Adherence to Evidence-Based Practice in Community-Based Treatment as part of Utah's JRI:

Aggregate Results from Correctional Program Checklist (CPC) Program Evaluations of Local Substance Abuse Authorities (LSAA)

Final Aggregate Report

August 2021

THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
COLLEGE OF SOCIAL & BEHAVIORAL SCIENCES
UTAH COMMISSION ON CRIMINAL AND JUVENILE JUSTICE
S.J. QUINNEY COLLEGE OF LAW

{THIS PAGE INTENTIONALLY LEFT BLANK}

Adherence to Evidence-Based Practice in Community-Based Treatment as part of Utah's JRI:

Aggregate Results from Correctional Program Checklist (CPC)
Program Evaluations of Local Substance Abuse Authorities (LSAA).

Final Aggregate Report
August 2021

Utah Criminal Justice Center
College of Social Work, University of Utah

Jessica Seawright, CSW
Christian Sarver, PhD

{THIS PAGE INTENTIONALLY LEFT BLANK}

Table of Contents

Land Acknowledgment

The University of Utah has both historical and contemporary relationships with Indigenous peoples. Given that the Salt Lake Valley has always been a gathering place for Indigenous peoples, we acknowledge that this land, which is named for the Ute Tribe, is the traditional and ancestral homelands of the Shoshone, Paiute, Goshute, and Ute Tribes and is a crossroad for Indigenous peoples. The University of Utah recognizes the enduring relationships between many Indigenous peoples and their traditional homelands. We are grateful for the territory upon which we gather today; we respect Utah's Indigenous peoples, the original stewards of this land; and we value the sovereign relationships that exist between tribal governments, state governments, and the federal government. Today, approximately 60,000 American Indian and Alaska Native peoples live in Utah. As a state institution, the University of Utah is committed to serving Native communities throughout Utah in partnership with Native Nations and our Urban Indian communities through research, education, and community outreach activities.

Acknowledgments

This aggregate report was supported by the Division of Substance Abuse and Mental Health as part of their ongoing commitment to connecting research and practice for justice-involved adults mandated to substance abuse treatment in Utah.

Thank you to the program leadership, staff, and clients for allowing the UCJC team into your programs. Our work as a center is improved by the opportunity to learn from your experience, and expertise.

Finally, thank you to UCJC staff members Aurene Wilford, M.A., Derek Mueller, M.S., Nic Siniscalchi, M.Ed., and Jess Shade, M.Div., M.Ed., ACMHC, who joined the authors in completing the program evaluations and contributed to the individual reports which informed this aggregate report.

Executive Summary

Since 2015, Utah has implemented a wide range of policy reforms, known collectively as the Justice Reinvestment Initiative (JRI), that impact criminal justice stakeholders across the state. A central focus of these efforts has been to improve the accessibility and quality of behavioral health treatment for justice-involved individuals. Improvements in accessibility are evident in a 34 percent increase between fiscal years 2015 and 2019 in the number of individuals accessing mental health and substance use treatment; an increase that has been supported through increased state funding to community treatment providers (Harvell, 2020, p.1). As mandated under JRI, community-based treatment providers continue to be a vital component of Utah- and national-based efforts to reduce recidivism. Ongoing assessment of Utah's community treatment providers, using the Correctional Program Checklist (CPC), supports efforts to ensure that the quality of treatment aligns with what we know reduces recidivism.

This final aggregate report provides a snapshot of providers' progress with respect to implementing evidence-based practice (EBP) for adult justice-involved clients mandated to substance use treatment. With respect to differences amongst programs state-wide, analyses in this report consider the following: 1) how well Utah's programs performed based on how many times the program has been evaluated, 2) how similar programs perform, 3) comparison between program evaluations completed before JRI implementation (e.g., 2015 evaluation) and six years after JRI implementation began across Utah (e.g., 2019 evaluation), and 4) comparison to the national averages (e.g., aggregate results from 600+ programs). Program leadership were provided with detailed reports of strengths as well as recommended areas of improvement.

On the aggregate level, the evaluations demonstrate improvements in assessment practices as well as increased capacity to provide evidence-based services to adult justice-involved clients. To aide stakeholders in prioritizing system-wide targets, three areas of improvement are presented: 1) support providers with the implementation of criminogenic risk screening tools to guide program placement and services; 2) review system-wide policies and procedures to connect resources in data collection and program practices; and 3) continue efforts to promote collaboration amongst treatment program leadership and criminal justice stakeholders.

Building an evidence-based criminal justice system requires an ongoing commitment from stakeholders to continually make improvements and promote collaborative work. The CPC assessment offers a snapshot of a wide range of treatment programs state-wide, and should be interpreted within the dynamic changes that were occurring in the six years since JRI was first implemented. Utah's treatment provider community should be commended on their provision of services during the COVID-19 pandemic.

Introduction

Building an evidence-based criminal justice system requires an ongoing commitment from stakeholders to continually make improvements and promote collaborative work. Through the Justice Reinvestment Initiative (JRI), first passed in 2015, the state of Utah joined 25 other states in implementing strategies to reduce recidivism (Welsh-Loveman & Harvell, 2018). With the passage of JRI, Utah committed to a wide range of priorities, encompassing criminal justice stakeholders across the state, designed to reduce recidivism. As part of those efforts, the Utah Division of Substance Abuse and Mental Health (DSAMH) has worked to improve public safety by increasing treatment providers' capacity to adhere to evidence-based principles in the treatment of individuals involved in the criminal justice system. To this end, stakeholders identified thirteen substance use treatment providers throughout the state to participate in program evaluation with the Utah Criminal Justice Center (UCJC) at the University of Utah. The majority of these sites, designated as the Local Substance Abuse Authority[1] (LSAA) for their counties, had been previously evaluated with the CPC as part of the Drug Offender Reform Act (DORA) between 2015-2017 (see Seawright et al., 2017 for the DORA aggregate report).

This final aggregate report provides a snapshot of providers' progress with respect to implementing evidence-based practice (EBP) for adult justice-involved clients mandated to substance use treatment. Demonstrated strengths as well as recommendations for program and system-level changes are provided.

Background

In January 2019, the Division of Substance Abuse and Mental Health (DSAMH), Department of Human Services (DHS) contracted with UCJC to assess thirteen treatment programs who serve the 29 counties in Utah as the Local Substance Abuse Authority (LSAA) providers with respect to adherence to EBP when providing services to adults who are justice-involved. See *Table 1* for a list of participating treatment providers and *Appendix A* for complete program descriptions. A majority of the LSAAs operate as generalist behavioral health providers in their communities and encounter some barriers to targeted EBP for justice-involved clients.

Table 1 Participating Treatment Providers (LSAA)

Provider Name	Counties Served
Bear River Health Department	Cache/Rich/Box Elder
Central Utah Counseling Center	Juab/Millard/Paiute/San Pete/Sevier/Wayne
Davis Behavioral Health	Davis
Four Corners Community Behavioral Health, Inc.	Carbon/Emery/Grand
Huntsman Mental Health Institute, Park City Behavioral Health Clinic	Summit
Northeastern Counseling Center	Daggett/Duchesne/Uintah

[1] All sites were the designated LSAAs, or network providers, for their county at the time of the site visit.

Provider Name	Counties Served
Odyssey House of Utah-Parents with Children Program	Salt Lake
San Juan Counseling	San Juan
Southwest Behavioral Health Center	Beaver/ Garfield/Iron/Kane/Washington
Valley Behavioral Health-Tooele	Tooele
Wasatch Behavioral Health, Substance Use Disorder Services, Utah County	Utah
Wasatch County Family Clinic	Wasatch
Weber Human Services-Women's Improvement Network Program	Weber/Morgan

Of the 13 programs, 11 had at least one previous CPC program evaluation completed between 2015-2017 that focused on the population served by the Drug Offender Reform Act (DORA). The second program evaluation broadens that scope to evaluate services provided to all justice-involved clients. Almost all programs are operating a Drug Court program in addition to providing services to adults who were mandated to substance use treatment.

Table 2 CPC Contracts

Partnership	# Sites	# Site Visits
Drug Offender Reform Act (DORA)-2015 evaluation	13	19
Division of Substance Abuse and Mental Health (DSAMH)-2019 evaluation	13	16

The purpose of this report is two-fold: 1) to summarize the completed CPC assessment results at the aggregate level, and 2) provide system-level recommendations based on those results.

Brief Overview of Methods: Correctional Program Checklist (CPC) Site Assessments

Programs were assessed using the Correctional Program Checklist (CPC 2.1), 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 the recidivism of justice-involved clients (see *Appendix B* for more detail). The CPC, which was updated to the CPC 2.1 in late 2019,[2] uses research to weigh items related to treatment that most strongly correlate with recidivism and provide an outcome score across five domains to programs with specific recommendations for improvement (Lowenkamp & Latessa, 2002, 2005a, 2005b). Because the CPC 1.0, 2.0 and 2.1 were developed and refined in conjunction with the evaluation of hundreds of programs, these tools indicate the ideal program. Thus, the intention of the tool is to provide a helpful benchmark for areas of continued growth and improvement for each actual program that is evaluated, and not to set the goal for Utah's LSAAs to score 100% on the checklist itself. A rating of "very high adherence" would suggest that the program is operating in a way that aligns with best practice and would therefore be expected to reduce recidivism of its participants. The CPC recommends that all programs track recidivism as

[2] UCJC staff received training on the CPC 2.1 and this version was used with all 13 evaluated programs.

well as other outcomes for its participants, participate with researchers and support their local community in navigating challenges to providing evidence-based practice.

Additionally, the CPC tool is used to increase awareness of the system-level barriers and areas of need for treatment providers across the state. 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.

Site visits were conducted with each of the 13 providers (see *Table 1* for the list of participating treatment providers). During planning, Program Directors were consulted about the scope of the CPC assessment. For the majority of programs, all sites were evaluated as one. This decision reflected centralized leadership charged with implementing EBP for justice-involved persons. For two programs, Southwest Behavioral Health Center and Central Utah Counseling Center, evaluators separated sites to provide leadership further insight into cross-site implementation. Two programs, Weber Human Services and Odyssey House of Utah selected specific programs to evaluate (e.g., the Women's Improvement Program (WIN) and the Parents with Children program respectively).

Five of the LSAA treatment providers were evaluated in-person and prior to COVID-19 restrictions (March 2020). The remaining site visits were completed in the first half of 2021 using a mixed evaluation approach, which included virtual site visits and site visits with virtual and in-person components. To ensure fidelity to the CPC 2.1, UCJC consulted with the University of Cincinnati Corrections Institute (UCCI) regarding virtual site visits.

The assessment team included 2-4 researchers from UCJC, each of whom scored the CPC independently. Each assessment took 1-5 days (an average of 3 days) depending on the method of site visit and size of the program. The site visit 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 process for conducting and scoring the CPC is described in the *Correctional Program Checklist (CPC)* sub-section within *Appendix B*.

