefore, ongoing support and allotment of resources (e.g., providing sufficient internal support staff and/or external technical assistance) for program leadership at a system-level when implementing EBP should be considered a priority. The recommendations specify that Program Directors be directly involved in responsibilities including program development, improvement, and dedication to treatment staff (e.g., interviewing potential staff, providing initial and ongoing training, supervision, and observation to all treatment staff), as well as practicing systematic and continuous direct service delivery to criminal justice-involved clients. This was difficult for Program Directors across the state. Programs currently employ a variety of approaches to refine, prioritize, and build support to accomplish these recommendations. Although programs in larger cities were more likely to have additional resources, such as dedicated teams serving criminal justice-involved clients, programs located in more rural jurisdictions struggled to serve a client-base that was dispersed over larger geographic areas with far fewer resources.

Staff Characteristics

The Staff Characteristics domain examines the qualifications, experience, stability, training, supervision, and involvement of the program staff. Staff considered in this domain include all full-time and part-time employees who conduct groups or provide direct service/treatment to the participants.

Similar to *Program Leadership and Development*, this domain was also an area of strength for most of the 13 programs reviewed in 2015-2017. The majority of staff had relevant experience and education. Also, program staff overwhelmingly supported the goals and values of treatment for the criminal justice population. Many programs had regular staff meetings, solicited staff feedback on program components, and provided clinical supervision to treatment staff who were working toward licensure. Most programs

did not provide clinical supervision to treatment staff post-licensure; some programs would choose to utilize a peer feedback structure to support clinical development and to reduce the burden on leadership.

Staff development is vital to ensure fidelity in treatment and includes pre-hire practices, such as identifying relevant experience, skills, and values in potential staff, and post-hire practices, such as offering consistent performance reviews (e.g., feedback on service delivery). It also includes formal training for new hires as well as ongoing training on service delivery, general training on the criminal justice population, and specific training on the use of assessments or curricula. Examples of practices that are not evidence-based include: 1) assigning new staff without criminal justice experience to be the person responsible for all criminal justice-involved clients, and 2) allowing clinicians to facilitate groups without receiving feedback via direct observation from a peer clinician or program leadership.

A review of materials used to recruit, interview, and evaluate staff suggest that hiring practices and performance evaluations rarely emphasize skill-driven elements. Stakeholders should consider providing programs with materials to improve staff development (e.g., position descriptions for recruitment, staff evaluations). For instance, annual staff performance evaluations should assess professional and interpersonal skills, focus on interactions with participants, and should include observations of service delivery. The evaluation should also provide feedback in the following areas: effective use of authority, effective reinforcement and disapproval, problem-solving and decision making skills, modeling behaviors, and communication.

Further, ongoing training on the principles and specific modalities for the treatment of the criminal justice-involved participants is vital for successful implementation and should continue to be sponsored by stakeholders. During the CPC assessments, program leadership described a need for staff training and development that pushes past a didactic model (e.g., in-training practice, fidelity monitoring including feedback). Trainings sponsored by stakeholders should include a variety of teaching styles where treatment staff can practice the skills they are learning (e.g., interpret and use an assessment in treatment planning). Where meaningful, post-training support should also be available. Post-training support could include feedback on service delivery, co-facilitation with trainers, shadowing, or review of recorded sessions. Further, treatment staff whose focus is not solely on criminal justice-involved clients (e.g., LSAAs) are challenged to meet the demands of a variety of populations needing services in their community. A need across the programs includes assisting each program in adopting and implementing the training to support the agency's mission and the communities served. Specifically, training should help staff understand how to prioritize the assessed criminogenic needs and responsivity factors (e.g., mental health, substance use disorders, and trauma) in treatment while maintaining fidelity to evidence-based treatment for criminal justice-involved participants.

Offender Assessment

The Offender Assessment domain examines three areas regarding assessment: selection of offenders; the assessment of risk, need, and personal characteristics of the offender or responsivity; and the manner in which these characteristics are assessed. The extent to which services provided are appropriate for the offender, and the use of proven assessment methods, is critical to effective treatment programs. Effective programs assess the risk, need, and responsivity of offenders, and then provide services and treatment accordingly. Assessments and treatment should be focused on the attributes of offenders that are directly related to criminal behavior, referred to as criminogenic needs.

Criminogenic risk and need assessments should assess offender risk for re-offense and provide measures of the "Central Eight" criminogenic needs: antisocial attitudes, peers, personality, and history; substance abuse; family/marital circumstances; school/work; and leisure/recreation. Responsivity factors may affect a participant's amenability to treatment and include factors such as: motivation, intelligence,

personality, mental disorders, and reading comprehension. These characteristics influence how offenders respond to efforts aimed at changing their behavior, thoughts, and attitudes (Braucht, 2009). The principles of specific responsivity should be utilized to remove barriers to treatment engagement and retention. The principles of general responsivity should also be more fully integrated into treatment programs. General responsivity posits that individuals learn new behaviors most effectively through cognitive-behavioral treatment (CBT) and social learning models (Andrews & Bonta, 2006). As such, programs need to consistently allow participants an opportunity to practice and rehearse new prosocial behaviors through role-playing and simulations. This practice should also include increasingly difficult scenarios with constructive feedback.

This domain was mostly scored in the "Ineffective" range indicating several areas for improvement across nearly all of the programs evaluated. The scores are not surprising considering that, during the CPC assessments, there were many system-wide changes occurring in assessment of criminal justice involved participants. Some of the changes included state-sponsored trainings in the Level of Service/Risk, Need, Responsivity (LS/RNR) assessment tool utilized by treatment staff and within Adult Probation & Parole (AP&P). A significant shift in assessment sharing between criminal justice stakeholders also occurred after all the CPC assessments were completed. This is important to consider, although the CPC requires that all programs be scored based on the consistent processes that were available at the time of the assessment. As such, the following recommendations for assessing offenders' risks, needs, and responsivity aim to assist in continuing the system-wide effort to improve assessment of criminal justice-involved treatment participants.

Overall, stakeholders should continue efforts improve the availability, consistent use, and documentation of standardized and objective criminogenic risk, need and responsivity assessments. Efforts in this domain will support the system improvements recommended in the next domain, *Treatment Characteristics.* Stakeholders can further assist the programs in promoting collaborative relationships between criminal justice stakeholders (e.g., AP&P, treatment providers). Programs could use support in identifying the variety of assessments currently in use throughout the criminal justice system including community treatment programs that serve criminal justice-involved participants. Further assistance is required to identify the relative strengths and weaknesses across assessments in relation to predicting offender recidivism and identifying criminogenic needs to address during treatment. This process should also review whether a single or few main points can be identified where appropriate risk, need, and responsivity assessments could be conducted and then shared across the system. A more centralized structure for conducting and sharing assessments would not only reduce duplication but would also improve consistency because it would allow the different stakeholders (e.g., AP&P, treatment providers) to be working towards the same goals. Stakeholders should explicitly identify the appropriate occasions, if any, where the individual programs are responsible for conducting the risk, need, and responsivity assessments. For example, there may be a need for individual programs to utilize different assessments or there may be different paths of referral to treatment providers for the criminal justice population.

If programs will be responsible for assessing participants, stakeholders should also consider the start-up (e.g., training) and ongoing (e.g., per test) costs associated with these assessments. Whether risk, need, and responsivity assessments are conducted at a few entry points or by individual treatment providers, staff at all programs should be trained and evaluated in their interpretation and use of the risk, need, and responsivity assessments to tailor client interventions and services to those areas. When reviewing treatment files, most programs appropriately focused a majority of their efforts on criminogenic targets (e.g., substance abuse, antisocial attitudes, impulsive behavior, and anger management) at a rate of 4:1 (or for 80% of treatment time) when compared to non-criminogenic needs. However, the majority of programs did not consistently target the top four criminogenic needs (i.e., antisocial attitudes, peers, personality and history) which have shown the greatest reductions in recidivism.

For more detail about the supervision specific recommendations for assessment see the supervision results section on page 10.

Treatment Characteristics

The Treatment Characteristics domain examines whether or not the program targets criminogenic behavior, the types of treatment used to target these behaviors, specific treatment procedures, the use of positive reinforcement and sanctions, the methods used to train participants in new pro-social skills, and the provision and quality of aftercare services. Other important elements of effective interventions include matching the participant's risk, needs, and personal characteristics with appropriate treatment programs, treatment intensity, and staff.

Like the *Offender Assessment* domain, there are several areas in need of improvement across all 13 programs. While the CPC assessments were being completed, program treatment staff were provided state-sponsored trainings focused on the criminal justice population (e.g., Moral Reconation Therapy). These evidence-based interventions were being implemented in some of the programs at the time of assessment. As improvements in this domain were occurring system-wide this section intends to compliment those efforts. Many of these recommendations reiterate the importance of the availability and consistent use of standardized, objective risk and need assessments that inform the development of individualized treatment plans for offenders.

