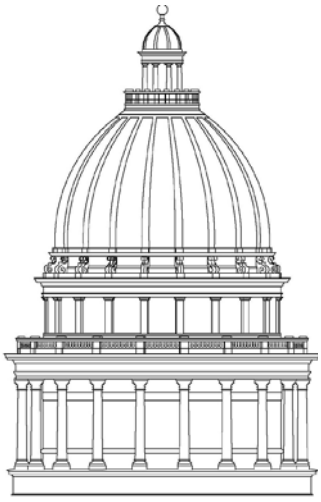
REPORT TO THE

UTAH LEGISLATURE

Number 2014-09



An In-Depth Budget Review of the Department of Human Services

October 2014

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH

Office of the Legislative Auditor General

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AUDITOR GENERAL

October 8, 2014

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **An In-Depth Budget Review of the Department of Human Services** (Report #2014-09). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of
An In-Depth Budget Review of the Department of Human Services

Chapter I
Introduction

The Utah Department of Human Services (DHS) can better control its costs and increase its effectiveness with increased use of baseline metrics. Establishing consistent, basic efficiency measurements can aid in tracking program success and benchmark achievement from year to year. Such measurement, when used with increased operational knowledge of each of the department's divisions, could be a basis for future legislative funding decisions.

Chapter II
DHS Needs to Proactively Monitor Efficiency and Effectiveness

Baseline Efficiency Measurements Provide for Future Comparisons. Due to the complexity of funding for each of DHS's divisions, basic measures of utilization—cost per individual served and the penetration rate—should be consistently maintained from year to year. Additionally, these data should be obtainable from other states for comparison. With the exception of the Division of Services for People with Disabilities, the remaining divisions experienced a decrease in total expenditures from fiscal year 2009 through 2013.

EDO Budget Was Reduced Due to Recessionary Cuts. The executive offices include the Executive Director's Office, the Office of Fiscal Operations, the Bureau of Administrative Services, the Office of Services Review, the Office of Recovery Services, the Office of Licensing, the Office of Legal Affairs, Human Resources, Information Technology, and the Utah Developmental Disabilities Council. Budget decreases of about 18 percent were initiated by the Legislature. FTEs were correspondingly reduced.

SAMH Budget Slightly Decreased While Client Costs Decreased. The overall cost per client for Substance Abuse and Mental Health has decreased while the penetration rate has remained stable. FTEs were reduced along with expenditures, resulting in a negligible increase in the cost per FTE. Seventy-five percent of SAMH's budget is state funded.

DAAS Service Levels Have Been Constant During Spending Cuts. The cost per client has decreased significantly, while the penetration rate has remained stable. A little more than half of the budget is state funded. Overall expenditures and the number of FTEs have decreased due to recessionary cuts. The cost per FTE has increased slightly.

DCFS Received Initial Cuts to Budget but Has Had a Portion of Budget Restored. The state portion of the DCFS budget has increased over the past five years to 70 percent. The cost per client has decreased while the penetration rate has remained stable. The overall budget hit a low point in 2012; some funding was restored in 2013 and 2014. FTEs have decreased while the cost per FTE has increased slightly.

DSPD's Costs Have Remained Constant Since 2009. State funding has increased since 2009. The cost per client has decreased while the penetration rate has stayed stable. Total FTEs decreased significantly while the cost per FTE increased.

Chapter III
JJS Program Needs to Reduce Recidivism

Reductions in Community and Rural Program Spending Are Problematic. From fiscal year 2009 through 2013, Community and Rural Programs saw the biggest funding reductions of approximately $16.8 million. The least restrictive community programs (community and rural) are subcontracted to private providers, which cost JJS $19.3 million in 2013. Youth recidivism was 53 percent in 2013. From 2010 through 2013, the high-risk youth population (those most likely to recidivate) increased from 64 percent to 70 percent of youth offenders in custody.

Improved Program Monitoring Will Reduce Recidivism and Cost. Reducing recidivism can reduce annual costs by $6 million. Reducing

the recidivism rate to 34 to 44 percent can save from $3 to $6 million of additional costs to community programming and secure care. Compared to Colorado, Idaho, and Arizona, Utah's recidivism rate of 53 percent is much higher. Programming is not monitored for effective treatment of youth offenders; monitoring of programming will assure that the needs of youth offenders are met. Utilizing data to focus on the highest-risk youth can allocate resources efficiently and improve efforts to reduce recidivism. The use of Evidence-Based Programming is key in evaluating programming effectiveness.

Chapter IV
State Hospital Can Decrease Cost and Risk

USH Offers Intermediate-Term Mental Health Treatment for Severely Mentally Ill Patients. A reduction in beds is one of the main factors in a decrease in spending. USH tracks numerous indicators of quality, efficiency, and effectiveness; however, they should also track the average patient days a patient is on the waitlist for a bed and the percent of patients ready for discharge who have barriers to discharge. USH has stayed close to full occupancy for the past four years.