After the site visit, the UCJC team then developed a comprehensive report detailing the program's strengths and recommended areas of improvement for serving justice-involved clients 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 and feedback to ensure accuracy of the draft report; over half of the programs engaged with UCJC

staff to discuss the results, questions and possible areas for technical assistance[3]. Final reports were issued to the Program Directors. In December 2020, with consent from the program leadership, the individual reports were shared with DSAMH leadership to promote continuous improvement efforts as part of JRI.

Aggregate Results from Program Evaluations

With respect to differences amongst programs state-wide, analyses in this report consider the following: 1) how well Utah's programs performed based on how many times the program has been evaluated, 2) how similar programs perform, 3) comparison between program evaluations completed before JRI implementation (e.g., 2015 evaluation) and six years after JRI implementation began across Utah (e.g., 2019 evaluation), and 4) comparison to the national averages (e.g., aggregate results from 600+ programs). Program leadership were provided with detailed reports of strengths as well as recommended areas of improvement.

As briefly described in the methods section, the CPC provides ratings based on percentages calculated from points scored in five domains (see *Appendix B* for more detail on scoring). In this section, results are shown largely as percentages. This is due to the fact that the progress seen amongst Utah's providers since the beginning of JRI implementation (approximately 6 years ago) has been slowed by a number of factors. These factors include the legislative implementation of JRI specifically with regard to insufficient funds being allotted for treatment services in 2015 (Office of the Legislative Auditor General, 2020a, p.53), barriers to information sharing amongst criminal justice stakeholders including data and assessment sharing (Office of the Legislative Auditor General, 2020b), and the COVID-19 pandemic. By presenting results as percentages, change can be demonstrated at the aggregate level where ratings would not capture the efforts toward implementation of EBP demonstrated across the state.

Aggregate Results by Number of CPC evaluations

In 2015, prior to the implementation of JRI in the State of Utah, UCJC began evaluating the 13 LSAAs across the state as requested by the DORA Committee (for more detail see the aggregate report from Seawright, Sarver, Worwood & Butters, 2017). In 2019, the DSAMH requested that all 13 LSAAs be evaluated for a second time.

The ability to establish a benchmark is an advantage of using the CPC. Over time, this "allows a program to reassess its adherence to Evidence-Based Practices" (UCCI, 2019; see *Appendix B* for more details). Further, it allows programs to take lessons learned from one site and employ improvement efforts across sites and program types. This was demonstrated by two sites, Odyssey House of Utah and Weber Human Services, who have each been evaluated

[3] Engagement may have been impacted by program leadership's priorities to client and staff safety during the COVID-19 pandemic. Where program leadership declined a feedback meeting, UCJC provided contact information as well as continued invitations to general technical assistance support.

more than three times (due to CPC evaluations being completed on these programs for other projects).

Overall, as shown in *Table 3,* 11 programs were being evaluated for the second time. Two counties changed the program who was designated as the LSAA. In Utah County, Wasatch Behavioral Health became the LSAA in 2020. University Health Plans became the LSAA for Summit County in 2019, and Huntsman Mental Health Institute, Park City, Behavioral Health Clinic (HMHI-Park City, BHC) became a primary service provider. Both of these programs were evaluated for the first time in 2021 as part of the DSAMH contract. A third program, San Juan Counseling Center, did not change ownership but experienced significant programmatic changes to leadership and staffing between site visits.

Table 3 CPC Sites- Number of Evaluations

Evaluation	# of sites
2015 evaluation	
First CPC	13
2019 evaluation	
First CPC	2
Second CPC	11[1]

[1] Of the 16 sites completing their second CPC program evaluation, 2 programs had additional CPC site visits as part of other contracts. In Table 4, they'll be considered as a site with more than 3 site visits.

Between 2015-2021, 15 individual sites had been evaluated for the first time. Using the results from these first evaluations, *Table* 4 shows the average total score of evaluated programs was 37% which is in the "low adherence to EBP" range at the time of the site visit. As an aggregate group, programs' *Overall Capacity* was rated at 52% or "moderate adherence to EBP." This rating can be attributed to the program's performance in the *Staff Characteristics*, and *Program Leadership & Development* domains and is indicative of the experience and education of leadership and direct service staff at treatment programs across Utah. Namely, the results reflect the fact that a majority of staff providing direct services have at least an Associate's Degree in a helping profession (e.g., social work, counseling, marriage and family therapy) and more than 2 years of experience working with justice-involved clients. Additionally, the majority (76%) of programs had been in operation without major programmatic changes for over 2 years and noted stable and adequate funding during their site visit. Each program was well-established in their communities of practice as demonstrated by relationships with local criminal justice stakeholders and community organizations.

Table 4 CPC Results-Number of Evaluations

Evaluation	First CPC	Second CPC	More than 3[1]	CPC Average[2]
Sample (n)	15	11	2	660+
Overall Mn (%)	37	43	68	49
Rating[3]	**LOW**	**LOW**	**VERY HIGH**	**MODERATE**
Overall Capacity Mn (%)	52	59	74	57
Rating[3]	**MODERATE**	**HIGH**	**VERY HIGH**	**HIGH**
Overall Content Mn (%)	29	32	64	43
Rating[3]	**LOW**	**LOW**	**HIGH**	**LOW**

[1] Of the 11, there were 2 sites that had additional CPC site visits as part of other contracts.

[2] National Average based on 660 program evaluations completed between 2005 and 2019.

[3] 1=Very High Adherence to EBP (65 % +), 2=High Adherence to EBP (55-64%), 3=Moderate Adherence to EBP (46-54%), 4=Low Adherence to EBP (45% or less).

Overall Content, which includes the *Treatment Characteristics* and *Offender Assessment* domains, was rated at 29% or "low adherence to EBP." This likely reflects the fact that the majority of programs in this aggregate group were unfamiliar with the concepts of RNR at the time of their first CPC site visit. Furthermore, coordination between criminal justice stakeholders and treatment providers was rapidly changing due to requirements of the JRI legislation (Seawright et al., 2017; Office of the Legislative Auditor General, 2020). This resulted in difficulties related to sharing information between stakeholders, such as assessment results. A strength identified for all of the evaluated programs during the first assessment was that staff reported that the majority of clients served were appropriate for substance abuse services provided (e.g., clients in need of domestic violence or sex offender treatment were referred elsewhere). Criminogenic risk and needs assessments would increase adherence to EBP by ensuring that justice involved clients mandated to substance use treatment are moderate- to high-risk.

Of the 11 programs completing their second CPC program evaluation as part of the DSAMH contract, *Table 4* shows slight increases state-wide in *Overall* adherence. This brings Utah's programs within 6% of the CPC national average and within 3 percentage points of a rating of moderate adherence to EBP.

Programs being evaluated for the second time were behind (11%) the CPC national average in *Overall Content.* The *Assessment* and *Treatment Characteristics* domains will be discussed in more detail in *Tables 9* and *10*.

In *Overall Capacity,* Utah's programs increased rating from moderate to high (7% increase), which is 2% above the national average. These are promising indicators of evidence-based practices for Utah's community treatment providers because the CPC is based on an ideal, and hypothetical, program; no program would be expected to achieve a perfect score. A perfect score is not necessary to achieve meaningful impacts on recidivism. Instead, program scores should be considered in light of the CPC national average scores (see *Table 4*), which are based on 660-plus assessments conducted between 2005 and 2019 by the University of

Cincinnati. The average of those 660-plus programs were scored overall with "moderate adherence to EBP" (49%).

One contributor to the increase between evaluations were consistent Quality Assurance practices being demonstrated at the time of the program evaluation. Some programs designated a program evaluator to analyze program data and drive improvement. Others increased consistency with internal and/or external quality assurance practices (e.g., group observation, file review). However, there were still a number of programs with zero Quality Assurance practices that met CPC recommendations during the second program evaluation. This will be described in more detail in *Table 9*.

While many programs were demonstrating a high capacity to provide EBP to justice-involved clients during the second CPC site visit, there are exceptions. When considering capacity, one aspect is whether the program can provide treatment to participants as it was designed. When there are disruptions to the program it is more difficult to accomplish this. During the second program evaluation, two programs did not have adequate or stable funding to implement programming as designed. Two programs were newer (i.e., less than two years old) at the time of the assessment and still establishing program practices. And one additional program had experienced significant programmatic changes. Finally, two programs changed from a stand-alone program to a being a provider within a larger behavioral health network, which created significant changes in the funding structure.

Of note, two programs exceeded the CPC program averages across all 3 areas (e.g., *Overall, Overall Capacity*, and *Overall Content*). See *Appendix C, Figure 1* for a bar chart of the results. These programs had been evaluated more than 3 times each at the time of the DSAMH contract (*Table 4)* and the most recent CPC program evaluations were completed with specific programs within larger LSAAs. In other words, the scope of the CPC was for a specific program (e.g., Women's Improvement Network, Parents with Children program) rather than all programs serving justice-involved adults. Some demonstrated practices were observed to be shared across the whole organization, but due to the limited scope of the assessment it is unknown whether the program as a whole shared very high adherence to EBP. These programs were encouraged by evaluators to progress their quality assurance efforts with formal evaluation comparing treatment outcome with a risk-control comparison group and tracking recidivism. These two programs may provide evidence that ongoing CPC assessments have benefits in terms of helping programs incorporate the concepts of RNR and distinguish between the unique needs of justice-involved clients compared to clients with only substance use issues. Finally, these results may also show the benefit of a commitment to continuous program improvement.

Aggregate Results by Program Type

Due to variations across the state in size and scope of programs, as well as characteristics of the communities served, this section looks at CPC results by program type (*Table 5)*. State leaders may need to organize system-level efforts for improvement in consideration of the challenges and barriers experienced by differing program types and communities. Additionally, program leadership may be able to learn from the strengths, or coordinate

efforts with similar programs. An aggregate analysis based on program type (e.g., rural, medium, large) is shown in *Tables 6-8.*

Table 5 CPC Sites-Program Type

Contract	# Sites	# Site Visits
2015 evaluation	13	19
Rural[1]	5	7
Medium-size[2]	4	5
Large-size[3]	4	7
2019 evaluation	13	16
Rural[1]	5	7
Medium-size[2]	4	5
Large-size[3]	4	4

[1] Rural includes 5 sites (Northeastern Counseling Center, Four Corners Counseling Center, Central Utah Counseling Center, Bear River Health Department, and San Juan Counseling Center).
[2] Programs designated as medium include 4 sites (Valley Behavioral Health-Tooele, Wasatch County Family Clinic, Valley Behavioral Health Summit, Huntsman Mental Health Institute, Park City Behavioral Health Clinic, and Southwest Behavioral Health Center).
[3] Programs designated as large include 4 sites (Odyssey House of Utah, Weber Human Services, Wasatch Behavioral Health, Utah County Division of Substance Abuse, and Davis Behavioral Health).