Program Targets. System-wide development in identifying and tracking program targets and completion could offer vital feedback in the pursuit of evidence-based practice. All programs should be encouraged to identify, or should be provided with, formal completion criteria for participants whereby successful completion of the program is based on behavior change, skill acquisition, and progress on treatment goals. Completion criteria should be objective and standard and defined by progress in acquiring pro-social behaviors, attitudes, and beliefs, as well as completion of treatment goals. A requirement for programs to consistently track program completion will help to evaluate the effectiveness of the program; successful programs have a completion rate within the range of 65% to 85%. Most program staff and leadership were not able to provide their program's completion rate during the assessment.

Risk, Need, and Responsivity. For the principles of risk, need, and responsivity to be more fully integrated into treatment programs, additional training and support for these issues is needed at the system level. Programs may also require more discretion on who to accept, rather than having to accept all referrals or court orders, so they may target the appropriate risk level for their intensity of services and not mix low- and high-risk participants. This type of systemic change likely requires further education of not only program staff, but also criminal justice stakeholders, such as defense attorneys, prosecutors, and judges.

Additional agency changes may also be necessary, such as increased staffing or lower caseloads/group sizes to allow staff more time to develop and practice these skills with participants. These changes will likely require additional resources.

Behavior Modification. Integrating behavioral principles into treatment programming can be a time-consuming task. In addition to being trained on the principles, treatment programs may need additional leverage and partnership with other criminal justice stakeholders (e.g., AP&P) to implement these strategies. This is particularly important at this time with the statewide implementation of the Response and Incentive Matrix (RIM). Additionally, there is a strong movement within the national criminal justice system to integrate behavioral principles more fully due to their ability to impact offender recidivism and substance use. One resource that could be a starting place for many programs is *Behavior*

*Management of Justice-Involved Individuals: Contemporary Research and State-of-the-Art Policy and Practice (*Carter, 2015).

***Aftercare*.** A final need across the system is quality aftercare for participants who exit treatment programs. Although the type and level of that care should vary based on participants' re-assessed risk level and needs, all aftercare services should begin while participants are still in their treatment phase and be designed to help the offender transition into the community. Consistent reassessment of participants near program exit will help determine which types of aftercare services should be provided. While many programs offered aftercare informally, stakeholders could assist program leadership in defining and funding aftercare for participants so that it is a more formal and consistently implemented component of programs.

For more detail about the supervision specific recommendations for treatment see the Supervision results section on page 10.

Quality Assurance

The Quality Assurance domain focuses on the quality assurance and evaluation processes used to monitor how well the program is functioning and its effectiveness.

This final domain of the CPC is an area of need across all 13 programs. All of the programs would benefit from strengthened internal quality assurance processes. This includes ongoing and regular feedback to facilitators, based on observation, regarding use of the curriculum, group facilitation, service delivery skills, and formal participant feedback on service delivery.

Monitoring recidivism of participants is an especially important piece of quality assurance; it is the best way programs can monitor their impact on participants. Programs and criminal justice systems should consider outcome evaluations as they develop and fund new programs, so that appropriate data elements can be identified and matched or risk-controlled comparison groups can be utilized to determine the actual impact of programs. Stakeholders can support programs in maintaining an in-house evaluator (whose primary job is program evaluation) or by providing assistance through a contracted evaluator.

Stakeholders should support directors and programs in making these quality assurance changes by training directors in these skills and providing them the support and resources to conduct observations and provide staff feedback (see recommendations in the *Program Leadership and Development).* For example, stakeholders could be a resource for identifying and weighing the merits of various pre- and post-treatment behavioral assessments. It is recommended that all programs collect some measures of target behaviors that their program is specifically addressing (e.g., substance abuse, anger management) at baseline and exit, if not more frequently (see the recommendations in the *Treatment Characteristics* section). Programs should also collaborate with one another on what measures may be appropriate for monitoring their impact on clients.

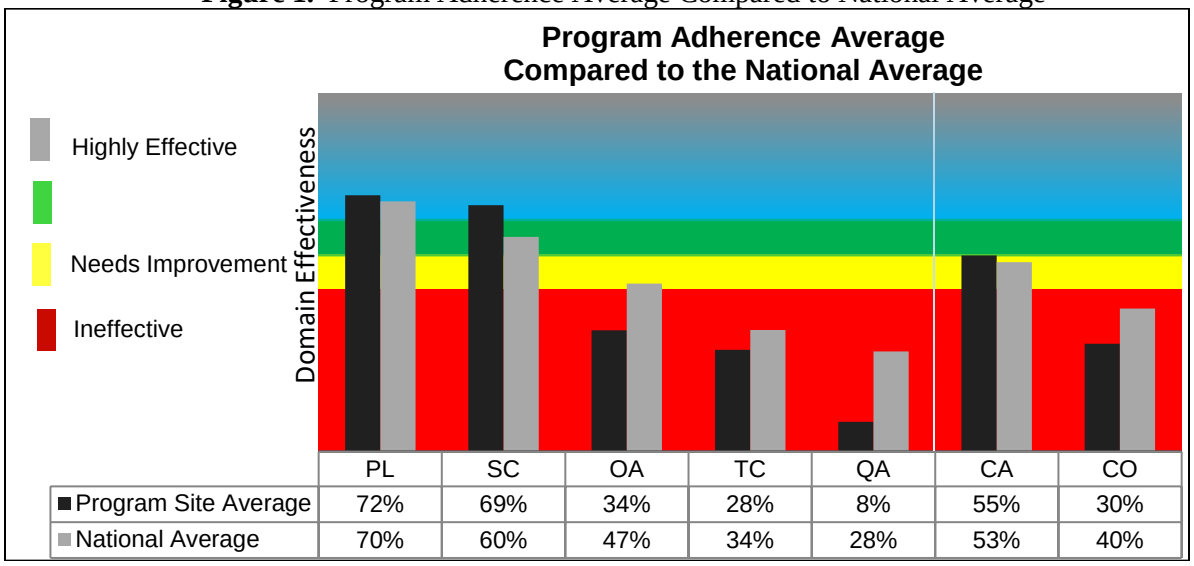
Summary of Findings

Overall, the 13 providers evaluated with the CPC during 2015-2017 had an average total score in the "Ineffective" range (see *Figure 1* on the following page for national and combined program average scores for Overall Capacity and Content, as well as each of the individual domains). This is not

surprising, as the majority of the 500-plus programs reviewed by the University of Cincinnati, while developing the instrument, were also scored as "Ineffective" (45%) or "Needs Improvement" (31%).[2]

Programs scored higher, relative to the other domains, in the CAPACITY area (specifically in *Program Leadership and Development and Staff Characteristics*), and scores are consistent with the national average. However, largely due to the low scores in the *Quality Assurance* domain, overall capacity was within the "Needs Improvement" range. The next section will explore the specific areas of strength and how they could be utilized when targeting areas of improvement for system-wide changes.

Figure 1. Program Adherence Average Compared to National Average[3]



	PL	SC	OA	TC	QA	CA	CO
Program Site Average	72%	69%	34%	28%	8%	55%	30%
National Average	70%	60%	47%	34%	28%	53%	40%

Within the CONTENT area (*Offender Assessment, Treatment Characteristics*), programs scored, on average, in the "Ineffective" range and below the national average. It is important to note the range across programs in both domains. While some programs were assessed within the "Highly Effective" range, others scored at the lower end of the "Ineffective" range. The next section will explore specific areas of improvement for system-wide changes.

Evidence-Based Practice in Supervision

Background and Methods

Criminal justice research (as cited in Solomon et al., 2008) demonstrates that surveillance-oriented supervision, in the absence of treatment that targets criminogenic factors, will not reduce recidivism. The National Institute of Corrections and the Crime and Justice Institute (as cited by Solomon and et al., 2008) recommend best practice supervision strategies to enhance outcomes for criminal justice-involved individuals. These include: actuarial assessment of risk/needs; strategies to enhance intrinsic motivation; targeted interventions (e.g., risk principle, need principle, responsivity principle, dosage, treatment); skill training with directed practice; use of positive reinforcement; engaging ongoing support in natural

[2] The scores reflect the treatment programs' adherence to Evidence-Based Practice for criminal justice-involved participants. As such, supervision was not considered when scoring program adherence.
[3] PL=Program Leadership, SC=Staff Characteristic, OA=Offender Assessment TC=Treatment Characteristic, QA=Quality Assurance, CA=Overall Capacity, CO=Overall Content; Average Total Score is not shown in Figure

communities; measuring relevant processes/practices; and providing measurement feedback. While the CPC assessment focuses on treatment programs, the assessments described in the current report were expanded in order to fully characterize the interaction between treatment providers and AP&P agents. In particular, the UCJC team sought to identify the degree to which supervision practices adhered to the principles of evidence-based supervision.