Key Controls in Forensic Program Are Lacking. Some forensic patients' length of stay has exceeded what is allowable by law. USH administrators are responsible to inform the courts when a patient is restored to competency, but the courts decide when to see the patient. The median length of stay for the forensic population is about 162 days; however, over the past 5 years, 64 patients have been held longer than 365 days. Twenty-seven patients were held beyond the maximum length of stay; had they been released before the legal deadline, the state could have saved up to $3 million; had they been civilly committed, the state could have saved up to $289 thousand. In addition, beds would have been made available for patients on the waitlist.

Off-Site Medical Visits Lack Financial Controls. USH is required to provide outside medical attention if needed. USH does not have contracts with any outside providers and does not use a fee schedule. Off-site medical records are not fully standardized.

REPORT TO THE
UTAH LEGISLATURE

Report No. 2014-09

An In-Depth Budget Review of the Department of Human Services

October 2014

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Chapter I
Introduction

The Utah Department of Human Services (DHS) can better control its costs and increase its effectiveness with increased use of baseline metrics. Establishing consistent, basic efficiency measurements can aid in tracking program success and benchmark achievement from year to year. Such measurement, when used with increased operational knowledge of each of the department's divisions could be a basis for future legislative funding decisions.

This in-depth budget review uses a risk-based approach both to establish basic measures that can be duplicated from year to year and to examine:

- The expending of state and federal funds for the whole of DHS
- The potential to lower recidivism rates for Juvenile Justice Services (JJS)
- The reduction of cost and risk at the Utah State Hospital

The following chapters of this report identify some basic efficiency measure and detail several ways DHS can improve within the above-mentioned divisions. Further, as a companion audit to this in-depth budget review, *Report 2014-10*: *A Performance Audit of the Division of Services for People with Disabilities*, examines how the Division of Services for People with Disabilities can be better structured to allow for greater accountability in the determination of services.

DHS Divisions Serve a Wide Variety of Clients

DHS provides diverse services for various groups of people, making it necessary to review each division separately. In fiscal year 2013, DHS received $676 million ($393 million in state funding) that was divided among six divisions. The divisions, the population they serve, and some of the services they provide include:

DHS receives $393 million in state funding for six divisions.

- **Division of Child and Family Services** (DCFS) is "the child, youth, and family services authority of the state." By statute, the division provides child abuse prevention services, child protective supervision, shelter care, foster care, residential care, adoption assistance, health care for children in state custody, family preservation services, protective supervision, and domestic violence preventive services.

- **Substance Abuse and Mental Health** (SAMH) is charged with ensuring the availability of a comprehensive continuum of services for people with mental health disorders and substance abuse issues. Services are available throughout the state for adults and children of all ages. SAMH contracts with local governments that are statutorily designated as local substance abuse and mental health authorities. Services include prevention, treatment, and recovery.

DHS offers services to people with mental health disorders, juvenile offenders, and people with disabilities.

- **Juvenile Justice Services** (JJS) provide services for youth ages 10 to 17, delivering a continuum of intervention, supervision, and rehabilitation programs for youth offenders while ensuring the safety of the public. Most of the programs are accessed through court orders.

- **Division of Services for People with Disabilities** (DSPD) provides services for people who have intellectual or physical disabilities or have an acquired brain injury. The division provides basic health, safety, and treatment services through three Medicaid Waiver programs, one Medicaid Waiver pilot program, three non-Medicaid programs, and the Utah State Developmental Center.

- **Division of Aging and Adult Services** (DAAS) provides various services ranging from responding to information requests to in-home services. The majority of these services are provided to the population aged 60 or older.

- **Executive Director's Office** (EDO) includes the department director's office as well as bureaus that serve other divisions in the department or provide administrative support.

Due to time constraints, our performance audit did not include every division of DHS. However, we reviewed the budgets of the Executive Offices (including the Office of Recovery Services) the

Division of Aging and Adult Services (DAAS) the Division of Children and Family Services (DCFS) and the Division of Services for People with Disabilities (DSPD).

DHS's Total Funding Has Decreased Since 2009

In addition to dealing with diverse client populations, the Department of Human Services is also challenged by funding issues. From 2009 to 2011, the department's funds were reduced by more than $56, with an increase of $24 million since then. Figure 1.1 shows the divisional breakdown of the department's total budget for fiscal years 2009 through 2013.