Rural programs included Northeastern Counseling Center, Four Corners Counseling Center, Central Utah Counseling Center, Bear River Health Department, and San Juan Counseling Center. These programs identified themselves as rural based on number of clients served, budget, and access to supplementary services. Rural programs identified many challenges in implementing evidence-based practices including retention and recruitment of direct services staff. Others challenges included the unpredictability of funding amidst the transition between funding provided as part of the Drug Offender Reform Act (DORA) to funding designated for Justice Reinvestment Initiative (JRI) to Medicaid Expansion. Compounding changes (e.g., loss of staff due to tragedy or transition, global pandemic, and changing expectations for justice-involved clients) were especially destabilizing to rural program staff and clients. Program staff from the three programs evaluated during the COVID-19 pandemic described day-to-day services being significantly impacted by the pandemic (e.g., suspension of services, attendance by participants due to variations in access to internet and technology). There were also notable efforts made on behalf of program staff to adapt to telehealth and utilize it as an advantage to increase access for clients to providers outside of the area.

Table 6 shows aggregate results for programs designated as rurally-based. Rurally-based providers saw larger increases than the other two program types in *Assessment* and *Staff Characteristic* domains. These programs also saw larger decreases than the other two program types in *Program Leadership and Development*. This was due to the fact that fewer Program Directors were conducting direct service for justice-involved clients. The research on program effectiveness asserts that involved Program Directors are more effective than those who are not (UCCI, 2019). More than that, the decrease can be contributed to a change in item scoring for the CPC between the 2.0 and 2.1 that specified Program Directors needing college-level coursework in corrections, forensics, or criminal justice. Increase in the *Staff*

Characteristics was due in part to more providers implementing annual evaluations for all direct service staff and initial training for new staff that included criteria for direct services skills. For example, leadership from one program developed and integrated modules into their online training system to provide training on the program's therapeutic model (cognitive behavioral) and about the risk-need-responsivity (RNR) model for justice-involved clients. In the *Assessment* domain, one program improved by 50% between program evaluations by systematically employing a validated risk screening tool to determine which justice-involved clients were higher risk. For all treatment providers, these successes will be more easily met with the DSAMH opening access to a validated criminogenic risk screening tool (i.e., the Level of Service Inventory-Revised: Screening Version, LSI-R:SV, in mid-2021) and providing an introductory training on the RNR model in late 2021. These options were not in place at the time of any site visits completed.

Table 6 CPC Results-Program Type, Rural[1]

Contract	2015 evaluation-Rural	2019 evaluation-Rural	% Change	CPC National Average[2]
Sample (n)	5	5		660+
Overall Mn (%)	35	35	<1	49
Overall Capacity Mn (%)	53	56	+3	57
Program Leadership & Development	74	65	-9	70
Staff Characteristics	63	83	+20	64
Quality Assurance	9	9	<1	28
Overall Content Mn (%)	23	21	-2	43
Assessment of Justice-Involved Clients	18	32	+14	54
Treatment Characteristics	22	16	-6	38

[1] Rural includes 5 sites (Northeastern Counseling Center, Four Corners Counseling Center, Central Utah Counseling Center, Bear River Health Department, and San Juan Counseling Center).
[2] National Average based on 660 program evaluations completed between 2005 and 2019.

Moderately-sized programs included Valley Behavioral Health-Tooele, Wasatch County Family Clinic, Valley Behavioral Health Summit, Huntsman Mental Health Institute, Park City Behavioral Health Clinic, and Southwest Behavioral Health Center. In addition to the COVID-19 pandemic, these programs experienced changes in leadership (e.g., retirement, or retention), funding structure (e.g., VBH-Tooele is the county service provider while Optum is the payor), and program (e.g., VBH-Summit changed to HMHI-Park City Behavioral Health Clinic, which operates as one provider within University of Utah Health Plans Behavioral Health Network serving Summit County). These programs serve larger populations than the rural-based programs, have larger budgets, have the ability to offer higher intensity services, and specificity of treatment. However, many are still organized to provide generalized services in their community as compared to the larger programs.

Table 7 shows aggregate results for programs designated as moderately sized. Similar to the rural programs, moderately-sized providers saw increases in the *Staff Characteristics*

domain. Smaller increases were made in *Assessment (*8% increase compared to 14% increase) and smaller decreases in *Program Leadership and Development (*-6% compared to -9%). Compared to rurally-based programs, moderately-sized programs saw an increase in *Treatment Characteristics* (12% compared to -6%). This increase, seen after the implementation of JRI in Utah, was demonstrated by new program leadership selecting curricula specialized for justice-involved clients (e.g., *A New Direction: A Cognitive-Behavioral Therapy Program* from Hazelden, or *Leisure Step Up*) in addition to maintaining Moral Reconation Therapy (MRT) as group curricula options to target identified criminogenic needs in justice-involved clients. These selections highlight providers considering manualized programming that meets different criminogenic targets within community-based substance use treatment programs.

Table 7 CPC Results-Program Type, Medium-size [1,2]

Contract	**2015 evaluation-Medium**	**2019 evaluation-Medium**	**% Change**	**CPC National Average[2]**
Sample (n)	4	4		660+
Overall Mn (%)	32	38	+6	49
Overall Capacity Mn (%)	50	51	+1	57
Program Leadership & Development	68	62	-6	70
Staff Characteristics	65	75	+10	64
Quality Assurance	3	0	-3	28
Overall Content Mn (%)	20	29	+8	43
Assessment of Justice-Involved Clients	20	28	+8	54
Treatment Characteristics	17	29	+12	38

[1] Programs designated as medium include 4 sites (Valley Behavioral Health-Tooele, Wasatch County Family Clinic, Valley Behavioral Health Summit, Huntsman Mental Health Institute, Park City Behavioral Health Clinic, and Southwest Behavioral Health Center).

[2] National Average based on 660 program evaluations completed between 2005 and 2019.

Programs designated as larger include Odyssey House of Utah, Weber Human Services, Wasatch Behavioral Health, Utah County Division of Substance Abuse, and Davis Behavioral Health. Of the programs evaluated during the COVID-19 pandemic, program staff also noted impacts of the pandemic to service delivery (e.g., external service providers and volunteers). However, adaptations to the pandemic including telehealth services were also developed and implemented in larger programs. Due to population size and access to resources in the community these programs offer multiple services as the LSAA (e.g., OP, IOP, Residential), or offer specific treatment (e.g., substance use disorder treatment programs for women, or parents with children). One large program, the Utah County Division of Substance Abuse was merged with Wasatch Behavioral Health between the 2015 and 2019 CPC assessment and was in operation for 1 year at the time of the site visit.

Table 8 shows aggregate results for programs designated as larger. Due to the specific scope for 2 programs (e.g., women, parents with children), results are also shown for more general LSAA providers (n=2; Limited Scope).

Programs designated as larger in the state of Utah saw increases comparable to the medium-sized programs in *Assessment (*+9% compared to +9% and +8% with limited scope). There were no changes demonstrated in the *Staff Characteristic* domains for larger size programs; this domain remained within the Very High Adherence to EBP between site visits. There was an increase in *Program Leadership and Development* as compared to medium-sized and rural programs (+5%, -6, and -9 respectively). However, when accounting for scope all locations showed decreases in this domain (-4% for large, -6% for medium, and -9% for rural). Performance in the *Program Leadership and Development* and *Staff Characteristics* domains are indicative of a difference in access to clinical staff in larger cities compared to staffing challenges faced by rural or medium-sized programs. Additionally, three-quarters of program leadership for this group of programs had criminal justice specialization. This was a challenge for rural and medium-sized programs whose leadership are tasked with supervising staff who provide generalized services to entire communities.

Overall, larger programs are closer to *Overall* national averages for CPC evaluated programs. As of the DSAMH CPC program evaluation, these programs met or exceeded the national averages for all areas and domains assessed by the CPC. However, when looking at larger programs that served a broader scope (i.e., Limited Scope) compared to programs designated as medium or rural, *Staff Characteristics* was the only domain where larger programs exceeded or met the national average.

These larger programs saw the highest increases within the *Quality Assurance* domain between site visits. However, only one-quarter of programs were found to be in high adherence to EBP in the *Quality Assurance* domain. Half of these programs had a designated program evaluator at the time of the site visit. This position is valuable in their ability to regularly analyze program data to support implementation and program improvement efforts. This type of position is more necessary when programs are serving larger numbers of clients. Additionally, only one-quarter of these programs was reassessing client's criminogenic risk and need to determine if clients were meeting target behaviors. Overall, reassessment was limited to the American Society of Addiction Medicine (ASAM) criteria to guide Level of Care which is mandated by Medicaid (Division of Medicaid and Health Financing, 2019).

Table 8 CPC Results-Program Type, Large-size[1,2]

Contract	2015 evaluation-Large	2019 evaluation-Large	% Change	CPC National Average[2]
Sample (n)	4	4		660+
Overall Mn (%)	50	55	+5	49
Limited Scope[3]	39	41	+2	
Overall Capacity Mn (%)	55	63	+8	57
Limited Scope[3]	50	53	+3	
Program Leadership & Development	67	72	+5	70
Limited Scope[3]	66	62	-4	
Staff Characteristics	75	75	0	64
Limited Scope[3]	68	68	0	
Quality Assurance	15	33	+18	28
Limited Scope[3]	6	16	+10	
Overall Content Mn (%)	47	48	+1	43
Limited Scope[3]	32	32	<1	
Assessment of Justice-Involved Clients	56	65	+9	54
Limited Scope[3]	38	46	+8	
Treatment Characteristics	41	43	+2	38
Limited Scope[3]	26	28	+2	

[1] Programs designated as large-sized include 4 sites (Odyssey House of Utah, Weber Human Services, Wasatch Behavioral Health, Utah County Division of Substance Abuse, and Davis Behavioral Health).
[2] National Average based on 660 program evaluations completed between 2005 and 2019.
[3] Limited Scope refers to two programs designated as large-sized who did not provide specialized services.

Aggregate Results Between Assessments

This section aggregates CPC results by contract (e.g., 2015 evaluation, 2019 evaluation) to allow for comparison between the two evaluation points and CPC National Averages. *Table 9* includes the 11 programs who had a CPC program evaluation as part of the 2015 evaluation and a second as part of the 2019 evaluation. *Table 10* includes all evaluated sites. The 11 programs in *Table 9* would have had more consistent access to resources, training and technical assistance for justice-involved clients.