During the assessment period, the state of Utah implemented widespread criminal justice reform, including the Justice Reinvestment Initiative[4] (JRI) and the Response and Incentive Matrix (RIM) used by Adult Probation and Parole. Adult Probation and Parole (AP&P) also opened new Treatment Resource Centers (TRCs) throughout the state. These changes were intended to bring treatment and supervision in line with evidence-based practice and, therefore, likely changed program's functioning on items assessed during the CPC. As such, the CPC results provide a snapshot of programs' adherence to EBP at a given point in time and may not capture changes that have occurred as a result of ongoing criminal justice reform.

As part of the CPC assessments, UCJC staff collected information regarding the intersection of treatment and supervision through: interviews with AP&P agents, program staff, and program participants; observing DORA-specific team meetings; and reviewing client files and program materials. AP&P agents were asked a set of relevant questions from the full CPC interview guide that were focused on interactions with supervisees as well as information sharing and collaboration with treatment providers. Likewise, program participants were asked questions regarding communication and coordination between AP&P agents and the treatment program and about their interactions with their supervising agent. Treatment program staff were also asked about their relationships with AP&P, including frequency and type of contact, shared decision-making, and collaboration in developing treatment plans. The primary goal of these interviews was to assess the relationship between AP&P agents and treatment providers.[5]

During the assessment period, the state was in the process of implementing the Response and Incentive Matrix (RIM); however, all programs were assessed before RIM had been implemented for a full year. As such, the results presented in this report likely do not reflect changes stemming from RIM implementation, including trainings that took place after the last CPC assessment in September of 2016. Nevertheless, the implementation of RIM was mentioned by agents, program staff, and program participants during CPC assessments at each of the programs.

Results and Recommendations

Overall, AP&P agents endorsed the importance of treatment in changing offenders' long-term behavior. Despite this endorsement of the importance of treatment, there was wide variation in terms of agents' perception of the appropriate role of AP&P agents in facilitating treatment goals. While some agents reported that they were very involved in developing and monitoring treatment goals, others felt those tasks were the domain of treatment providers. In the latter case, there appeared to be little coordination between supervision and treatment strategies.

At sites with DORA-funded agents, interviewees typically described the contact between treatment and supervision as being both structured and regular. At non-DORA sites, Drug Courts sometimes provided a structured process that integrated treatment, the courts, and supervision; however, those practices were not consistently applied to the supervision and treatment of court-ordered offenders who were not in Drug

[4] For more detail on Utah's Justice Reinvestment Initiative see https://justice.utah.gov/JRI/

[5] One program was in transition at the time of the assessment and had minimal contact with AP&P. As such, there were no team meetings. While the UCJC team did speak with AP&P, no full interviews were conducted because, at the time of the assessment, it was reported that there was no coordination between treatment and supervision.

Court. In general, collaboration between supervision and treatment was not common practice for criminal justice-involved participants receiving outpatient treatment, without the structure of DORA or Drug Court models. In these cases, agents expressed a strong willingness to work with treatment providers, but they were not regularly in contact with providers regarding offenders' treatment progress.

Across the state, participants′ risk assessment results were not shared with treatment providers by AP&P at the time of the CPC assessment. However, as previously mentioned, significant strides have since been made in this area. Sharing of assessments amongst criminal justice stakeholders is an important step toward EBP (Solomon et al., 2008) and efforts should be made to continue to improve access to this information for treatment planning. The use of risk assessments in treatment planning is discussed in more detail below.

Agent skills and training

Agents who were part of interagency DORA teams described relatively greater focus on the use of supervision to facilitate treatment participation when compared to non-DORA AP&P agents. Throughout the state, very few agents had received recent training on cognitive behavioral techniques or the use of rewards and sanctions; however, agents who were part of interagency DORA teams were more familiar with treatment goals and reported participating in decision-making processes for responding to offenders' failures and successes in treatment.

Assessment

AP&P agents consistently assessed offenders using some version of the LSI (during the course of the project, AP&P switched from the LSI-R to the LS/RNR); however, sharing of risk assessment results between AP&P agents and treatment providers was inconsistent, throughout the state, at the time of the CPC assessment.

For the collaboration between treatment and supervision to meet EBP, treatment staff would need to consistently receive both overall risk scores, based on a standardized assessment (e.g., LS/RNR), and the domain scores to identify treatment targets (e.g., criminogenic needs). This criteria was not met by either the DORA sites with agents assigned or with DORA treatment-only funding or non-DORA providers. Based on interviews, attendance at DORA team meetings, and a review of treatment files conducted as part of the CPC assessment, only a few providers reported receiving overall risk scores for some clients and no providers received domain scores from the LSI-R or LS/RNR assessments.

DORA sites with assigned AP&P agents reported having regular meetings between treatment and supervision which facilitated the sharing of additional information from the standardized risk, need, and responsivity assessments as well as discussion about placement and treatment implications. As such, at these sites treatment programs were familiar with offenders' overall risk levels, which were reviewed as part of the meeting agenda. However, no sites had practices with assessment sharing and treatment planning that were systematic. As such, all sites were meeting the requirements of EBP in supervision in terms of using risk assessments to determine supervision level with AP&P, but varied in the degree to which they were aligning risk assessment with treatment planning, with none doing this consistently. None of the providers reported coordination with AP&P to determine program completion. *Table 2* shows each program type (e.g., DORA with agents, DORA treatment only, and LSAA) and whether systematic adherence to EBP with assessments and treatment planning was shown during the CPC assessment. Programs were coded as not adhering to EBP if there were inconsistencies between interviews, files, or policy review. Based on the findings in this area, stakeholders should continue to promote greater coordination between treatment and supervision, specifically with respect to risk assessment, to improve

EBP and to reduce duplicative efforts (Solomon et al., 2008) across the state. Programs should ensure that practices are shared with all staff and shown consistently in participant treatment files.

Table 2. Systematic coordination between Treatment and Supervision.

	Assessment Sharing	Treatment Plan-Development	Treatment Plan-Monitoring	Treatment Plan-Completion
DORA with agents with agents	N	N	Y	N
DORA treatment only	N	N	N	N
LSAA	N	N	N	N

Treatment Plan

The use of surveillance strategies to promote offenders' treatment compliance is associated with reduced recidivism (as cited by Solomon et al., 2008). Janetta and colleagues (2008) offer an example of utilizing the treatment plan to focus resources:

> An example of focusing resources other than surveillance on high-risk parolees came from a respondent in Oregon, who described assessing risk to reoffend, motivation to change, and treatment needs. In his office, moderate-to-high-risk parolees with a low degree of motivation to change participate in cognitive-behavioral interventions. Once an assessment of their motivation indicates their readiness to change, they are referred to programming to address other criminogenic needs, such as substance abuse treatment or anger management classes (p. 24-25).

In the programs assessed, development of treatment plans was largely the responsibility of the treatment team. In some programs, the pre-sentence investigation report (PSI) or the Case Action Plan (CAP), both developed by AP&P, or a police report was used to guide treatment decisions. For the most part, AP&P agents relied on the conditions of supervision and the CAP to structure supervision while treatment providers relied on the ASAM and a semi-structured biopsychosocial assessment to develop treatment plans. Outside of DORA program requirements, there was no notable difference in treatment plan development between DORA and non-DORA sites.

Collaborative treatment plan monitoring between AP&P and treatment providers occurred informally in most programs; however, DORA sites had more collaboration, primarily due to the weekly DORA team meetings. There were not consistent practices in place to coordinate monitoring in non-DORA programs, with one exception. Non-DORA programs serving drug court clients demonstrated collaborative treatment plan monitoring, including regular team meetings; however, that collaboration did not extend to court-ordered clients who were not in drug court.

The majority of treatment staff described AP&P as having full responsibility to monitor offenders' whereabouts in the community, peer relationships, and employment. Typically, treatment programs in non-DORA sites were not notified when AP&P identified problematic behaviors; however, these behaviors were often discussed in DORA team meetings. In addition to monthly meetings with offenders, AP&P agents relied on therapists to notify them of any problems with treatment, including failure to attend treatment sessions. Likewise, therapists relied on AP&P to communicate any violations in the community. Outside of DORA team meetings, these efforts to monitor offenders were discrete, with minimal sharing between treatment providers and AP&P. As such, most sites did not have a consistent,

planned, and collaborative response to reward or sanction participants' behavior or progress on treatment goals.

Similarly, program completion criteria were not consistently defined between treatment providers and AP&P. The program requirements of DORA or drug court outlined treatment completion criteria for participants in these programs. However, for court-ordered offenders who were not in those programs, there was little consensus regarding who was responsible to decide that an offender had made sufficient progress on treatment goals and could be discharged. Typically, AP&P left decisions regarding treatment completion up to treatment staff, but no sites based this decision on a review of offender change as characterized in risk and need assessments. AP&P agents typically viewed treatment completion as one of many requirement to be completed under the condition of supervision; as such, treatment completion was not necessarily conceptualized as a reduction in risk that was associated with a reduction in supervision.