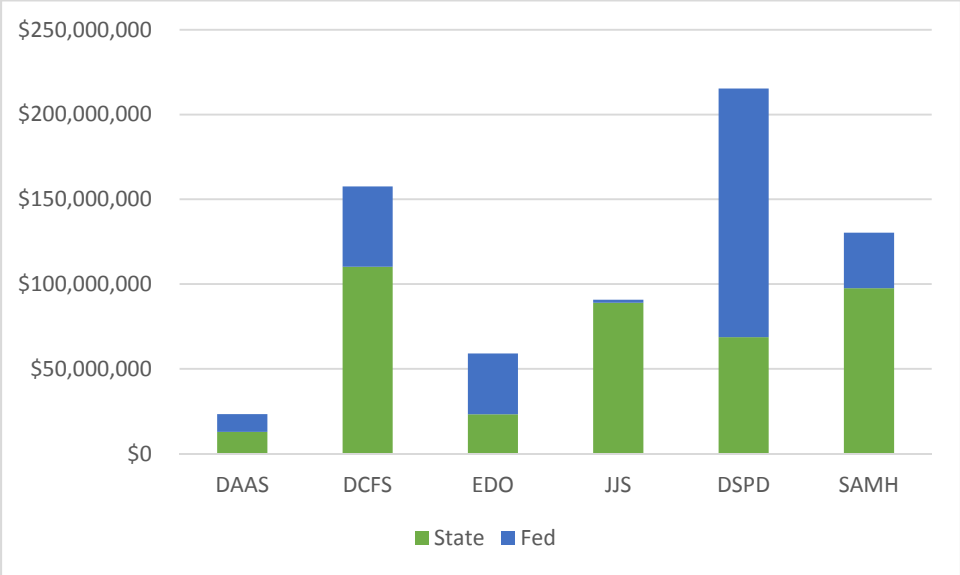
Figure 1.1 DHS Budget Has Decreased. The department funding was $708 million in fiscal year 2009 but decreased to $676 million in fiscal year 2013.

	2009	2010	2011	2012	2013
SAMH	$ 135.0	$ 128.5	$ 126.2	$ 126.2	$ 131.5
DAAS	24.7	23.1	22.5	23.0	22.8
DCFS	168.2	157.2	151.0	153.2	158.8
JJS	106.3	100.0	94.1	91.5	90.9
DSPD	206.2	203.8	199.4	202.1	214.9
EDO	67.6	64.3	61.2	55.9	55.8
Total	**$ 708.0**	**$ 676.9**	**$ 654.4**	**$ 651.9**	**$ 674.7**

Overall, DHS funding has decreased by 4.7 percent since 2009. With the exception of DSPD, the divisions have received less funding over the past five years.

All of the divisions receive federal funding, two of which receive over 60 percent of their respective budget from federal funds. Figure 1.2 shows the distribution of state and federal funds.

Figure 1.2 Federal and State Funding. All division receive a portion of their funding from both state and federal sources.



DHS divisions rely on federal funding and therefore must comply with federal requirements.

Figure 1.2 illustrates which divisions have greater reliance on either federal or state dollars. As examples, the Division of Substance Abuse and Mental Health (SAMH) receive about 25 percent of their total budget from federal sources; however, the vast majority of the federal funds can only be used for mental health services, which subjects the division to federal requirements that are independent of any state requirements. As a result, the division must comply with the federal mandates or risk losing funding, which will decrease services to communities throughout the state.

Total State Funding Has Increased Since 2009

Loss of federal funds has been somewhat balanced by selective increases in state funding. While four divisions have received equivalent or somewhat less funding since 2009, two have received increases of $17 million and $11 million. Figure 1.3 shows the state funding for each division from FY 2009 through FY 2013.

Figure 1.3 State Funding. State funding for DHS has increased from $370 million in fiscal year 2009 to $393 million in fiscal year 2013.

	2009	2010	2011	2012	2013
EDO*	$25.5	$21.2	$21.2	$19.8	$19.6
SAMH	94.9	87.6	$84.8	$88.8	$94.3
DSPD	49.6	39.0	$45.0	$57.7	$66.7
DCFS	101.9	100.0	$117.7	$110.8	$112.8
JJS	85.5	81.0	$91.4	$87.6	$86.9
DAAS	12.9	$12.5	$12.4	$12.4	$12.8
Total	**$370.3**	**$341.3**	**$372.5**	**$377.1**	**$393.1**

*** EDO includes Executive Director Operations and Recovery Services**

As Figure 1.3 shows, the state had allocated approximately $371 million on average during FY 2009 through 2013. The biggest increases were seen in DSPD and DCFS. DSPD increased by 35 percent and DCFS increased by 11 percent since 2009. The increase in funding for DSPD will be addressed in the companion performance audit of DSPD; further, DCFS funding was reviewed in a previous audit report (Report 2011-02: *A Performance Audit of the Division of Child and Family Services*). Three divisions, SAMH, JJS, and DAAS, have not received substantial changes in legislative funding while the state has reduced EDO funding by 23 percent since 2009.

Audit Scope and Objectives

This audit is an in-depth budget review conducted by the Office of the Legislative Auditor General (OLAG). It is based on methodology developed to focus our efforts and evaluation on the highest risk areas. In 2011, the Legislature passed HB 176 that, with the approval of the Legislative Audit Subcommittee, directs OLAG to conduct two in-depth budget reviews annually.