Aggregate-Before & During JRI implementation

There were 11 programs that had been evaluated prior to the beginning of JRI implementation in Utah (2015 evaluation), and 6 years after JRI implementation began in Utah (2019 evaluation). Scores for programs that had multiple sites evaluated (e.g., Central Utah Counseling Center and Southwest Behavioral Health Center) were averaged. The results for these programs are shown in Table 9 (see Appendix C, Figure 2 for a bar chart of the results). The overall results are similar to the results in Table 10 with notable increases

in the *Assessment* and *Staff Characteristics* domains. Of programs evaluated as part of both contracts there was a 15% increase in the Assessment domain as compared to 11% in the overall aggregate analysis.

Table 9 CPC Results- 2015 and 2019 evaluation comparison

Contract	2015 evaluation	2019 evaluation	% Change	CPC National Average[1]
Sample (n)	11	11		660+
Overall Mn (%)	40	43	+3	49
Overall Rating	**LOW**	**LOW**		**MODERATE**
Overall Capacity Mn (%)	54	59	+5	57
Overall Capacity Rating	**MODERATE**	**HIGH**		**HIGH**
Program Leadership & Development	71	68	-3	70
Staff Characteristics	69	80	+11	64
Quality Assurance	9	16	+7	28
Overall Content Mn (%)	30	32	+2	43
Overall Content Rating	**LOW**	**LOW**		**LOW**
Assessment for Justice-Involved Clients	28	43	+15	54
Treatment Characteristics	27	29	+2	38

[1] National Average based on 660 program evaluations completed between 2005 and 2019.

The use of effective risk and need assessment tools is an essential component of interventions that will reduce recidivism among justice-involved adults. Research shows that correctional interventions and programs are more effective when their intensity is matched to the client's level of risk and when dynamic risk factors, or criminogenic needs, directly related to recidivism are targeted in treatment. All programs scored with at least one indicator of evidence-based practices for assessment and eight programs (72%) improved between site visits. Over half of evaluated programs (54%) improved by more than one indicator of evidence-based practices for assessment.

Almost one-third of evaluated programs (27%) demonstrated less indicators of evidence-based practices in assessment between the 2015 evaluation and the 2019 evaluation, and almost one-fifth of programs evaluated (18%) had reductions between CPC site visits in multiple indicators of evidence-based assessment practices for justice-involved clients. In some cases, these reductions were the result of fragmented accessibility to assessment tools or results from criminal justice partners. For example, the RANT assessment is used the Utah Courts but has not been validated. This resulted in confusion, frustration and resistance by some program staff and leadership in utilizing criminogenic risk screening instruments in addition to other substance use or mental health assessments. These examples offer insight to different barriers in implementation across community treatment providers.

Although there was a slight increase in the *Quality Assurance* domain, the lowest percentage was 0% and the highest percentage was 62% (not shown in *Table 9).* Over half of programs (54%) evaluated remained at zero or reduced in performance on this domain between CPC

site visits. If a program reduced in indicators, it means that at the time of the site visit consistent quality assurance practices were not evident across multiple sources of data (e.g., file review and interviews). The CPC is a point-in-time instrument that evaluates practices as occurring or not. Due to this, there were a number of emerging practices across programs that demonstrate movement toward the implementation of EBP; however, those would not show in program's scores if they were not meeting the full criteria at the time of evaluation. Programs with evidence of quality assurance that were not consistently applied to all justice-involved clients did not meet the indicator for evidence-based practices. For example, clinicians would submit tapes for review for modalities such as Motivational Interviewing (MI), but not for other interventions that specifically target criminogenic needs. In some cases, file reviews or group observations were conducted, but staff did not consistently report receiving feedback or coaching as a result.

Almost half of programs (45%) improved in evidence-based practices for quality assurance between the 2015 evaluation and the 2019 evaluation. Of those five programs, almost all (85%) improved by more than one indicator of evidence-based quality assurance practices. Across all evaluated sites, leadership were familiar with internal quality assurance practices (e.g., file review, group observation). Between first and second assessments, three sites have created an internal evaluator position to focus on quality assurance practices. Other programs have utilized student interns, peer support specialists, and case managers to track, record and analyze client data. These indicators are relevant considering that evaluated programs who demonstrated more systematic internal and external quality assurance practices performed better across domains of the CPC. Of note, many sites were not reassessing risk through treatment which is an important component of evidence-based practice with justice-involved clients.

Aggregate-All Programs

There were 19 total site visits that occurred prior to the beginning of JRI implementation in Utah (i.e., 2015 evaluation) and 16 total site visits that took place since JRI implementation began in Utah (i.e., 2019 evaluation). *Table 10* shows overall aggregate CPC results for both contracts and CPC National Averages. Program and system strengths are noted in *Tables 11-15* throughout the sections, as they pertain to skills or resources that should be leveraged when addressing the areas for improvement.

Table 10 CPC Results-2015 and 2019 evaluation comparison-all programs

Contract	2015 evaluation	2019 evaluation	% Change	CPC National Average[1]
Sample (n)	19	16		660+
Overall (%)	39	41	+3	49
Overall Capacity (%)	53	57	+4	57
Program Leadership & Development	71	66	-5	70
Staff Characteristics	68	79	+11	64
Quality Assurance	8	13	+5	28
Overall Content (%)	29	29	>1	43
Assessment of Justice-Involved Clients	26	37	+11	54
Treatment Characteristics	27	27	>1	38

[1] National Average based on 660 program evaluations completed between 2005 and 2019.

Overall Capacity

Programs scored higher in the area of *Capacity* compared to *Content.* A score of 57% suggests that Utah's community-based treatment providers are demonstrating high adherence to EBP for justice-involved clients. This is comparable to the CPC national average.

Overall Content

Within the *Content* area (*Assessment of Justice-Involved Clients, Treatment Characteristics*), programs scored, on average, in the Low Adherence to EBP range and below the CPC national average. However, Utah's community-based treatment providers saw increases in *Assessment of Justice Involved Clients.*

Staff Characteristics. For the DSAMH contract, Utah programs exceeded the CPC national average in one category, the *Staff Characteristics* domain (79% to 64%). As noted earlier, a large number of the direct service staff providers had relevant experience and education to meet their responsibilities in working with justice-involved individuals. Program staff overwhelmingly supported the goals and values of treatment for the population. Their commitment to improving EBP for this population was reinforced by ethical guidelines at the program-level, and for most staff members, by clinical licensure (e.g., NASW Code of Ethics).

Table 11 Aggregate Strengths-Staff Characteristics domain

Staff Characteristics
Majority of direct services staff had relevant experience (+2 years with justice-involved clients)
Majority of direct services staff had relevant education (e.g., >Associate's Degree in a helping profession)
Majority of staff reported receiving clinical supervision commensurate with their responsibilities[1]
Majority of staff overwhelmingly supported the goals and values of treatment for the justice-involved population
Regular staff meetings take place and include client staffing, staff input, and training components
Program leadership solicited staff feedback on program components, and made specific changes as a result
Staff are increasingly being formally trained on concepts specific to serving justice-involved clients, and these trainings occur largely prior to delivering services[2]
[1] Models of supervision demonstrated have included video/audio recording sessions and utilizing a peer feedback structure for file review. [2] Examples included new hire training having embedded components on RNR and attending a curricula training prior to delivering the group intervention.

Assessment of Justice-Involved Clients. The most notable change from first to second evaluations is shown in *Table 10*. For the aggregate group, the domain of *Offender Assessment* shows an 11% increase since the implementation of JRI in Utah. System-wide programs were selecting the right clients for mandated substance use treatment and many programs were following DSAMH guidance in regards to criminogenic risk screening. Many providers were working with the criminal justice stakeholders to screen clients for high to low risk using the RANT assessment. Across the state, justice-involved clients, primarily as part of Drug Court programs, are assessed for risk on the RANT at intake. Although the RANT provides a standardized and objective measure of risk and needs, it has not been widely validated nor validated on the local population. The RANT has only been validated on a sample of 627 felony drug and property offenders in Minneapolis (Marlowe et al., 2011). Although the validation study was published in a peer-reviewed article, the RANT has not been the subject of an independent validation study and has not been validated on a sample of offenders outside of the state of Minnesota (see, e.g., Serin & Lowenkamp, 2015). Therefore, without local validation it is not clear that the RANT is providing valid assessment of risk and needs in the area. The impact of using an unvalidated assessment is that sites cannot reliably know whether they are accurately separating clients by high and low risk. At many sites, the percentage of moderate- or high-risk clients being served by the program could not be determined. Additionally, the RANT does not provide important detail on individual client's criminogenic needs.

In mid-2021, the DSAMH began offering programs access to use the LSI-R: SV instrument created by Drs. Andrews and Bonta and hosted by Multi-Health Systems via a shared platform (i.e., GIFR Electronic Assessment & Reporting System, G.E.A.R.S.). Implementation of a validated criminogenic risk screening tool at every site would result in higher adherence to EBP across the state of Utah. Subsequent to, and as indicated by standardized

criminogenic risk screening instruments, full criminogenic risk/needs assessments should be utilized for justice-involved clients to guide targeting of criminogenic needs.

Table 12 Aggregate Strengths-Assessment of Justice-Involved Clients domain

Assessment of Justice-Involved Clients
The majority of programs reported that the clients mandated for substance use treatment are appropriate
The majority of programs were utilizing some criminogenic risk screening instrument
Almost one-third (38%) of programs were consistently utilizing a validated criminogenic risk screening instrument
Almost one-quarter (23%) of programs were utilizing a validated criminogenic risk/needs assessment
Approximately one-third (30%) of programs were utilizing validated responsivity instruments to reduce client barriers to successfully complete treatment

Quality Assurance. Also seen in *Table 10*, there was a slight increase in *Quality Assurance* practices evaluated in the 2019 program evaluations compared to the 2015 program evaluations. Almost half of programs (46%) demonstrated at least one indicator of evidence-based quality assurance practices during their site visit, and almost one-third of programs (30%) demonstrated more than one indicator of evidence-based quality assurance practices during their site visit. However, Utah's community treatment providers as an aggregate group are still performing lower (12%) than the national average.

Table 13 Aggregate Strengths-Quality Assurance domain

Quality Assurance
Almost half (46%) of programs demonstrated at least one indicator of evidence-based practices for quality assurance during their site visit
Almost one-third (30%) of programs demonstrated multiple indicators of evidence-based practices for quality assurance
Three programs created in-house evaluator positions
The SURE instrument was introduced as an outcome measure for substance use by DSAMH
Access to treatment providers state-wide to the G.E.A.R.S. platform, hosted by the Multi-Health Systems, as part of DSAMH's implementation of the LSI-R:SV

Program Leadership & Development. Although slight decreases were seen in this category, this domain remained in high adherence across the state. Programs were well-established in their communities of practice as demonstrated by relationships with local criminal justice stakeholders and community organizations. These included Drug Court partners, volunteers, local businesses, and other social service providers. Program leadership have the education and expertise to serve in their communities. Of the Program Directors evaluated (n=17) the average years of experience working with justice-involved clients was 16 with the lowest number of years being three years and the highest number being 30 years; 70% of Program Directors had more than 14 years of experience working with justice-involved clients. Program Directors had been in their leadership position for an average of six years. A majority (70%) had been in their position after the implementation of JRI began. Almost one-quarter (23%) of Program Directors were in their

position for the 2015 program evaluation and 2019 program evaluation. And, over one-third (35%) of Program Directors were in leadership positions with the program during both program evaluations. Reductions in the *Program Leadership and Development* domain may be largely contributed to a change in item scoring for the CPC between the 2.0 and 2.1 that specified Program Directors needing college-level coursework in corrections, forensics, or criminal justice.