Rewards and Sanctions

The CPC assesses how treatment staff use rewards and sanctions as part of a larger behavioral modification strategy. AP&P agents indicated that RIM would structure the use of rewards and sanctions in response to offender behavior; however, given the relative infancy of RIM at the time of these assessments, those strategies had not been fully implemented. With the exception of one treatment program, treatment staff indicated that they relied on AP&P to administer sanctions for noncompliance in treatment.

EBP suggests that supervision should be as engaged in rewarding positive behavior in parolees/probationers as treatment providers (Solomon et al., 2008). However, at the time of the assessments, AP&P agents did not describe collaboration with treatment staff to provide rewards or sanctions to supervisees. Largely, AP&P was responsible for administering sanctions and treatment providers were responsible for giving positive responses to in-treatment successes. To move toward evidence-based practice in supervision, Solomon and colleagues (2008) recommend shifting supervision contacts toward an intervention itself, where motivational interviewing and positive reinforcement are utilized to enhance engagement. Further, Janetta and colleagues (2008) offer an example of rewarding positive behavior change:

> In addition to monetary incentives, parole officers in the Connecticut field office also provided incentives for positive behavior by calling parolees' families to let them know when the parolee was doing well and incorporating regular verbal compliments into interactions between parole officers and parolees. And unlike incentives such as reduced reporting or early discharge, which require that field offices be allowed to set or modify conditions of supervision, any office can use these powerful and effective day-to-day incentives (p. 27).

Of note, many offenders interviewed endorsed the belief that their AP&P agent gave them positive feedback when they accomplished a goal; that feedback, however, was not tied to reduction of criminogenic risk level in treatment because agents were rarely involved in developing and monitoring treatment plans. As such, treatment-related rewards from agents were typically related to attendance rather than engagement with treatment and development of new skills.

Treatment Resource Center (TRC)

There were no specific interview questions about the AP&P's Treatment Resource Centers included in the CPC assessment. Nevertheless, a number of interviewees described the TRCs when answering questions about collaboration between AP&P and treatment providers as well as when describing barriers to meeting EBP. As such, the areas mentioned will be briefly discussed.

In areas where a TRC was located, there were differing perspectives about these Centers' role in treatment. Some treatment staff, typically from non-DORA sites, expressed some concerns about TRCs and their impact of their program's ability to serve clients. Specific concerns included questions of: whether TRCs would be held to the same standards for staff licensure and training as the treatment programs; when referrals would be made from supervision to the treatment programs versus the TRC; and whether this additional treatment option would reduce the provider's clientele and their ability to implement EBP.

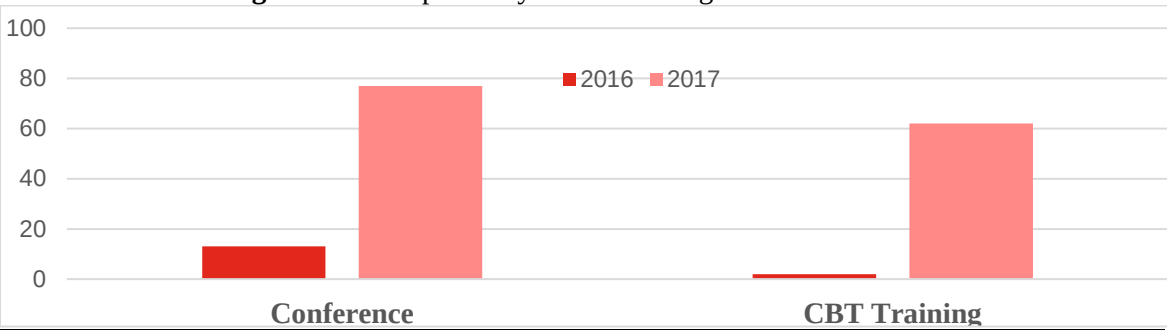
In contrast, AP&P agents felt that the creation of more TRCs alleviated the financial burden of treatment for probationers/parolees. Stakeholders may consider efforts to more clearly communicate the role of TRCs, in relation to other treatment providers, to help alleviate some of these concerns.

Technical Assistance

Technical assistance to enhance adherence to evidence-based supervision was provided and described above in the technical assistance portion for program evaluations. AP&P participation in program-focused technical assistance was not tracked separately for each site. In addition, UCJC, with support from stakeholders, hosted two Beck Institute trainings on Cognitive Behavioral Therapy (CBT) and coordinated two interdisciplinary criminal justice conferences. As shown in *Figure 2*, participation by Utah Department of Corrections (UDC) staff, including AP&P, substantially increased during the second offering of both the CBT training and the conference.

In November 2016, UCJC worked with AP&P to facilitate the sharing of risk assessments between agents and treatment providers. As part of these efforts, AP&P drafted a memo detailing what information from the LS/RNR *Offender Assessment Summary* could be shared with the treatment team. Additionally, the letter documented agents' role and restrictions sharing that information, including providing programs with a signed release of information from the probationer/parolee. This would allow programs to separate participants by risk and to collaborate with AP&P in terms of treatment planning (e.g., identifying the specific criminogenic needs that should be prioritized at intake). This memo was published by UCJC in a technical assistance newsletter, emailed to all program directors, and published on the online training site to be available to all programs enrolled in the online training modules.

Figure 2. Participation by UDC staff in general technical assistance



Technical Assistance	Number of UDC Staff
1st Beck Institute Cognitive Behavior Therapy Training	2
2nd Beck Institute Cognitive Behavior Therapy Training	62
1st Utah Criminal Justice Conference	13
2nd Utah Criminal Justice Conference	77

Summary of Findings

Collaboration between AP&P agents and treatment providers is a central part of EBP. During 2015-2016, technical assistance provided by the Utah Criminal Justice Center focused, in part, on strengthening that relationship.

Substantial differences were observed in EBP adherence in the assessed programs. In general, the existence of DORA agents (or a drug court) was associated with greater support and structure with respect to the integration of supervision and treatment goals. Where such programs existed, treatment staff and AP&P agents discussed criminal justice-involved participants more consistently. Specifically, programs with assigned DORA agents in addition to DORA treatment funding were able to accomplish greater adherence to evidence based practice. However, across the state, AP&P agents and treatment providers were unclear about the boundaries of collaboration (e.g., sharing of risk assessments, monitoring treatment progress, collaborating in behavior modification strategies, and the role of separate treatment providers in the community).

Additionally, there were area differences between rural and urban programs with respect to implementing EBP. This is not unique to Utah, as Janetta and colleagues (2008) also found different approaches in rural and urban areas when implementing EBP supervision. Implementing evidence-based practices, like any organizational change, requires leadership, resources, and training support. Many rural field offices, however, reported that they had not receiving the requisite training and support (Janetta et al., 2008, p.17). This disparity in resources for EBP was evident throughout the current project.

Continued improvement in collaboration between treatment and supervision would have significant positive impacts on many of the areas for improvement described in the program assessment section above. Since the efforts of supervision and treatment are so closely tied, additional recommendations for stakeholders for system-wide improvements are described in the overall recommendations section below.

Program Staff Focus Group and Additional Feedback

Background and Methods

To further understand system issues that could be addressed by stakeholders, UCJC staff collected qualitative information from program staff in the form of a focus group. The primary purpose of this focus group was to supplement information gathered through the CPC program evaluation process.

Program directors and staff from each participating program were invited to take part in a nominal focus group conducted by UCJC researchers on May 19, 2017; five people, representing four programs attended. The focus group meeting lasted approximately two and half hours, with one facilitator and one note-taker. The facilitator provided background information and provided an overview of the process. Participants were asked to draw upon their experiences participating in the program evaluation, quality improvement and technical assistance. The focus group was conducted using a facilitator guide with three questions for the participants (see *Table 3* for specific focus group questions). The information provided was also captured on a white board and photographed. Information was validated by providing a summary after each question/category at the end of the focus group so that participants could correct any misperceptions and/or add information. Ranked information was then summarized and analyzed for use in this report (see *Appendix B* for more information on the nominal focus group method).

Table 3. Focus Group Questions.

Questions
1. What about the CPC program evaluation and quality improvement process/technical assistance has been most helpful to your agency?
2. What areas of the CPC program evaluation and quality improvement/technical assistance process were problematic or not helpful?
3. Based on your experience with the CPC program evaluation and quality improvement/technical assistance process, what larger system changes need to take place?

Due to the low participation, UCJC staff reached out to the program directors to solicit further feedback from those who were unable to participate in the in-person focus group. The same questions were proposed and multiple contacts were made to allow program staff the opportunity to provide feedback. Four additional program directors responded to the secondary call for feedback. These additional comments are provided after the summary of results from each focus group question.