We note that a new DHS executive director was appointed in October of 2013, close to the commencement of this audit. The timeframe of our analysis coincides with fiscal years 2009 through 2013, which is prior to the arrival of the current director. Therefore, much of this audit focused on information and actions made under the direction of the previous director.

We performed a risk-based in-depth budget review of DHS that identified key budget areas within the department. The review

provides a baseline look at the department's ability to efficiently perform its duties within its budgetary constraints and is intended to be used as a current and long-term view for the benefit of the state.

To maximize our office's resources, we conducted a risk analysis to determine which budget areas could be most improved by an in-depth budget review. We set the scope of the in-depth budget review to include the following objectives:

- Conduct a risk-based assessment of DHS's budget
- Review select expenses to determine the department's efficient and effective use of appropriated funds
- Review certain expense trends over a selected period of time for changes to determine whether appropriated funds were being effectively used
- Determine whether management of select appropriated funds led to the most efficient and effective outcomes

We defined risk areas as areas where greater efficiencies and cost savings were possible, determining that Juvenile Justice Services (JJS) and Substance Abuse and Mental Health (SAMH) had the highest risk and most areas for improvement. We separated each chapter as follows:

- Chapter II: This chapter discusses the lack of monitoring of state funds by DHS.
- Chapter III: This chapter evaluates improving JJS programming to lower recidivism and lead to lower future costs.
- Chapter IV: This chapter looks at how the state hospital can decrease risk and cost by reducing stays of less serios offenders and strengthening controls for off-site medical visits.

Chapter II
DHS Needs to Proactively Monitor Efficiency and Effectiveness

The Department of Human Services (DHS) lacks the necessary information to evaluate the efficiency of its use of state and federal funding; without this information it is difficult to measure effectiveness, or how well the department is performing. DHS's divisions rely on different combinations of state and federal matching funds that the department views as one funding source; use of state funding is not analyzed separately but is estimated after the fact. We believe that tracking of: both total and state expenditures, the actively served population, and the affected population should be used as a baseline of general effectiveness of spending. When this information is used in conjunction with programmatic knowledge, it can be a general baseline of effectiveness.

Currently, DHS management does not monitor the disposition of state funding nor is the use of state funding compared with program success. We were unable to find any historical metrics used to evaluate the efficiency and effectiveness for the whole of DHS. The Legislature allocated approximately $393 million in fiscal year 2013, which was combined with about $282 million of federal funds for a total of about $675 million. DHS has studied, from time to time, its overall expenditures. DHS says it is difficult to measure state costs because federal allocations differ from division to division.

DHS does not analyze state funding to determine program success.

For example, in order for Substance Abuse and Mental Health (SAMH) to receive federal funding, the state must provide 20 percent of the total funding to qualify for the remaining 80 percent of federal funding for costs associated with SAMH services. Because the funds are pooled together, no distinction is possible of the proportion of federal versus state dollars expended nor of the effectiveness of the funding. As a result, SAMH is unable to measure the efficiency and effectiveness of the funding disposition.

Baseline Efficiency Measurements Provided for Future Comparisons

Measuring utilization and penetration provides the Legislature with trackable information.

Establishing an initial point of reference for comparisons with other states and future evaluations gives the Legislature knowledge. Because of the complexity of funding for each of the divisions, we elected to identify basic measures of utilization (cost per individual served) and penetration (individuals served as a percentage of the population eligible to receive services). Both of these measures are general in nature and therefore can be more consistently maintained and compared from year to year. Additionally, these data should be obtainable from other states. Without this consistency, maintaining a fund-use trend line would not be possible. These measures are discussed with the admonition that they are no more than a starting point and require operational knowledge to be used most effectively.

Figure 2.1 identifies these values for fiscal year 2013, showing how much was spent on DHS services for certain demographics and the number of those utilizing services compared to the overall population. Figure 2.1 shows one metric that DHS could use as a historical measure or as a comparison against other states.

Figure 2.1 Cost per Individual Served and Penetration Rate Provides Comparable Data from Year to Year. In fiscal year 2013, DHS had costs per clients ranging from as high as $95,000 to as low as $709.

FY 2013	Cost-Per-Served	Penetration Rate
DCFS	$2,818	2%
SAMH	2,136	2
JJS	60,347	>1
DSPD	40,804	7
DAAS	709	9

Figure 2.1 includes both federal and state funding in the cost per individual served. The penetration rate is equal to the number of those receiving services in fiscal year 2013 divided by the total eligible population. For example, JJS served 1,506 youth in 2013 and there was a total of 357,358 youth ages 10 to 17 years old; dividing these numbers provided the penetration rate of 0.4 percent. We did not include the Executive Director's Office (EDO) since it is primarily an administrative division. EDO includes the Office of Recovery Services (ORS), through which EDO passes all of its funds. The following sections go into greater detail on the development and use of these fund-use measurements.