Table 14 Aggregate Strengths-Program Leadership & Development domain

Program Leadership and Development
For this domain, Utah's community-based treatment providers remained in high adherence to EBP between site visits across the state
Program Directors had an average of 16 years of experience working with justice-involved clients
The majority of Program Directors were Master's Level clinicians
The majority of Program Directors provide some level of direct service to clients
The majority of Program Directors select new staff, provide new staff training and supervision to staff
All programs described strong support within their community as evidenced by community partnerships, volunteers, and support services being available to clients.
All programs described ongoing collaboration with criminal justice stakeholders

Treatment Characteristics. The *Treatment Characteristics* domain saw the least change between CPCs. However, three programs exceeded the national average and two of those three programs demonstrated high adherence to EBP. Further, there were a number of promising practices in this domain that programs utilized for clients in Drug Court including behavior management systems, specific completion criteria, and completion rate tracking. Further, program treatment staff were provided state-sponsored trainings focused on the criminal justice population (e.g., Moral Reconation Therapy). MRT has been a system-supported intervention since JRI began, with trainings being regularly provided by DSAMH. This intervention was conducted at most programs and was observed to be facilitated by trained staff who followed the curriculum. The implementation of MRT across the state of Utah offers an example of how the system can provide resources that support programs in adopting evidence-based curricula, interventions, and processes for increasing adherence to fidelity. Further, new EBP curricula were being introduced to target criminogenic needs (e.g., Leisure Skills, Antisocial Thinking, Antisocial Peers).

Table 15 Aggregate Strengths-Treatment Characteristics

Treatment Characteristics
Almost one-quarter (23%) of programs exceeded the national average in this domain
Almost one-sixth (15%) of programs demonstrated high adherence to EBP in this domain
Drug Court programs demonstrated a number of evidence-based practice indicators across the state[1]
Selection and utilization of EBP curricula increased between evaluations[2]
[1] Including evidence of behavior management systems, completion criteria, and completion rate tracking. [2] These included *Moral Reconation Therapy, Leisure Step Up*, and *New Direction: A Cognitive-Behavioral Therapy Program* from Hazelden.

Recommendations

Recommendations by Area, Domain

System recommendations that will assist program's increase adherence to EBP, by area and domain, are offered below. For more detail about each domain see *Appendix B.* The domains are organized by recommended prioritization.

Content

Within the *Content* area (*Assessment of Justice-Involved Clients, Treatment Characteristics*), programs scored, on average, in the Low Adherence to EBP range and below the national average. However, Utah's community-based treatment providers saw increases in *Assessment of Justice-Involved Clients* (*Table 16).* Going forward, system-wide efforts should focus on these domains.

Table 16 CPC Results- 2019 evaluation, Content

Contract	DSAMH	CPC National Average[1]
Sample (n)	16	660+
Assessment of Justice-Involved Clients	**37**	**54**
Treatment Characteristics	**27**	**38**
Overall Content (%)	29	43
Overall (%)	41	49

[1] National Average based on 660 program evaluations completed between 2005 and 2019.

Assessment of Justice-Involved Clients

Validated Instruments. Screening and assessment of risk, need, and responsivity factors is indicated prior to providing services (Andrews, & Bonta, 2010; Bonta, & Andrews, 2007). Reassessment of risk, need, and responsivity factors is indicated throughout and at the end of treatment and should be used to make decisions regarding treatment placement, progress, and completion. All clients who are justice-involved should be screened with a validated risk instrument and, as indicated, receive a full criminogenic risk/needs assessment. Leadership should be provided with materials needed to support staff in understanding the utility of risk screening tools, and how criminogenic screening and assessment will be implemented consistently at the program-level.

Since the implementation of JRI in Utah, more community-based treatment providers are utilizing criminogenic risk screening instruments to separate justice-involved clients. However, there have been significant shifts in screening and assessment practices including the ability to share assessment results amongst criminal justice stakeholders, trainings sponsored by the Department of Corrections in the Level of Service/Risk, Need & Responsivity (LS/RNR) instrument, adoption of the Risk and Needs Triage (RANT) by Utah Courts including Drug Court programs state-wide, and the initial implementation of the LSI-R: SV by the DSAMH. The majority of programs were consistently utilizing the RANT instrument for Drug Court clients across the state of Utah. However, as noted earlier, it is

recommended that Utah criminal justice stakeholders participate in a validation study for the RANT. Once the RANT is validated or a validated risk/needs assessment is adopted by the program, programs will have the ability to establish and monitor justice-involved clients' risk levels. This will allow providers to separate low risk clients from high- and moderate-risk clients. And, will allow providers to focus additional treatment resources on those clients with the highest risk to recidivate.

Additionally, the majority of sites (80%) were conducting additional assessments on identified criminogenic needs to enhance treatment planning for the need areas identified by the general risk/need assessments. For example, the Substance Abuse Subtle Screening Inventory (SASSI) and the Drug Use Screening Inventory (DUSI) were used to assess substance use and guide treatment. Providers should continue to use validated screening and needs assessment tools to assess alcohol and drug use severity (Latessa et al., 2020). This practice is crucial to ensuring that substance abuse treatment is being prioritized appropriately in consideration of all of the client's highest criminogenic need areas.

Treatment Characteristics

Program Targets and Completion. All programs should be encouraged to identify, or should be provided with, formal completion criteria for justice-involved 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%.

This practice is already being demonstrated with clients participating in Drug Court across the state. Again, support staff positions including Peer Support Specialists, Substance Use Disorder Counselors, and Case Managers were tracking clients in Drug Court programs. However, these practices did not extend to justice-involved clients who were not participating in Drug Court. System-wide development in identifying and tracking program targets and completion could offer vital feedback in the pursuit of evidence-based practice.

Behavior Management Systems. Behavior management systems can help to promote positive behavioral change and compliance while extinguishing antisocial behaviors. 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, Drug Court partners) to implement these strategies. Program staff were familiar with behavior management systems for clients in Drug Court but did not extend these practices to clients who were not involved in Drug Court; even when these clients were participating in groups together. While not all practices can be shared from Drug Court, the DSAMH should support programs in identifying the practices of behavior management that can be implemented by all direct services staff with all justice-involved clients.

***Aftercare*.** A final need across the system is quality aftercare for participants who exit treatment programs. This need was noted as a priority across many program leaders. The type and level of that care should vary based on participants' re-assessed risk level and needs. And, similar to Drug Court (i.e., phase 5) all aftercare services should begin while participants are still in their treatment phase and be designed to help the justice-involved clients 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.

Capacity

Programs scored higher in the area of *Capacity (Program Leadership & Development, Staff Characteristics and Quality Assurance)* compared to *Content.* A score of 57% suggests that Utah's community-based treatment providers are demonstrating high adherence to EBP for justice-involved clients. This is comparable to National Averages (*Table 17)*. Going forward, system-wide efforts should focus on supporting programs in maintaining stability in programs including staff retention while increasing program's quality assurance efforts.

Table 17 CPC Results- 2019 evaluation, Capacity

Contract	DSAMH	CPC National Average[1]
Sample (n)	16	660+
Quality Assurance	**13**	**28**
Program Leadership & Development	66	70
Staff Characteristics	79	64
Overall Capacity	57	57
Overall	41	49

[1] National Average based on 660 program evaluations completed between 2005 and 2019.

Quality Assurance

Prioritizing QA. For all programs, evidenced-based quality assurance practices should be an area of focus going forward. All of the programs would benefit from strengthened internal quality assurance processes. This includes reassessment of criminogenic risk. Additionally, ongoing and regular discussion amongst program leadership and staff based on observation of direct service including the use of the curriculum, group facilitation, and participant feedback.

Studying Outcome and Recidivism. Programs who have demonstrated high and very high adherence to EBP should be encouraged to participate in outcome evaluations and monitoring of the recidivism of their participants to determine the actual impact of the programs. Further, these programs should share data collection and quality assurance practices at shared leadership meetings (i.e., the Clinical Director Meeting). Programs should

also collaborate with one another and outside criminal justice stakeholders on what measures may be appropriate for monitoring their impact on clients.

Program Leadership and Development

Literature Reviews and Piloting. Program Directors are expected to play some consistent role in staff selection, training, supervision and provision of direct services to program participants. As such, Program Directors should collaborate with DSAMH leadership in regularly consulting the literature regarding EBP for justice-involved clients. In this 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. Programs would commit to maintain a core where all of its components are based on a coherent theoretical model that has empirical evidence supporting its effectiveness. And, all staff should also be continually exposed to the literature to the extent that they can demonstrate a thorough understanding. As programs implement new practices as part of JRI (e.g., screenings, assessments, curricula), formal piloting should take place with successes, modifications, and updates being shared amongst program leadership (i.e., Clinical Directors) to support in state-wide efforts to implement EBP.

Staff Characteristics

Skill-driven training and coaching. State-wide trainings should emphasize teaching and practice in the areas of core correctional practice, including effective behavior management strategies. This would include sessions on the effective use of use of authority, effective reinforcement and disapproval, problem-solving and decision-making skills, and modeling behaviors. For direct service staff, there should be regular and systematic feedback on service delivery, opportunities to co-facilitate with senior clinicians, and review of recorded sessions. Additionally, aggregate feedback should be shared at the program leadership (i.e., Clinical Director) level to guide ongoing training initiatives. Committees organized by shared curricula, or core correctional practices may be considered at the system-level.

Matching Treatment to assessed need. When implementing shared curricula and direct service practices, DSAMH leadership and program leadership should support direct services staff in understanding 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. For example, EBP curricula (e.g., Moral Reconation Therapy) should not be implemented as a blanket curriculum for all justice-involved clients but should be used address clients who have been assessed as being moderate to high risk in the criminogenic need area of antisocial cognitions and attitudes. Furthermore, clients who are assessed as being high risk in that area should receive more treatment than those who are moderate risk (e.g., more hours of treatment, more time practicing new skills, a wider variety of treatment modalities).