Results and Recommendations

The focus group generated priority areas that the DORA committee could address to continue toward its goal of becoming an evidence-based system. This section is a summary of the priority areas that emerged from the focus group held on May 19, 2017. For each question, all consolidated responses (i.e., non-duplicated responses) are provided and ranked in order of what participants viewed as their top priorities.

Question 1: What about the CPC program evaluation and quality improvement/technical assistance process has been most helpful to your agency?

Focus group participants offered a range of ideas of how the CPC program evaluation and quality improvement process has been beneficial to their organization. *Table 4* provides a comprehensive

representation of what participants viewed as most helpful and the top areas they viewed as most beneficial highlighted in red.

Table 4. Consolidated Responses: Most Helpful Areas[6]

Consolidated Responses	Votes for Top 5 Priorities
Correctional Program Checklist (CPC)	
Insight about evidence-based practice in criminal justice	4
Defined strengths & weaknesses	4
Insight into programming limitations	1
Greater awareness of expectations and requirements	1
Quality Improvement/Technical Assistance Process (QI/TA)	
Online training site resources (the second version is more organized)	3
Training (MRT 2-day, CBT certification training)	3
Scheduled calls-(coaching about work plan/goals, accountability, focus on moving forward)	3
Recommendations about assessment tools (TCU, pre- and post-tests)	1
LS/RNR training (awareness)	1
Centralizing relevant communication	0

The top-ranking themes favored ideas related to the programs learning more about evidence-based practice for the criminal justice population through the CPC process, trainings, and the online technical assistance resources. Participants viewed the assessment as a way to gain insight about their program's strengths and weaknesses, and about technical assistance as an accountability measure to ensure progress on the Quality Improvement Plan (QIP). Also, the different methods of training and resources (e.g., online site, scheduled calls), that allowed staff members to remotely participate, was listed as a benefit of the QI/TA process.

The four program directors who provided feedback after the focus groups indicated that the CPC assessment was helpful in identifying areas for programs to prioritize and quickly improve with the additional confidence that the recommendations were supported by research. These program directors also favored the clear steps to understand concepts and to articulate what the programs are moving toward. While most found the process to be too intensive, a few program directors appreciated the depth of the evaluation and the lens it offered on their entire program. Additionally, these program directors thought the process was beneficial because it was program-driven, not mandated and though it was helpful to have a process (e.g., technical assistance) that was flexible enough to meet the needs of small and large programs.

[6] Responses that are listed with "0" votes in Table 4, 5 and 6 are those that were mentioned during the "Individual Responses" phase of the nominal process, but were not voted as a priority area during the "Ranking Responses" phase.

Question 2: What areas of the CPC program evaluation and quality improvement/technical assistance process were not helpful or problematic?

Focus group participants offered numerous ideas of how the CPC program evaluation and quality improvement process could be improved to better support the providers' implementation of EBP. *Table 5* provides a comprehensive representation of what participants viewed as most problematic and highlights the top areas they viewed as being the greatest challenges.

Table 5. Consolidated Responses: Not Helpful or Problematic Areas

Consolidated Responses	**Votes for Top 5 Priorities**
Correctional Program Checklist (CPC)	
Mental Health/Substance Abuse agencies shaped/forced to be criminal justice-only therapy	5
Lack of clarity about CPC and why it was happening; messaging from DSAMH	4
Feedback did not consider wide range of client needs specifically trauma-informed care and support for the severe and persistently mentally ill (SPMI)	4
Long interview process	3
Tied up a lot of staff resources	2
Bad timing; a lot of audits/reviews close together	1
"Offender" language instead of client/treatment language	1
No compensation for participating	0
Inaccuracies in initial report; not all errors were corrected	0
Quality Improvement/Technical Assistance Process (QI/TA)	
A lot of training did not match agency needs	4
A lot of Canvas (online training site) not applicable	1
Cannot get access to Canvas (online training site)	0

The top-ranking themes suggest some programs did not feel the assessment and corresponding technical assistance was the best fit for their program or that a criminal justice focus would negate other emphases or populations. Participants described a wish that there were more communication and preparation for the assessment or highlighted the demand on internal resources to participate.

Similar to focus group participants, most of the program directors who provided feedback after the focus group felt that the on-site CPC assessment took too much time to prepare and took leadership away from other priorities during the assessment. Many programs reported that they had additional required audits, assessments, and evaluations before the CPC assessment and after the CPC assessment. A few participants described a need for continued access to scholarships for trainings. To illustrate, the Utah Criminal Justice Center offered one training at no-cost and a follow-up training at-cost. Far fewer community-based treatment providers participated in the at-cost training and conference. Program

directors also expressed the need to have a clear list of options that programs can take advantage of for technical assistance to aide in taking advantage of the support.

Question 3: Based on your experience with the CPC program evaluation and quality improvement process, what larger system changes need to take place?

The participants identified areas for larger system changes based on their experience with the whole process. *Table 6* provides a comprehensive representation of what participants viewed as areas the larger system needs to change to make EBP sustainable and highlights the top areas they viewed as needing the most change.

Table 6. Consolidated Responses: Needed System Changes

Consolidated Responses	**Votes for Top 5 Priorities**
Correctional Program Checklist (CPC), Quality Improvement, & Technical Assistance	
Criminal behavior does not meet medical necessity; billing issues	4
DSAMH has different auditors	3
Cannot get access to LS/RNR/LS-CMI or LS-SV from AP&P or other supervision	3
Funding/limited funding; Medicaid Expansion never came through	3
Need ongoing technical assistance	2
More focus on fidelity to models (need funding)	1
Clarity with DSAMH about expectations/role: SA/MH or criminal justice	1
Local authorities should not be doing criminal justice; these individuals should go somewhere else	1
Integration of criminogenic and trauma	1
Need standardization of risk/need assessments	1
Observe sessions and give feedback	0
Training in role-play and contingency management	0
Help defining case manager-therapist role in RNR	0
DORA-specific new employee training	0
Increase collaboration with other DORA providers	0

The primary themes that emerged were limitations in criminal justice focused treatment due to billing structures and funding to approach treatment with a focus on reducing recidivism. Other areas suggested were duplication of what programs perceived as audits and access to risk assessments. Other less prioritized responses emphasized program-based ambivalence about community treatment for criminal justice populations.

Program directors who provided feedback after the focus group indicated that they would like to continue to improve their relationship with criminal justice stakeholders (e.g., AP&P) to communicate, receive assessments more easily, and reduce duplication through information sharing agreements. Additionally, program directors described the need for consistent decisions about who is receiving treatment through

community health programs and/or AP&P's Treatment Resource Centers. These program directors also noted the difficulty of building toward evidence-based practice in rural areas, especially when participant numbers are unpredictable. Lastly, a number of program directors described a need for mental health and substance use to be prioritized alongside criminal justice goals for treatment.

Summary of Findings

Through the focus group and follow-up with program directors, over half of the programs (62%) were able to offer feedback on the CPC and technical assistance process. In general, program directors valued the assessment and program-specific recommendations that were provided. However, UCJC collaboration with the DSAMH should be improved to lessen the burden of the on-site assessment and to ensure the subsequent technical assistance offered by UCJC is not a duplication or in competition with DSAMH. Resources provided by the UCJC should complement trainings and meetings sponsored by the DSAMH and be informed by current recommendations for substance use and mental health treatment. Additionally, the focus group, and subsequent follow-up, highlights a need for additional communication from stakeholders about how programs that are predominantly focused on community based substance use and mental health are expected to integrate evidence-based treatment for their criminal justice-involved participants.

Conclusion

The CPC assessment offers a snapshot of a wide range of programs and supervision structures, and should be interpreted within the dynamic changes that were occurring over the last two years in Utah (e.g., Justice Reinvestment Initiative). However, the overall findings of the initial CPC assessments for these 13 programs throughout the state of Utah suggest that there is room for improvement. These findings are not surprising and are in line with national averages, with a few areas being of higher priority in Utah (i.e., *Offender Assessment, Treatment Characteristics, and Quality Assurance).*

Further, the programs assessed included DORA sites that offer services in more densely populated cities as well as rural programs without DORA-specific funding that provide therapeutic services to their entire community. Each program was provided with specific feedback on its strengths and areas to consider for improvement. Furthermore, recommendations provided in this report aimed to target system-wide barriers that most, if not all, programs experienced. The supervision-based recommendations aim to improve collaboration between treatment staff and supervision. Many of the highest priority recommendations are actively being pursued but there are still system-wide barriers to evidence-based practice. Other recommendations will take considerable ongoing effort to ensure EBP.