Penetration rate is the number receiving services divided by the total eligible population.

EDO Budget Was Reduced Due to Recessionary Cuts

The executive offices include the Executive Director's Office, the Office of Fiscal Operations, the Bureau of Administrative Services, the Office of Services Review, the Office of Recovery Services, the Office of Licensing, the Office of Legal Affairs, Human Resources, Information Technology and the Utah Developmental Disabilities Council. The executive offices comprise about 3 percent of the total department budget; about 46 percent of the office's operations are state funded. The Office of Recovery Services makes up the vast majority of EDO's budget. We did not include a five year history of units served and penetration rate because EDO mainly deals with employees and not a client population in Utah.

EDO comprises 3% of DHS total budget.

Figure 2.2 Executive Offices (EDO) Expenditures from Fiscal Years 2009 through 2013. Expenditures (all values are in millions) have decreased since 2009 because of recessionary cuts.

	2009	2010	2011	2012	2013	Percent Change
Personal Service	$42.6	$38.7	$36.4	$33.8	$34.2	(20%)
Current Expense	13.9	13.0	12.5	11.7	10.0	(27)
Data Proc. Current Expense	9.4	11.0	10.5	8.5	8.9	(5)
Other*	1.5	1.5	1.6	1.7	1.8	(23)
Total	**$67.3**	**$64.2**	**$60.9**	**$57.7**	**$55.0**	**(18%)**

*Other charges include pass-through funds to other providers.

Total expenditures have reduced over the past five years. The reductions were initiated by the Legislature in fiscal year 2008 because of the recession, and continued until 2013. The EDO budget decreased by roughly 18 percent. Much of this reduction is related to reductions in FTEs. This reduction is reflected in the personnel services category, shown below.

Figure 2.3 shows that FTEs have decreased while the cost has increased. The cost per FTE is the total expenditures of EDO divided by the number of FTEs.

Figure 2.3 EDO Staffing Levels from Fiscal Years 2009 through 2013. FTEs have decreased since 2009 while cost per FTE has increased.

	FTEs	Cost per FTE
2009	629.6	$106,931
2010	568.3	112,896
2011	524.5	116,096
2012	485.4	114,799
2013	493.8	111,422

Between fiscal years 2009 and 2013, EDO reduced FTEs by about 136 or about 22 percent. The cost per FTE has increased slightly, by $4,491.

SAMH Budget Slightly Decreased While Client Costs Decreased

Substance Abuse and Mental Health (SAMH) is funded with state and federal dollars. SAMH receives about 25 percent of its funding from federal dollars. The cost per client and penetration rate are shown in Figure 2.4.

Figure 2.4. SAMH Performance Values from Fiscal Year 2009 through 2013. Since 2009, the cost per client adjusted for inflation has decreased by approximately $291 per client.

	2009	2010	2011	2012	2013
Cost/Client	$2,235	$2,119	$2,051	$2,048	$2,136
CPI-Adjusted Cost/Client	$2,427	$2,263	$2,124	$2,078	$2,136
Penetration Rate	2%	2%	2%	2%	2%

Figure 2.4 shows that the cost-per-client has decreased and the penetration rate has remained constant. The penetration rate was determined by the number of individual receiving services divided by the eligible population. Figure 2.5 shows a breakdown of certain cost categories.

Figure 2.5. SAMH Expenditures from Fiscal Year 2009 through 2013. Data processing and current expense costs have increased 18 percent but this category only makes up 2 percent of the total budget.

	2009	2010	2011	2012	2013	Percent Change
Personal Service	$46.4	$45.7	$46.7	$44.8	$45.9	-1%
Current Expense	$12.2	$11.6	$12.0	$10.8	$10.8	-11%
Data Proc. Current Expense	$2.4	$2.4	$2.4	$2.2	$2.8	18%
Other	$73.9	$68.8	$65.2	$68.5	$71.9	-3%
Total	**$134.8**	**$128.5**	**$126.2**	**$126.2**	**$131.5**	-2%

*Other charges include pass-through funds to other providers.

According to Figure 2.5, most categories have expended less since 2009. In 2010, SAMH received less funding as a result of the

recession but it has received some restoration funds starting in 2012. Figure 2.6 shows the number of FTEs and the cost per FTE.

Figure 2.6. SAMH Staffing Levels from Fiscal Year 2009 through 2013. FTEs have decreased by approximately 20 since 2009, whereas cost per FTE has increased negligibly.

	FTEs	Cost per FTE
2009	812.3	$165,924
2010	801.3	$160,324
2011	795.0	$158,737
2012	785.4	$160,737
2013	791.5	$166,080

Figure 2.6 shows that the number of FTEs has decreased somewhat, whereas the cost-per-FTE has slightly increased, by $858, which is only a 1.5 percent increase.