Overall Recommendations

Similar to the reports provided to the programs based on their CPC assessment, this aggregate report offers recommendations to facilitate implementation of statewide evidence-based practices with justice-involved individuals receiving community-based treatment. To aide stakeholders in prioritizing system-wide targets, four areas of improvement will be presented: 1) support providers with the implementation of criminogenic risk screening tools to guide program placement and services; 2) review system-wide policies and procedures to connect resources in data collection and program practices; and 3) continue efforts to promote collaboration amongst treatment program leadership and criminal justice stakeholders.

Support providers with the implementation of criminogenic risk screening tools to guide program placement and services. Overall, stakeholders should continue efforts improve the availability, consistent use, and documentation of standardized and objective criminogenic risk, need and responsivity screening and assessment tools. Efforts to improve screening, assessment and reassessment will support the system improvements recommended for treatment interventions and practices. As identified in *A Performance Audit of Information Sharing in the Criminal Justice System* (Office of the Legislative Auditor General, 2020b), a more centralized structure for conducting and sharing assessments will 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 toward the same goals and coordinating interventions and responses to achieve those goals. Specifically, stakeholders, including the DSAMH and Utah Courts, should partner to agree upon a criminogenic risk screening and needs assessment tool. If it is the RANT, there should be a validation study completed.

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 on their interpretation and use. This would enable clinicians to assign justice-involved clients to the specific interventions that target assessed criminogenic need(s). Additionally, the assessments should be part of completion criteria (e.g., assessed risk level is lower) and their use would facilitate tracking programs' completion rates.

Review system-wide policies and procedures to connect resources in data collection and program practices. Quality Assurance (QA) practices serve as information for the program about its efficacy (Latessa et al., 2020). These QA practices may include criminogenic treatment target review, reassessment using validated risk, need and responsivity instruments to document the progress of the justice-involved client, clear and regular communication with the justice-involved client about progress in meeting completion criteria, and tracking client satisfaction with services to identify barriers to remaining in treatment. In collaboration with all criminal justice stakeholders tracking outcomes should be prioritized (Office of the Legislative Auditor General, 2020a).

Overall, the goal will be to find system-wide solutions that help program leadership navigate barriers while still empowering program leadership and staff to meet the specific needs of

their community. However, with the implications of recidivism (e.g., cost, public safety) for this population, community-based treatment providers should be integrating practices that 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. Practices that are evidence-based should not be separated between justice-involved clients (e.g., Drug Court and non-Drug Court). Stakeholders are in a unique position to help programs and supervision understand and address how to integrate practices with a wide lens. These include behavior management practices, specific completion criteria, and the collection of completion rate data for all justice-involved clients. With these practices being largely organized and structured by outside criminal justice stakeholders, collaboration between LSAAs, and among all criminal justice stakeholders will be vital to supporting sustainable action going forward.

Additionally, practices that are occurring informally by providers due to funding deficits need to be identified. This is particularly evident with 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. There are currently many iterations of treatment availability after a participant has completed initial treatment. However, almost no programs have a sustainable way to formalize policies and procedures for offering aftercare. Currently, informal practices by individual programs, or even individual providers who feel it is their ethical obligation, are preventing Utah leadership from knowing how these aftercare efforts are supporting the reduction of recidivism across the state.

Continue efforts to promote collaboration amongst treatment program leadership and criminal justice stakeholders. Over the past two years, evaluators noted instances where treatment providers were reluctant to adopt and share EBP practices. Examples of this have included reluctance to sharing local practices out of concern that another program will adopt them as well. Some providers also expressed resistance to adopting EBP practices until mandated to do so, accompanied by a lack of commitment to promoting understanding amongst direct service staff of why those practices are meaningful rather than compulsory. Finally, some programs expressed overt resentment toward peer program leadership who are adopting EBP practices. Modeled behaviors such as this delay progress toward EBP for justice-involved clients across the state. There is considerable opportunity for LSAA program leadership and the larger community treatment provider network, to intentionally share practices, lessons learned and successes. These practices may be included in existing peer audit practices, as part of existing leadership meetings, or through the development of committees that guide statewide implementation. These committees may be organized by program type, comparable areas or domains of recommended improvement, or curricula. Committees may share results of pilots, implementation strategies, or organize efforts toward training or selection of tools and curricula.

Collaboration is also recommended between different stakeholders to provide consistent, behavioral intervention with justice-involved adults mandated to substance use treatment. Correctional supervision should be focused on treatment engagement and retention and

clinicians should work with correctional agencies to provide behavioral reinforcements (sanctions and rewards) for clients' progress, or lack thereof, in treatment. Because of the rapport clinicians establish with clients, and their role as a key prosocial person in the client's life during treatment, clinicians play an important part of behavior management, and in promoting clients' development and use of specific behavioral skills (Latessa et al., 2020). These practices should not be limited to specific groups of clients or programs (e.g., Drug Court).

Further, partnership amongst criminal justice stakeholders, namely research institutions like the UCJC, can be used in service of staying up-to-date with current research practices, completing outcome evaluations, or recidivism studies. Consolidation of effort and resources should be prioritized to ensure that practices are shared state-wide and not limited to the efforts of single programs.

Conclusion

Since 2015, Utah has committed to a wide range of policy initiatives regarding reduced recidivism that encompass all criminal justice stakeholders across the state. A central focus of these efforts has been to improve access and quality of behavioral health treatment for justice-involved individuals. Improved access is demonstrated by the 34 percent increase between fiscal years 2015 and 2019 in the number of individuals accessing mental health and substance use treatment; an increase that has been supported through increased state funding to community treatment providers (Harvell, 2020, p.1). With JRI, community-based treatment providers are a vital component of Utah- and national-based efforts to reduce recidivism. Evaluating Utah's community treatment providers to determine their adherence to the principles of EBP for justice-involved persons supports efforts to ensure that the quality of treatment aligns with what we know reduces recidivism.

This final aggregate report provides a snapshot of providers' progress with respect to implementing Evidence-Based Practice (EBP) for adult justice-involved clients mandated to substance use treatment. With respect to differences amongst programs state-wide, analyses in this report consider the following: 1) how well Utah's programs performed based on how many times the program has been evaluated, 2) how similar programs perform, 3) comparison between program evaluations completed before JRI implementation (e.g. ,2015 evaluation) and six years after JRI implementation began across Utah (e.g., 2019 evaluation), and 4) comparison to the national averages (e.g., aggregate results from 600+ programs). Program leadership were provided with detailed reports of strengths as well as recommended areas of improvement.

To aide stakeholders in prioritizing system-wide targets, three areas of improvement were presented: 1) support providers with the implementation of criminogenic risk screening tools to guide program placement and services; 2) review system-wide policies and procedures to connect resources in data collection and program practices; and 3) continue efforts to promote collaboration amongst treatment program leadership and criminal justice stakeholders.

References

American Society of Addiction Medicine. (no date). ASAM Criteria. https://www.asam.org/asam-criteria/about

Andrews, D., & Bonta, J. (2010). *The Psychology of Criminal Conduct* (5th ed.). Cincinnati, OH: Anderson Publishing.

Bonta, J., & Andrews, D. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation*, *6*(1), 1-22.

Division of Medicaid and Health Financing (2019, January). Utah Medicaid Provider Manual. Rehabilitative Mental Health and Substance Use Disorder Services. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/Archive/2019/RehabMentalHealthSubAbuse1-19.pdf

Gendreau, P. (1996). The principles of effective intervention with offenders. In A. T. Harland (Ed.), *Choosing Correctional Options that Work: Defining the Demand and Evaluating the Supply*, 117-130. Thousand Oaks, CA: Sage Publications, Inc.

Gendreau, P., & Andrews, A. (1996). *Correctional Program Assessment Inventory (CPAI)* (6th ed.). Saint John, New Brunswick: University of New Brunswick.

Harvell, S. (2010, March). Justice Reinvestment Initiative (JRI): Utah. Urban Institute. https://www.urban.org/sites/default/files/2020/03/27/justice_reinvestment_initiative_jri_utah.pdf

Latessa, E. J., Johnson, S. L., & Koetzle, D. (2020). *What works (and doesn't) in reducing recidivism (*2nd edition*)*. Routledge.

Lowenkamp, C. T. (2003). *A program level analysis of the relationship between correctional program integrity and treatment effectiveness*. (Doctoral Dissertation). University of Cincinnati, Cincinnati, OH.

Lowenkamp, C. T., & Latessa, E. J. (2002). *Evaluation of Ohio's community based correctional facilities and halfway house programs: Final report*. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice.

Lowenkamp, C. T., & Latessa, E. J. (2003). *Evaluation of Ohio's halfway houses and community based correctional facilities.* Cincinnati, OH: Center for Criminal Justice Research, University of Cincinnati.

Lowenkamp, C. T., & Latessa, E. J. (2005a). *Evaluation of Ohio's CCA Programs.* Cincinnati, OH: Center for Criminal Justice Research, University of Cincinnati.

Lowenkamp, C. T., & Latessa, E. J. (2005b). *Evaluation of Ohio's Reclaim Funded Programs, Community Correctional Facilities, and DYS Facilities.* Cincinnati, OH: Center for Criminal Justice Research, University of Cincinnati.

Makarios, M., Lovins, L. B., Myer, A. J., & Latessa, E. (2019). Treatment Integrity and Recidivism among Sex Offenders: The Relationship between CPC Scores and Program Effectiveness. Corrections, 4(2), 112-125

Marlowe, D. B., Festinger, D. S., Dugosh, K. L., Caron, A., Podkopacz, M. R., & Clements, N. T. (2011). Targeting dispositions for drug-involved offenders: A field trial of the Risk and Needs Triage (RANT)™. *Journal of Criminal Justice*, *39*(3), 253-260.

Office of the Legislative Auditor General. (2020a). *A Performance Audit of Justice Reinvestment Initiative.* [October, 2020]. https://olag.utah.gov/olag-doc/2020-08_RPT.pdf

Office of the Legislative Auditor General. (2020b). *A Performance Audit of Information Sharing in the Criminal Justice System* [October, 2020]. https://olag.utah.gov/olag-doc/2020-09_RPT.pdf

Ostermann, M., & Hyatt, J.M. (2018). When frontloading backfires: Exploring the impact of outsourcing correctional interventions on mechanisms of social control. Law & Social Inquiry, 43(4), 1308-1339.

Seawright, J., Sarver, C., Worwood, E., & Butters, R. (2017). *Adherence to Evidence-Based Practice in Community Treatment: Aggregate Report for LSAA Providers and DORA Sites*. Salt Lake City, UT: University of Utah, Utah Criminal Justice Center.

Serin, R. C., & Lowenkamp, C. T. (2015). *Selecting and using risk and need assessments*. National Drug Court Institute: Alexandria, VA.