Overall, the goal will be to find system-wide solutions that help programs navigate barriers while still empowering programs to meet the specific needs of their community. However, with the implications of recidivism (e.g., cost, public safety) for this population, the recommendations for system-wide improvement listed below have been proven by research and will support evidence-based practice for the criminal justice population. Research has identified that some practices do nothing to reduce recidivism, but other practices can increase recidivism and put participants at more risk to reoffend. Stakeholders are in a unique position to help programs and supervision understand and address these differences with a wide lens.

Recommendations

Similar to the reports provided to the programs based on their CPC assessment, this aggregate report offers a considerable amount of recommendations to continue to move toward implementing statewide

evidence-based practices with criminal justice-involved individuals receiving community-based treatment. To aide stakeholders in prioritizing system-wide targets, four areas of improvement will be presented: 1) promote collaboration amongst criminal justice stakeholder; 2) review system-wide policies and procedures; 3) expand capacity within leadership; and 4) additional trainings and tools.

Promote collaboration amongst criminal justice stakeholders, specifically between treatment staff and corrections-based staff (e.g., AP&P). Continued efforts to refine and ensure that the practice of sharing assessments with the treatment programs is consistent across the state will reduce duplication of efforts and will allow programs to identify specific circumstances or referral pathways where criminal-justice involved participants will not be assessed prior to treatment intake. Currently, there is a lot of variation in what programs have chosen to do. Some programs have employed screening risk assessments or shorter assessments that only determine if the participant is high or low risk; others are waiting for further direction and are not assessing participants for risk prior to placement in treatment groups. None of these efforts allow for risk, need, and responsivity of each participant to be included in treatment planning in a formalized and consistent manner. An additional area for collaboration is the statewide implementation of the Response and Incentive Matrix (RIM). Treatment providers have the opportunity to partner with supervision to bring behavior modification into programming and supervision, however, at the time of this report, treatment and supervision efforts remained largely siloed.

Review system-wide policies and procedures. Throughout the state, treatment programs expressed frustration with the lack of clarity and direct support to implement evidence-based recommendations. For instance, a number of providers expressed concerns over the impact of AP&P's Treatment Resource Centers (TRCs) on their clientele and confusion regarding when a person is best served within the TRC's or an outside treatment provider. Further communication and clarification from stakeholders on the intended role of the TRCs within the larger treatment provider framework could help dispel concerns and improve collaboration. In general, treatment staff need more clarity on their role in serving criminal justice-involved individuals in the community. Namely, which participants are being served and if any can be excluded from services. During interviews, many program staff felt that they must serve everyone. Clarification is needed about when external referrals are appropriate. One example involves the EBP of providing single-sex treatment. Research has found that single-sex treatment is important to reduce recidivism amongst women. However, if programs are unable to provide treatment that separates by risk and gender, individual treatment should be maintained for women. Individual treatment is also the recommended approach for low-risk individuals who are mandated to treatment. Another example is aftercare; there are currently many iterations of treatment availability after a participant has completed initial treatment. However, almost no programs have a formalized policies and procedure for offering aftercare. Required attendance at aftercare is an important component of a successful program where reassessment, involvement of significant others, and a level of intensity and services that match the participants' remaining needs is available. Stakeholders should consider supervision's role in aftercare, especially for individuals who remain under supervision after treatment completion. Finally, stakeholders should consider how outcome evaluations and/or recidivism tracking might be integrated into the quality assurance of treatment providers and what support can be offered to assist programs in implementing this recommendation.

Expand capacity within leadership. As discussed earlier, the burden on leadership is a barrier to the implementation of evidence-based practice. Program directors across the state had both the education and experience recommended for EBP adherence, but programs that also have the capacity for additional in-house staff members who are solely focused on staff development, quality assurance, and the dissemination of the research behind evidence based practice have an advantage. Stakeholders should consider whether they can provide such resources at the state-level or whether that role is better addressed by in-house program staff members to increase the capacity across the system. In either case, resources should include literature reviews with included training, identifying completion or treatment targets for

programs to utilize, and staff development resources (see recommendations above for more detail). This recommendation should be applied to supervision leadership as well.

Additional training and tools. This recommendation is complementary of the prior recommendation. Statewide, treatment and supervision will continue to need access to additional training and tools. This might include leadership training, staff development tools, and staff training. Program staff and supervision staff would benefit from continued training on the research specific to their field and application of evidence-based practice for the criminal justice populations served by community treatment programs and within community supervision settings.

Appendix A: Evaluated Program Descriptions (listed alphabetically)[7]

1. Bear River Health Department

Bear River Health Department (BRHD) Division of Substance Abuse is the licensed substance abuse authority (LSAA) for Box Elder, Cache, and Rich Counties. All services are offered on-site at one of the following Health Department facilities: 655 East 1300 North, Logan, Utah 84321; 817 West 950 South, Brigham City, Utah 84302; 40 West 100 North, Tremonton, Utah 84337.

Established in 1971, BRHD is contracted to provide Intensive Outpatient (IOP) and General Outpatient (GOP) substance abuse treatment to DORA participants, all of whom are adults sentenced to treatment. The length of IOP is a minimum of four consecutive weeks, consisting of nine or more hours per week of individual and group counseling sessions. GOP consist of eight hours a week (maximum) of individual, group or family counseling and/or education. Services include individual, group, and family therapy, psycho-educational programming, and substance abuse treatment; if needed, residential treatment is provided through contracted providers. Program length can be modified based on a number of factors such as a client's individual needs, agency contract specifications, or judges' orders. Treatment modalities include: Cognitive-Behavioral, 12-step, life skills training, and relapse prevention.

The leadership team supervises 13 clinicians; four are specific to the DORA program. As part of DORA, clients are monitored by DORA-designated AP&P agents.

2. Central Utah Counseling Center

Established in 1976, Central Utah Counseling Center (CUCC) is a community mental health and substance abuse treatment program that serves Juab, Millard, Piute, Sanpete, Sevier and Wayne counties. CUCC offices are located in Ephraim, Delta, Fillmore, Nephi, Richfield, Loa, Junction, and Gunnison. Geographically, CUCC is separated into three primary areas, with one team leader assigned to each area. The team leaders are located at the largest offices in each area, which are Ephraim, Nephi, and Richfield respectively. CUCC has a clinical director to serve all locations.

The San Pete area includes the Ephraim and Gunnison offices. The Ephraim office is located at 370 West 100 North, Ephraim, Utah. The Gunnison location is located at 34 East 100 North, Gunnison, Utah. The majority of services, and all groups, are provided at the Ephraim location. CUCC-Ephraim provides outpatient substance abuse treatment to Drug Court participants as well as other court-ordered clients. Available treatment includes group and individual therapy, medication management, and case management. The Ephraim site employs seven clinical therapists (six full-time and one part-time) who treat all clients, including those who are court-ordered. There are two part-time family resource facilitators (FRF) and four peer support specialists. Additionally, two AP&P agents are assigned to the county and supervise probationers/parolees who live in the county and select CUCC-Ephraim for their court-mandated treatment.

The Juab/Millard area includes the Nephi, Delta, and Fillmore locations. The Nephi office is located at 944 N. Main Street, Nephi, Utah. The Delta location is at 51 North Center, Delta, Utah. The Fillmore location is at 90 North Main, Fillmore, Utah. The largest location in the Juab/Millard area, CUCC-Nephi, provides outpatient substance abuse treatment to Drug Court participants as well as other court-ordered clients. Available treatment includes group and individual therapy, medication management and case management. The Nephi site employs five treatment providers, three of whom serve the criminal-justice population. There is one part-time family resource facilitator (FRF), two case managers and one peer

[7] Program descriptions describe the program at the time of the CPC assessment.

support specialist. In addition, one AP&P agent is assigned to the county and supervises probationers/parolees who live in the county and select CUCC-Nephi for their court-mandated treatment.

The Tri-County area includes the Richfield, Loa and Junction offices. The Richfield office is located at 255 South Main Street, Richfield, Utah. The Loa office is located at 56 South Main, Loa, Utah. The Junction office is located at 550 North Main, Junction, Utah. The majority of services are provided at the Richfield office where there is a Drug Court program in addition to intensive outpatient (IOP) and outpatient (OP) substance abuse treatment for court-ordered clients. The treatment offered combines group and individual therapy, medication management, and case management. The Richfield site employs seven clinical therapists, four of whom serve the criminal justice-involved population. Additionally, one AP&P agent is assigned to the county and supervises probationers/parolees who live in the county and select CUCC-Richfield for their court-mandated treatment.