DAAS Service Levels Have Been Constant During Spending Cuts

The Division of Aging and Adult Services is funded by both state and federal funds. State fund comprise about 56 percent of the overall budget. The cost per client and the penetration rate are shown in Figure 2.7.

Figure 2.7 DAAS Performance Values from 2009 through 2013. The budget is comprised of 56 percent state funding and 44 percent federal funding.

	2009	2010	2011	2012	2013
Cost/Client	$865	$776	$778	$776	$709
CPI-Adjusted Cost/Client	939	829	805	787	709
Penetration Rate	9%	9%	8%	8%	9%

According to Figure 2.7, the cost-per-client has decreased, whereas the penetration rate, which is the number of clients receiving services divided by the population in the state aged 60 and older, has been consistent. Figure 2.8 breaks down certain cost categories.

Figure 2.8 DAAS Expenditures from Fiscal Years 2009 through 2013. The data below reflect a $2 million reduction to the budget because of recessionary cuts.

	2009	2010	2011	2012	2013	Percent Change
Pers. Service	$4.3	$3.6	$3.5	$3.5	$3.5	(17%)
Current Exp.	.518	.422	.453	.485	.517	(0)
Data Proc. Current Exp.	.271	.387	.256	.208	.222	(18)
Other	19.7	18.7	18.3	18.9	18.6	(6)
Total	**$24.7**	**$23.1**	**$22.5**	**$23.0**	**$22.8**	**(8)**

*Other charges include pass-through funds to other providers.

Over the past five years, DAAS has reduced its expenditures by almost $2 million, largely in budget cuts that were instituted in 2009 because of the recession and have not been restored. Data processing was the category with the greatest reduction in funding.

DAAS has reduced its workforce by 13 FTEs. However, the cost per FTE has increased slightly. This increase in the use of general funds coincided with the elimination of ARRA funds and a slight increase in Medicaid transfers. ARRA funds went from $1.3 million in 2010 to zero in 2013. The amount of Medicaid money transferred from DAAS increased since 2009, when the agency actually received Medicaid transfers from other agencies.

Loss of ARRA funds and an increase in Medicaid transfers has led to an increase in the use of general funds.

Figure 2.9 shows the number of FTEs and the cost per FTE for fiscal years 2009 through 2013. The cost per FTE is the total costs of DAAS divided by the number of FTEs. So in this case, the cost per FTE is not the wages and benefits of each FTE, but the total costs of DAAS.

Figure 2.9 DAAS Staffing Levels from Fiscal Years 2009 through 2013. FTEs have decreased since fiscal year 2009, whereas the cost per FTE has increased since fiscal year 2009.

	FTEs	Cost per FTE
2009	65	$383,035
2010	54	432,186
2011	50	451,742
2012	50	458,955
2013	52	442,475

DAAS reduced FTEs by 13 or about 20 percent of total staff. The cost per FTE has increased by $59,441. These reductions account for a significant amount of the total budget decrease over the past five years; however, as mentioned above, service levels appear to be constant.

DCFS Received Initial Budget Cuts but Has Had a Portion of Budget Restored

Decreased federal funds have been accompanied by an increase in state funding.

The Division of Child and Family Services (DCFS) is funded with both state and federal dollars. Since fiscal year 2009, the state portion has increased from 59 percent to almost 70 percent. State funds have increased by almost $9 million over the same time period. Federal funds have decreased by over $20 million over the same period of time. Despite these federal cuts, the division has able to reduce the overall budget by more than $9 million. The cost per client and the penetration rate are shown in Figure 2.10.

Figure 2.10 DCFS Performance Values from Fiscal Years 2009 through 2013. The adjusted cost per client shows a greater decrease in costs, thus showing that the costs of services have decreased.

	2009	2010	2011	2012	2013
Cost/Client	$2,903	$2,735	$2,659	$2,775	$2,818
CPI-Adjusted Cost/Client	3,152	2,922	2,753	2,814	2,818
Penetration Rate	2%	2%	2%	2%	2%

Figure 2.10 shows that the cost per client has decreased since fiscal year 2009 and that the penetration rate, which is the number of clients receiving services divided by the total state population, has remained constant over this period. Figure 2.11 breaks down certain cost categories.

Figure 2.11 DCFS Expenditures from 2009 through 2013. Expenditures have decreased from $168 million in fiscal year 2009 to $159 million in fiscal year 2013.

	2009	2010	2011	2012	2013	Percent Change
Personal Services	$66.8	$63.0	$61.3	$61.7	$64.7	(3%)
Current Exp.	18.8	17.9	15.6	16.8	18.7	0
Data Proc. Current Expense	4.1	4.2	5.5	5.0	4.7	13
Other	78.4	72.0	68.5	69.7	70.7	(10)
Total	**$168.2**	**$157.2**	**$151.0**	**$153.2**	**$158.8**	**(6%)**

*Other charges include pass-through funds to other providers.