Smith, P., Gendreau, P., & Goggin, C. (2005). Correctional treatment: Accomplishments and realities. In P. Van Voorhis, M. Braswell, & D. Lester (Eds.), *Correctional Counseling and Rehabilitation* (5th ed.). Cincinnati, OH: Anderson Publishing

Utah State Legislature. (2015). *H.B. 348: Criminal Justice Programs and Amendments* [2015 General Session, State of Utah). le.utah.gov/~2015/bills/hbillenr/HB0348.pdf

Utah Commission on Criminal Juvenile Justice. (2017). HB348 Criminal Justice Reform (JRI) 2017 Annual Report. *Annual Report*, 36.

Welsh-Loveman, J. & Harvell, S. (2018, May). Justice Reinvestment Initiative Data Snapshot: Unpacking Reinvestment. Urban Institute. https://www.urban.org/sites/default/files/publication/98361/justice_reinvestment_initiative_data_snapshot_0.pdf

Appendix A: Evaluated Program Details (listed alphabetically)[4,5]

Program Name	Counties Served	Age of Program (yrs.)	2015 evaluation	2019 evaluation	Program Type[1]	Level of Care-offered[2]	Drug Court	Specialized Program
Bear River Health Department	Cache/Rich/Box Elder	50	Y	Y	R	OP, IOP	Y	N
Central Utah Counseling Center	Juab/Millard/Paiute/ Sanpete/Sevier/Wayne	45	Y	Y	R	OP, IOP	Y	N
Davis Behavioral Health	Davis	24	Y	Y	L	OP, IOP, Residential	Y	N[3]
Four Corners Community Behavioral Health, Inc.	Carbon/Emery/Grand	24	Y	Y	R	OP, IOP	Y	N
Huntsman Mental Health Institute, Park City Behavioral Health Clinic[4]	Summit	1	N	Y	M	OP, IOP	Y	N
Northeastern Counseling Center	Daggett/Duchesne/ Uintah	24	Y	Y	R	OP, EOP[5]	Y	N
Odyssey House of Utah-Parents with Children Program	Salt Lake	50[6]	Y[7]	Y	L	OP, IOP, Residential[8]	N[9]	Y
San Juan Counseling	San Juan	23	Y	Y	R	OP, mIOP[10]	Y	N
Southwest Behavioral Health Center	Beaver/ Garfield/Iron/Kane/ Washington	36	Y	Y	M	OP, IOP, Residential	Y	N
Utah County Division of Substance Abuse	Utah	15	Y	N	L	OP, IOP	N	N
Valley Behavioral Health-Summit	Summit	24	Y	N	M	OP, IOP	Y	N
Valley Behavioral Health-Tooele	Tooele	25	Y	Y	M	OP, IOP	Y	N[3]
Wasatch Behavioral Health, Substance Use Disorder Services, Utah County	Utah	1[11]	N	Y	L	OP, IOP, Residential	Y	N[3]
Wasatch County Family Clinic	Wasatch	7	Y	Y	M	OP, IOP	Y	N
Weber Human Services-Women's Improvement Network Program	Weber/Morgan	28[12]	Y[13]	Y[13]	L	OP, IOP[14]	N	Y

[4] Program details describe the program at the time of the CPC assessment.
[5] The aggregate report for the first CPC evaluations is available online (Seawright et al., 2017).

Program Name	Counties Served	Age of Program (yrs.)	2015 evaluation	2019 evaluation	Program Type[1]	Level of Care-offered[2]	Drug Court	Specialized Program

[1] R=rural; M=medium-sized; L=larger-sized. Program type was organized by location, population density in community served, and size of the program.
[2] Levels of Care are established by ASAM criteria and are as follows: Level 1 is Outpatient (OP) is <9 hours of treatment services per week; Level 2.1 is Intensive Outpatient (IOP) is > 9 hours of treatment services per week; Level 3.1 is Residential which is at least 5 hours of clinical service per week within a 24-hour structured living environment.
[3] These programs offer specialized programs (e.g., gender-specific residential care, parents with children residential services, in-jail treatment services). However, the scope of the CPC site visits excluded these programs (e.g., in-jail treatment programs) or included them as a broader evaluation of EBP for justice-involved clients in substance use services.
[4] HMHI-PC BHC operates as a network provider within University Health Plans.
[5] Extensive Outpatient (EOP) corresponds to 1-8 hours of treatment services per week. This is less than the >9 hours required for IOP.
[6] Odyssey House of Utah has been in operation for 50 years. The Parents with Children program has been in operation for 27 years.
[7] Odyssey House of Utah's Outpatient and Adult Residential Programs were evaluated in 2015. The Parents with Children program was selected to be evaluated in 2019.
[8] The Parents with Children program is a residential program. During the 2015 evaluation, the Residential Adult program was evaluated. Odyssey House Outpatient offers OP and IOP levels of care.
[9] The Parents with Children program does not offer Drug Court. However, there is a Drug Court program offered at the Outpatient program for Odyssey House of Utah.
[10] San Juan Counseling offers a modified IOP program (mIOP) which corresponds to 1-5 hours. This is less than the >9 hours required for IOP.
[11] Wasatch Behavioral Health, formerly known as Wasatch Mental Health, has been in operation for 54 years.
[12] Weber Human Services has been in operation for 28 years. The Women's Improvement Network Program has been in operation for 6 years.
[13] Weber Human Services DORA program was evaluated in 2015. The WIN program was selected to be evaluated in 2019.
[14] The WIN program offers an IOP level of care which corresponds to 9 hours per week.

Appendix B: Methods

Correctional Program Checklist (CPC) [6]

The Evidence-Based Correctional Program Checklist (CPC) is a tool developed by the University of Cincinnati Corrections Institute (UCCI)[7] for assessing correctional intervention programs[8]. The CPC is designed to evaluate the extent to which correctional intervention programs adhere to evidence-based practices (EBP) including the principles of effective interventions. Data from four studies[9] conducted by UCCI on both adult and youth programs were used to develop and validate the CPC indicators. These studies produced strong correlations between outcome (i.e., recidivism) and individual items, domains, areas, and overall score. Two additional studies[10] have confirmed that CPC scores are correlated with recidivism and a large body of research exists that supports the indicators on the CPC[11]. To continue to align with updates in the field of offender rehabilitation, the CPC has been revised twice. A substantial revision was released in 2015 (CPC 2.0) and in 2019, minor revisions were made (CPC 2.1).

Throughout this document, all references to the CPC are a direct reference to the revised CPC 2.1 version of the assessment tool.

The CPC is divided into two basic areas: capacity and content. Capacity measures whether a correctional program has the capability to deliver evidence-based interventions and services

---

[6] 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.

[7] In the past, UCCI has been referred to as the University of Cincinnati (UC), UC School of Criminal Justice, or the UC Center for Criminal Justice Research (CCJR). We now use the UCCI designation.

[8] The CPC is modeled after the Correctional Program Assessment Inventory (CPAI) developed by Drs. Paul Gendreau and Don Andrews. The CPC, however, includes a number of items not included in the CPAI. Further, items that were not positively correlated with recidivism in the UCCI studies were deleted.

[9] A large component of this research involved the identification of program characteristics that were correlated with recidivism outcomes. References include 1) Lowenkamp, C. T., & Latessa, E. J. (2002). Evaluation of Ohio's community-based correctional facilities and halfway house programs: Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice; 2) Lowenkamp, C. T., & Latessa, E. J. (2005a). Evaluation of Ohio's CCA funded programs. Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice; 3) Lowenkamp, C. T., & Latessa, E. J. (2005b). Evaluation of Ohio's RECLAIM funded programs, community corrections facilities, and DYS facilities. Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice; 3) Latessa, E., Lovins, L. B., & Smith, P. (2010). Follow-up evaluation of Ohio's community-based correctional facility and halfway house programs—Outcome study. Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, School of Criminal Justice.

[10] The two additional studies include: 1) Makarios, M., Lovins, L. B., Myer, A. J., & Latessa, E. (2019). Treatment Integrity and Recidivism among Sex Offenders: The Relationship between CPC Scores and Program Effectiveness. Corrections, 4(2), 112-125; and 2) Ostermann, M., & Hyatt, J.M. (2018). When frontloading backfires: Exploring the impact of outsourcing correctional interventions on mechanisms of social control. Law & Social Inquiry, 43(4), 1308-1339.

[11] Upon request, UCCI can provide the CPC 2.1 Item Reference List which outlines the UCCI and independent research that supports the indicators on the CPC.

for justice-involved participants. There are three domains in the capacity area including: *Program Leadership and Development, Staff Characteristics*, and *Quality Assurance*. The content area includes the *Assessment of Justice-Involved Clients* and *Treatment Characteristics* domains. This area focuses on the extent to which the program meets certain elements of the principles of effective interventions. The CPC is comprised of a total of 73 indicators, worth up to 79 possible points. Each domain, each area, and the overall score are tallied and rated as either "very high adherence to EBP" (65% to 100%); "high adherence to EBP" (55% to 64%); "moderate adherence to EBP" (46% to 54%); or "low adherence to EBP" (45% or less). It should be noted that not all of the five domains are given equal weight, and some items may be considered "not applicable" in the evaluation process.

The *Program Leadership and Development* domain examines the Program Director's qualifications and previous experience, as well as their current involvement with the staff and the program participants. Additionally, the development, implementation, and support (i.e., both organizational and financial) for treatment services is examined. 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 community and criminal justice stakeholders, are evaluated.

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.

The *Assessment of Justice Involved Clients*[12] domain examines three areas regarding assessment: selection of the justice-involved clients; the assessment of risk, need, and personal characteristics of the justice-involved client or responsivity; and the manner in which these characteristics are assessed. The extent to which services provided are appropriate for the justice-involved client, and the use of proven assessment methods, is critical to effective treatment programs. Effective programs assess the risk, need, and responsivity of justice-involved clients, and then provide services and treatment accordingly. Assessments and treatment should be focused on the attributes of justice-involved clients that are directly related to criminal behavior, referred to as criminogenic needs.

Criminogenic risk and need assessments should assess the justice-involved client's 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 justice-involved clients respond to efforts aimed at changing their behavior, thoughts, and attitudes

[12] Throughout this aggregate report, UCJC has revised this domain to Assessment of Justice-Involved Individuals from Offender Assessment.

(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, 2010). 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.

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.

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

The CPC assessment process requires a site visit to collect various program traces. These include, but are not limited to: interviews with executive staff (e.g., Program Director and Clinical Supervisor), direct service delivery staff, and key program staff; interviews with program participants; observation of direct services; and review of relevant program materials (e.g., participant files, program policies and procedures, treatment curricula, handbooks, etc.). Once the information is gathered and reviewed, assessors score the tool. When the program has met a CPC indicator, it is considered an area of strength for the program. When the program has not met an indicator, it is viewed as an area in need of improvement. For each area in need of improvement, the assessors craft a practical recommendation to help the program develop a plan to better align with current research.