3. Davis Behavioral Health

Davis Behavioral Health (DBH) is a private, non-profit corporation providing behavioral health services to residents of Davis County. Established in 1969, DBH operates seven programs to address substance abuse: Adolescent Outpatient Substance Abuse; Adult Outpatient Substance Abuse; Men's Intensive Outpatient Substance Abuse (MRC: IOP); Men's Day Treatment Substance Abuse (MRC: Day Treatment); Women's Intensive Outpatient Substance Abuse (WRC: IOP); Women's Day Treatment Substance Abuse (WRC: Day Treatment); and Jail Drug Program (RSAT Intensive). The Women's Recovery Center houses the WRC IOP and WRC Day Treatment programs and the Men's Recovery Center houses the MRC IOP and MRC Day Treatment, both of which serve clients who are sentenced to treatment under Utah's Drug Offender Reform Act (DORA). DBH provides services to individuals who have been sentenced to substance abuse treatment by Davis Drug Court, Davis Dependency Court, DORA, and Drug Probation Program. In addition, referrals from other Davis County Courts, social service agencies, and individuals are accepted. The WRC and MRC are located at 2250 North 1700 West, Layton, Utah. Outpatient services is located at 934 South Main Street, Layton, Utah.

The length of IOP treatment is eight weeks and Day-Treatment is between 4-12 weeks. The length of adult outpatient treatment is 9-12 months. However, program length can be modified based on a number of factors such as: a client's individual needs, agency contract specifications, or judges' orders.

All programs utilize the Person-Centered Recovery Model as a basis for treatment interventions and a multi-method approach to working with clients on additional issues. Services include individual and group therapy, psycho-educational programming, substance abuse treatment, case management, and sober living. Treatment modalities include: Cognitive-Behavioral, Motivational Interviewing, gender specific addictions and PTSD trauma treatment, family counseling, 12-step, behavioral contracting, medication management, case management, life skills training and relapse prevention.

The WRC program employs three full-time clinical therapists, one advanced substance use disorder counselor (ASUDC), four health service techs, and one full-time program director. The MRC program employs two full-time clinical therapists, one full-time ASUDC, four health service technicians, and one full time program director. The Adult Outpatient program employs nine full-time clinic therapists, one part-time clinical therapist, and one full-time program director. DBH also has a DORA program director. In addition, two full-time AP&P DORA agents collaborate with the program staff.

4. Four Corners Community Behavioral Health

Four Corners Community Behavioral Health is the licensed substance abuse authority (LSAA) for Carbon, Emery, and Grand Counties. The outpatient program is located at 575 East 100 South, Price, Utah. Four Corners Behavioral Health has been in operation since 1986.

The program provides individual and family counseling, psycho-educational programming and group treatment. The outpatient program is designed to last 12-18 months; however, program length can be extended based on a client's individual treatment needs. The program is described as outpatient treatment that uses a cognitive-behavioral approach to modify substance abuse and anti-social beliefs and behaviors. The majority of the outpatient program clients are individuals who have been sentenced to receive substance abuse treatment, including those who have been sentenced to treatment under Utah's Drug Offender Reform Act (DORA).

At the time of the assessment, there were 17 full-time staff and one part-time; nine are treatment staff. The outpatient program employs nine full-time and one part-time therapist. The leadership team includes the Executive Director, Clinical Director, and Program Director, who is charged with overseeing programming and services. Additionally, six AP&P agents supervise DORA participants in the outpatient program.

5. Northeastern Counseling Center

The Northeastern Counseling Center (NCC) has been providing mental health and outpatient substance abuse treatment in the cities of Vernal and Roosevelt since 1997 and the licensed substance abuse authority (LSAA) for Daggett, Duchesne, and Uintah Counties. The Roosevelt site is located at 285 West 800 South, Roosevelt, Utah. The Vernal site is located at 1140 West 500 South, Vernal, Utah.

Northeastern Counseling Center provides a broad range of services from mental health counseling to substance abuse treatment for criminally-involved adults. Substance abuse treatment services include individual, group, and family therapy and psycho-educational programming. The Northeastern Counseling program was designed to last an average of 12 months.

In the substance abuse program, NCC employs six full-time clinical therapists, two full-time site supervisors and one full-time clinical director. In addition, there are six AP&P agents in Vernal and Roosevelt who supervise criminally-involved clients and collaborate with program staff.

6. Odyssey House of Utah

Odyssey House, a nonprofit organization in Salt Lake City, Utah, operates inpatient and outpatient programs for substance abuse and addiction treatment. Odyssey House has been in operation since 1971. The Odyssey House adult outpatient program is located at 2100 South 350 East, Salt Lake, Utah. The Odyssey House adult residential program is located at 68 South 600 East, Salt Lake, Utah.

The inpatient and outpatient programs, both of which serve clients sentenced to treatment under Utah's Drug Offender Reform Act (DORA), utilize a Modified Therapeutic Community (MTC) treatment model. Services include individual, group, family therapy, psycho-educational programming, substance abuse treatment, case management, vocational development, sober housing, medical care, and psychiatric services. Both the inpatient and outpatient programs are designed to last 6-12 months, with an average length of seven months; however, program length can be extended based on a client's individual needs.

The Odyssey House Outpatient program employs eight full-time clinical therapists, three part-time clinical therapists, and eight interns. A program director oversees the day-to-day operations of the program. In addition, four AP&P agents supervise DORA participants in the outpatient program.

The Odyssey House Adult Residential program employs eight full-time clinical therapists. A program director oversees the day-to-day operations of the program. In addition, four AP&P agents supervise DORA clients in the residential program.

7. San Juan Counseling Center

San Juan Counseling Center has been in operation since 1998 and is the licensed substance abuse authority (LSAA) for San Juan County. Services include individual, group, and family therapy, psycho-educational programming, and substance abuse treatment. The program is located at 356 South Main Street, Blanding, Utah.

For court-mandated clients, there is an outpatient program that offers substance abuse treatment services. Clients sentenced to supervision are monitored through Drug Court or AP&P. The San Juan Counseling Center Drug Court program is a minimum of 18 months. Program length for outpatient substance abuse treatment is determined by the client's treatment plan.

San Juan Counseling Center employs eight full-time clinical therapists including the clinical director, one full-time family resource facilitator, and one part-time family resource facilitator. Four full-time clinical therapists are assigned the court-involved clients, and two of those therapists manage the majority of the Drug Court clients. A program director oversees the day-to-day operations of the program. In addition, one full-time AP&P agent collaborates with the program staff.

8. Southwest Behavioral Health Center

Southwest Behavioral Health is a local substance abuse authority (LSAA) serving the counties of Beaver, Garfield, Iron, Kane and Washington and it is supported, in part, by County, State and Federal funding. Southwest Behavioral Health has been in operation since 1985. The Southwest Behavioral Health Program has two major sites in the cities of St. George and Cedar City, Utah. The St. George program is located at 474 West 200 North, St. George, Utah. The Cedar City program is located at 245 East 680 South, Cedar City, Utah.

Both sites provide inpatient and outpatient substance abuse treatment to criminal justice-involved adult participants. Services include individual, group, and family therapy, psycho-educational programming, substance abuse treatment, anger management, communication skill building, and relapse prevention.

The Cedar City site employs eight full-time clinical therapists, one part-time clinical therapist, and two human service workers. The program director oversees the day-to-day operations of the site. In addition, four AP&P agents supervise criminal justice involved participants in both the residential and outpatient programs.

The St. George site of Southwest Behavioral Health employs eleven full-time clinical therapists and one part-time clinical therapist. There is a program director who oversees the day-to-day operations of the St. George site. In addition, four AP&P agents supervise criminal justice-involved participants in both the residential and outpatient programs.

9. Utah County Division of Substance Abuse

The Utah County DORA program, established in 2006, is an outpatient substance abuse treatment program and the licensed substance abuse authority (LSAA) for Utah County that provides case management and treatment services to adults who have been sentenced to substance abuse treatment. The program is located at 151 South University Ave., Suite 3200, Provo, Utah.

Services include individual, group, and family therapy, psycho-educational programming, substance abuse treatment, and case management. The Utah County DORA program is 6-9 months. Program length can be extended based on a client's individual needs.

The Utah County DORA program employs two full-time clinical therapists, one full-time case manager, and one full-time program director. In addition, two full-time AP&P DORA agents collaborate with the program staff.

10. Valley Behavioral Health - Summit

Valley Behavioral Health (VBH) – Summit has been in operation since 1997 and is the licensed substance abuse authority (LSAA) for Summit County. The program is located at 1753 Sidewinder Drive, Park City, UT.

Services include individual, group, and family therapy, psycho-educational programming, case management services, and substance abuse treatment. For court-mandated clients, there is a Drug Court program and an intensive outpatient program (IOP) that offers substance abuse treatment services. The VBH – Summit Drug Court program is a minimum of 27 months. Program length for outpatient substance abuse treatment is determined by the client's treatment plan.

VBH – Summit employs six full-time generalist clinical therapists, four case managers, one peer support specialist and one director. Four full-time clinical therapists are primarily assigned to court-involved clients; two of those therapists manage the majority of the Drug Court clients. One case manager is assigned to the court-involved clients while the other three provide support as needed. The program director oversees the day-to-day operations of the program. In addition, one full-time sheriff collaborates with the program staff to provide supervision.