Federal stimulus funding has restored some of DCFS's budget.

Overall funding decreased as a result of the recession, however, some of that decrease was restored in fiscal year 2013 because of federal stimulus funding. DCFS's personnel services and pass-through (other) expenditures are the two biggest expense areas of DCFS. Changes in personnel expenditures follow FTE levels fairly consistently.

Figure 2.12 shows the total FTEs and the cost per FTE. The cost per FTE is the total costs of DCFS divided by the number of FTEs.

Figure 2.12 DCFS Staffing Levels. FTEs have decreased since fiscal year 2009, whereas, the cost per FTE has slightly increased since fiscal year 2009.

	FTEs	Cost per FTE
2009	1101	$152,816
2010	1029	152,737
2011	965	156,476
2012	970	157,921
2013	1036	153,365

Between 2009 and 2011, DCFS reduced FTES. Since that time, the division has been gradually increasing FTEs because of some restoration to its budget, but not to the 2009 level. Cost per FTE has increased slightly.

DSPD's Costs Have Remained Constant Since 2009

The Division of Services for People with Disabilities (DSPD) is funded by state and federal money. The majority of the budget comes from Medicaid transfers. The state portion and the Medicaid transfers have both increased since fiscal year 2009. State dollars increased from $47 million in 2009 to almost $66 million (about 40 percent) in 2013. The Medicaid transfer amount has increased less (both actually and proportionally) from $142 million in 2009 to $145 million in 2013. The cost per client and the penetration rate are shown in Figure 2.13.

DSPD is mostly funded with federal funds of approximately $160 million in 2013.

Figure 2.13 DSPD Performance Values from Fiscal Years 2009 through 2013. Accounting for inflation, the cost per client has decreased since fiscal year 2009.

	2009	2010	2011	2012	2013
Cost/Client	$40,842	$41,507	$39,789	$40,546	$40,804
CPI-Adjusted Cost/Client	44,345	44,345	41,186	41,121	40,804
Penetration Rate	7%	7%	7%	6%	7%

Figure 2.13 shows that the cost per client has decreased since 2009 and that the penetration rate, which is the number of clients receiving services divided by the total clients receiving services plus clients on the waiting list, has remained constant over this period. Figure 2.14 breaks down certain cost categories.

Figure 2.14 DSPD Expenditures from Fiscal Years 2009 through 2013. Expenditures have increased from $206 million to $215 million since fiscal year 2009.

	2009	2010	2011	2012	2013	% Change
Personal Services	$48.0	$40.2	$33.9	$32.3	$33.6	(30%)
Current Expense	8.9	7.4	6.7	6.1	5.5	(38)
Data Proc. Current Expense	2.1	1.6	1.4	1.7	1.8	(13)
Other	147.2	154.5	157.4	162.0	174.0	(18)
Total	**$206.2**	**$203.8**	**$199.4**	**$202.1**	**$214.9**	**4%**

*Other charges include pass-through funds to other providers.

Some federal and legislative cuts were restored in 2012 and 2013.

DSPD had an initial decrease in funding as a result of the recession; however, because the division was deemed a critical program, both state and federal funding have increased. Personnel services have decreased; however, this can be attributed to contracting with outside providers. The area that experienced the most growth in expenditures over the past five years is pass-through funding (other category). This category is also the largest area of expenditures. Pass-through money is passed from the division to non-government entities who provide services. Pass-through is comprised of mostly Medicaid dollars, with some supplemental state dollars.

The number of FTEs had been reduced by more than 25 percent between 2009 and 2013. Fiscal year 2012 saw the smallest number of FTEs in the five-year period. The number of FTEs increased more than 20 in 2013.

Figure 2.15 DSPD Staffing Levels from Fiscal Years 2009 through 2013. The number of FTEs has decreased significantly.

	FTEs	Cost per FTE
2009	923	$223,368
2010	817	249,448
2011	664	300,273
2012	646	312,880
2013	667	322,212

Figure 2.15 shows that FTEs have decreased by 256 since 2009; as mentioned above, this can be attributed to contracting these FTEs privately.

Recommendations

1. We recommend that the Department of Human Services develop reports that identify how state funds have been expended.

2. We recommend that the Department of Human Services develop and utilize measurements to ascertain if state funds are being used efficiently and effectively.

Chapter III
JJS Program Needs to Reduce Recidivism

The Juvenile Justice Services (JJS) division serves a unique population of youth in need of custodial control and programming to improve behavioral problems of delinquent youth. The division has the highest cost per individual served and the lowest penetration rate of all DHS divisions. This means that the division must be successful on a case-by-case basis as its number of participants is lower and the cost of each case is higher than those of the other divisions. Figure 3.1 shows the last five fiscal years of JJS service level and penetration.

Figure 3.1 Service Level and Penetration Rate for Fiscal Years 2009 through 2013. Factoring for inflation, the cost-per-youth has decreased by approximately $5,000 since fiscal year 2009.