All of the assessment results are compiled into a report where program scores are also compared to the average scores across all programs that have been assessed with the CPC. The report is first issued in draft form and feedback from the program is sought. Once feedback from the program is received and considered, a final report is submitted. Unless otherwise discussed, the scores and report are the property of the program/agency requesting the CPC and UCCI will not disseminate the results without prior program approval. The scores from each program assessed are added to our CPC database, which we use to update scoring norms.

There are several limitations to the CPC that should be noted. First, the instrument is based upon an "ideal" program; that is, 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[13]. As such, no program will ever score 100% on the CPC. Second, as with any explorative process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is reliable and accurate, given the nature of the process, decisions about the information and data gathered are invariably made by the assessors. Third, the process is time-specific. The program may have plans for future changes or modifications; however, only those activities and processes in place at the time of the review are considered for scoring. Fourth, the process does not take into account all of the "systems" issues that can affect the integrity of the program. Finally, the process does not address the reasons why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

Despite these limitations, there are a number of advantages to this process. First, it is applicable to a wide range of programs[14]. Second, all of the CPC indicators have been found to be correlated with reductions in recidivism. Third, the process provides a measure of program integrity and quality; it provides insight into the "black box" of a program, something an outcome study alone does not provide. Fourth, the results can be obtained relatively quickly; usually the site visit process takes a day or two and the report process described above is completed within three months of the assessment date. Fifth, it identifies the strengths and areas for improvement for a program as well as specific recommendations that will bring the program closer in adherence to EBP. Finally, it allows for benchmarking. Comparisons with other programs that have been assessed using the same criteria are provided. Since program integrity and quality can change over time, it also allows a program to reassess its adherence to EBP.

[13] Upon request, UCCI can provide the CPC 2.1 Item Reference List which outlines the UCCI and independent research that supports the indicators on the CPC.

[14] Programs assessed include: male and female programs; adult and youth programs; prison-based, jail-based, community based, and school-based programs; residential and outpatient programs; programs that served prisoners, parolees, probationers, and diversion cases; programs in specialized settings such as boot camps, work release programs, case management programs, day reporting centers, group homes, half-way houses, and community-based correctional facilities; and specialized offender/youth settings/populations such as therapeutic communities, intensive supervision units, and individuals who have sexual offending, substance use, drunk driving, and domestic violence behaviors.

Method for Aggregate Results from Program Evaluations

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

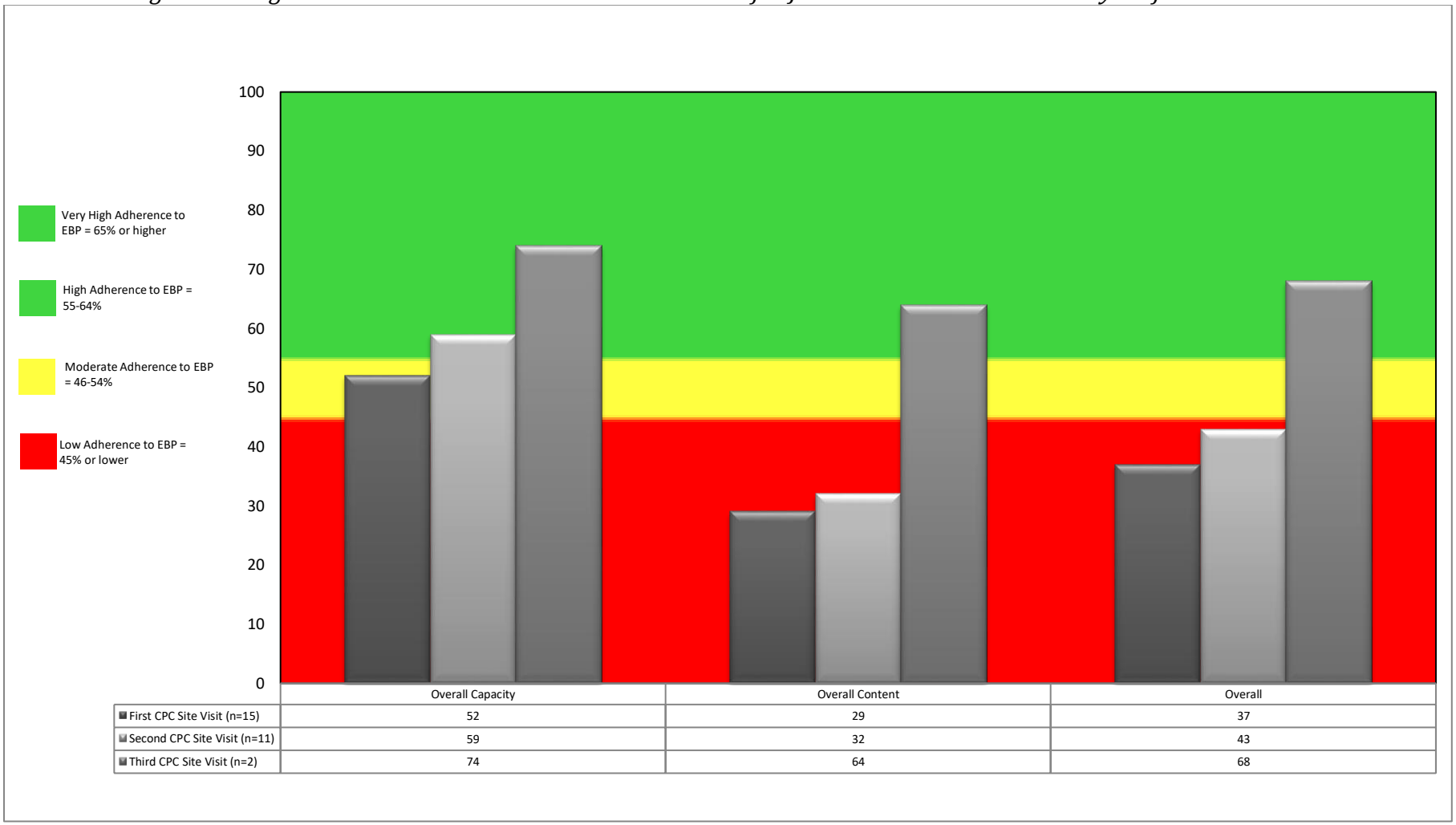
CPC item scores for each of the evaluated programs were entered into a database. Programs assessed between 2015-2017 using the CPC 2.0 were rescored using the 2.1 scoring sheet. In order to meet scoring criteria for the 2.1 within the *Assessment* domain if the program did not meet all criteria for risk, need, or responsivity for the 2.0, the program was scored at a zero for that indicator in the 2.1.

For each analysis, applicable program scores were averaged, and the percentage to the nearest tenth and/or rating were noted. If the program had multiple sites evaluated, and the analysis was on the program level, the program sites were averaged prior to inclusion into the group analysis.

Items where the majority of programs were assessed as being in full compliance with the CPC were identified as strengths across programs. 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 for the purposes of this preliminary report.

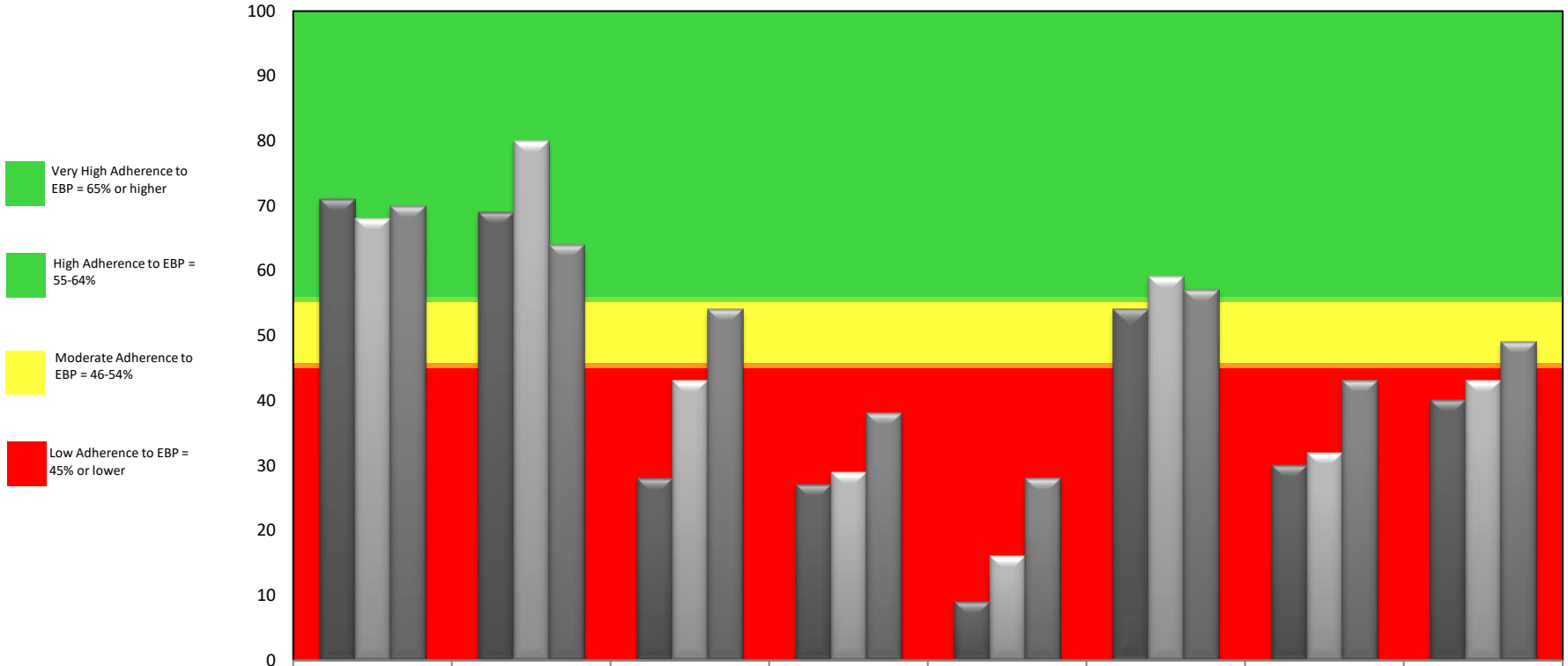
Appendix C: Figures

Figure 1: Program Adherence to Evidence Based Practices for Justice-Involved Individuals by # of site visits



	Overall Capacity	Overall Content	Overall
First CPC Site Visit (n=15)	52	29	37
Second CPC Site Visit (n=11)	59	32	43
Third CPC Site Visit (n=2)	74	64	68

Figure 2: Program Adherence to EBP for Justice-Involved Individuals (2015 evaluation, 2019 evaluation, and national average)



	Program Leadership & Development	Staff Characteristics	Assessment for Justice-Involved	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
2015 evaluation (n=11)	71	69	28	27	9	54	30	40
2019 evaluation (n=11)	68	80	43	29	16	59	32	43
CPC national average (n=660+)	70	64	54	38	28	57	43	49