11. Valley Behavioral Health - Tooele

Valley Behavioral Health (VBH) has been providing outpatient substance abuse treatment in Tooele since 1996. The program is located at 100 South 1000 West, Tooele, Utah.

VBH-Tooele is the licensed substance abuse authority (LSAA) for Tooele and contracted to provide substance abuse treatment to DORA participants, all of whom are adults sentenced to treatment. Services include individual, group, and family therapy, psycho-educational programming, substance abuse treatment, and case management. The VBH-Tooele program is 6-24 months. The length can be extended based on a client's individual needs.

VBH employs four full-time clinical therapists, one part-time clinical therapist, two full-time case managers, and one full-time program director. The program director oversees the day-to-day operations of the program. In addition, there are six AP&P agents in Tooele who supervise DORA clients and collaborate with program staff.

12. Weber Human Services

Weber Human Services (WHS) was established in 1993 and is the licensed substance abuse authority for Weber and Morgan Counties. The DORA program provides outpatient treatment to adults who have been sentenced to substance abuse treatment. The program is located at 237 26th St, Ogden, Utah.

Program services include individual and group therapy, substance abuse treatment, case management, family and medication-assisted therapy, psycho-educational programming, and peer mentor groups. The WHS DORA program is 12 months; however, program length can be extended based on a client's individual needs.

The WHS DORA program employs two full-time clinical therapists, one part-time clinical therapist, and one full-time program director. The program director oversees the day-to-day operations of the program. Weber Human Services also employs a full-time case manager who assists DORA clients upon referral from program staff. In addition, two full-time AP&P DORA agents supervise DORA clients receiving treatment from WHS.

13. Wasatch County Family Clinic

Wasatch County Family Clinic (WCFC) is a community mental health center and the licensed substance abuse authority for Wasatch County. The program is located at 55 South 500 East, Heber, Utah 84032. WCFC is a part of Wasatch Mental Health, with administrative offices located in Provo, Utah. WCFC has been in operation since 2014.

Services provided at WCFC include individual, group, and family therapy; psycho-educational programming; and outpatient substance abuse treatment, including a Drug Court program. Drug Court is a 14-month program. WCFC outpatient substance abuse treatment services last an average of three to six months, but vary in length based on the participant's treatment plan. As the licensed substance abuse authority for the county, WCFC will serve all court-ordered clients who need services.

At WCFC, four clinicians serve all court-ordered clients. The program also employs one full-time family resource facilitator and one full-time Drug Court case manager. The program director oversees the day-to-day operations of the program. In addition, one full-time Adult Probation and Parole (AP&P) agent collaborates with the program staff.

Appendix B: Methods

Correctional Program Checklist (CPC)[8]

As the first step to implementing and sustaining EBP (mentioned above), programs were assessed by UCJC staff using the Correctional Practice Checklist (CPC).[9] The CPC is a tool developed to ascertain how closely correctional programs meet known principles of effective intervention.

Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, research suggests that cognitive behavioral and social learning models of treatment for offenders are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Gendreau & Goggin, 2005). As such, during the last several years legislatures and policymakers have requested that interventions are consistent with the research literature on evidence-based practices.

Several recent studies conducted by the University of Cincinnati on both adult and juvenile programs were used to develop and validate the indicators on the CPC.[10] These studies found strong correlations with recidivism between overall scores, domain areas, and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp & Latessa, 2003, 2005a, 2005b).

The CPC is divided into two basic areas: CAPACITY and CONTENT. The CAPACITY area is designed to measure whether a correctional program has the capability to deliver evidence-based interventions and services for offenders. There are three domains in the capacity area: (1) Leadership and Development; (2) Staff; and (3) Quality Assurance. The CONTENT area focuses on the substantive domains of: (1) Offender Assessment and (2) Treatment Characteristics. This area evaluates the extent to which the program meets the principles of risk, need, responsivity, and treatment. There is a total of seventy-seven indicators, worth up to 83 total points. Each area and all domains are scored and rated as either “HIGHLY EFFECTIVE" (65% to 100%); "EFFECTIVE" (55% to 64%); "NEEDS IMPROVEMENT" (46% to 54%); or "INEFFECTIVE" (45% or lower).

The scores in all five domains are totaled, and the same scale is used for the overall assessment score. It should be noted that not all of the five domains are given equal weight, and some items may be considered NOT APPLICABLE, in which case they are not included in the scoring.

There are several limitations to the CPC that should be noted. First, the instrument is based upon an “ideal” program. The criteria have been developed from a large body of research and knowledge that combines the best practices from the empirical literature on “what works” in reducing recidivism. Second, as with all applied research, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, given the nature of the process, decisions about the information and data gathered are invariably made by the assessor(s). Third, the process is time-specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be under development, only those activities and processes that are present at the time

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[8] Portions of this report that pertain to standard CPC issues were provided by University of Cincinnati, Corrections Institute, and are used with the Institute’s permission.

[9] The CPC is modeled after the Correctional Program Assessment Inventory (CPAI) developed by Gendreau and Andrews; however, the CPC includes a number of items not contained in the CPAI. In addition, items were deleted that were not found to be positively correlated with recidivism.

[10] These studies involved over 40,000 offenders (both adult and juvenile), and over 400 correctional programs, ranging from institutional to community-based. All of the studies are available at www.uc.edu/criminaljustice. A large part of this research involved the identification of program characteristics that were correlated with a recidivism outcome.

of the review are considered for scoring. Fourth, the process does not take into account all "system" issues that can affect the integrity of the program.[11] Lastly, the process does not address why a problem exists within a program.

Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs. Second, all of the indicators included in the CPC are correlated with reductions in criminal recidivism. Third, the process provides a measure of program integrity and quality; it provides insight into the "black box" of a program, something that an outcome study alone does not provide. Fourth, the results can be obtained relatively quickly. Fifth, it identifies both the strengths and weaknesses of a program; it provides the program with an idea of what it is doing that is consistent with the research on effective interventions, as well as those areas that need improvement. Sixth, it provides useful recommendations for program improvement. Finally, it allows for comparisons with other programs that have been assessed using the same criteria. Furthermore, since program integrity and quality can change over time, it allows a program to reassess its progress.

Norm Information

Researchers at the University of Cincinnati have assessed over 500 programs nationwide and have developed a large database on correctional intervention programs.[12] Approximately 7 percent of the programs assessed have been classified as "HIGHLY EFFECTIVE," 17 percent "EFFECTIVE," 31 percent "NEEDS IMPROVEMENT," and 45 percent "INEFFECTIVE."[13] The table below represents the types of programs that were assessed to develop and refine the CPC:

Types of Programs Assessed for CPC Development	
• Boot Camps	• Residential Substance Abuse Programs
• Community Correctional Facilities	• Residential Substance Abuse Programs for Habitual Drunk Drivers
• Correctional Education Programs	• School-Based Programs
• Day Reporting Centers	• Sex Offender Programs
• Diversion Programs	• Therapeutic Communities, both institutional and community-based
• Group Homes	• Work Release Facilities
• Intensive Supervision Units	• Halfway Houses

[11] One of the purposes of this summary report is to address this limitation of the CPC and provide some system recommendations to the DORA Committee to assist individual programs in overcoming system barriers to meeting evidence-based principles.

[12] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

[13] The previous categories used were "very satisfactory," "satisfactory," "needs improvement," and "unsatisfactory."

Aggregate Results from Program Evaluations

The methodology for identifying the aggregate strengths and areas for improvement are as follows:

- Item scores for each of the thirteen CPCs were entered into a database.
- Items where the majority of programs did not receive the point for full compliance with the CPC were identified as areas for improvement.
- Items that might best be addressed at a broader systems-level were identified and prioritized.
- Items where the majority of programs were assessed as being in full compliance with the CPC were identified as strengths across programs.
- The results of the summary are organized under each of the five CPC domains: Program Leadership and Development, Staff Characteristics, Offender Assessment, Treatment Characteristics, and Quality Assurance.

Program Staff Focus Group

Nominal Focus Group Methods. A nominal focus group design was used to elicit the study information from the participants. The nominal focus group was conducted in four stages:

1) **Introduction** – facilitator introduced the purpose of the session, rules, and structure;
2) **Elicit Individual Responses** – responses were collected on the chosen topic in a silent generation phase;
3) **Clarification and Consolidation** – responses were read out loud and clarified one-by-one by participants, then similar/same items were merged under one response by the facilitator; and
4) **Ranking Responses** – participants ranked their top five responses individually in order of importance. Ranked results were then calculated to identify the unified ranking of the group.

This type of design was chosen to: 1) give an equal voice to each participant, 2) reduce personality effects or strong/dominating opinions, 3) obtain quantifiable results immediately after the session, 4) easily share results with participants, and 5) provide a more cost effective process by minimizing the need for transcription or extensive coding and analysis.

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