	2009	2010	2011	2012	2013
Cost/Youth*	$60,795	$60,454	$58,739	$56,194	$60,347
CPI-Adjusted Cost/Youth	$66,015	$64,587	$60,471	$56,992	$60,346
Penetration Rate	0.51%	0.47%	0.44%	0.44%	0.40%

**Youth population is the average number of youths each night in major categories of DJJS placement*

As noted in the previous chapters, the values demonstrated in Figure 3.1 serve as a baseline or starting point for understanding what is happening in DHS's divisions. In Figure 3.1, the youth population includes an unduplicated count of youth in all services provided by JJS, however, throughout the chapter the youth population we refer to those who are in community programming and secure care. In this case, the high individual cost and low penetration rate demonstrate the importance of each case. Supporting data indicates that JJS has a high recidivism rate that results in longer individual stays. Bringing Utah in line with peer state operations could potentially decrease annual costs by $6 million by reducing recidivism through improved program monitoring and targeting high-risk youth offenders. Focusing on higher risk youth through the appropriate use of evidence-based practices may reduce youth recidivism rates. JJS could realize additional savings or improved outcomes through greater program

Reducing recidivism can lead to a potential savings of $6 million.

oversight. Utilizing data to focus on the highest risk youth can allocate resources efficiently and decrease recidivism.

Reductions in Community and Rural Program Spending Are Problematic

For 2013, JJS's nearly $91 million of expenditures were divided among its six areas: Administration, Secure Facilities, Community Programs, Rural Programs, Early Intervention, and the Youth Parole Authority. Federal funding has decreased significantly (about 15 percent) since 2009. This loss of funding has resulted in limits in programming availability. A by-product of funding decreases has been an increase in recidivism. Other states faced similar federal cutbacks but have significantly less recidivism than Utah. This funding reduction affects a changing population of youths who, while their number in state programs is decreasing, are becoming a more problematic population of reoffenders.

One symptom of decreased federal funding has been increased recidivism.

Funding Reductions Have Affected Programs

The reduction in federal funding of community and rural programs began in 2010 and resulted in a funding reduction of about $17 million. However, the providers did not necessarily lose $17 million; they bill Medicaid directly, as opposed to having these funds passed through JJS. Figure 3.2 shows the breakdown of expenses for each division since 2009.

Figure 3.2 Total Expenditures for JJS from Fiscal Year 2009 to 2013. Community programming and rural programming experienced the largest decreases since 2009.

	2009	2010	2011	2012	2013
Administration	$ 4.2	$ 4.0	$4.4	$4.2	$4.5
Secure Facilities	27.8	27.1	27.7	27.0	27.0
Community Programs	35.8	32.9	27.9	26.8	22.1
Rural Programs	25.5	24.3	22.4	21.8	22.2
Early Intervention	12.7	11.4	11.3	11.4	14.7*
Youth Parole Authority	.355	.343	.349	.343	.364
Total	**$ 106.4**	**$ 100.0**	**$ 94.0**	**$ 91.5**	**$ 90.9**

**Observation and Assessment was moved to Early Intervention, thus increasing expenditures from 2012 to 2013.*

While some JJS expenditures remained fairly consistent, the areas that saw the biggest reductions were Community Programs and Rural Programs. These areas are where youth correctional programs reside. In fiscal year 2013, JJS spent approximately $19 million for private provider programming, which is approximately 21 percent of JJS's expenditures. Youth programs under the Community and Rural Programs are privatized and paid for by JJS; these programs need to improve the review of programming effectiveness. Specifically, high-risk youth should be targeted, using evidence-based methodology, which we discuss later in the chapter.

Private provider programming accounts for $19 million of total JJS costs.

Juvenile Court sentencing alternatives for youth offenders include: levying fines, ordering payment of restitution to victims, placing the offender on probation under the continuing jurisdiction of the Juvenile Court, and placing the youth in the custody of JJS. Traditionally, granting custody to JJS has been reserved for the most serious or chronic offenders. The majority of JJS youth are court-determined delinquents who have been ordered by the court system to be held in a detention center operated by JJS.

JJS offers programming with minimal security up to secure care with maximum security.

Youth offenders may be sentenced to one of several JJS programming options, ranging from the least restrictive community programs (which are subcontracted to private providers) to the most restrictive secure facilities. JJS has little control over who enters the programs but is charged with providing corrective programming to reduce the likelihood of the youth reoffending. Figure 3.3 shows the expenditures in millions for private community programming (which is a combination of rural and community programming) from 2009 through 2013.

Figure 3.3 The Cost of Private Programming for Rural and Community Programs. Expenditures for private community programming, used by both rural and community programming, has decreased by approximately $10 million since fiscal year 2009.

	2009	2010	2011	2012	2013
Community Programming	$30.0	$27.7	$20.1	$19.4	$19.3

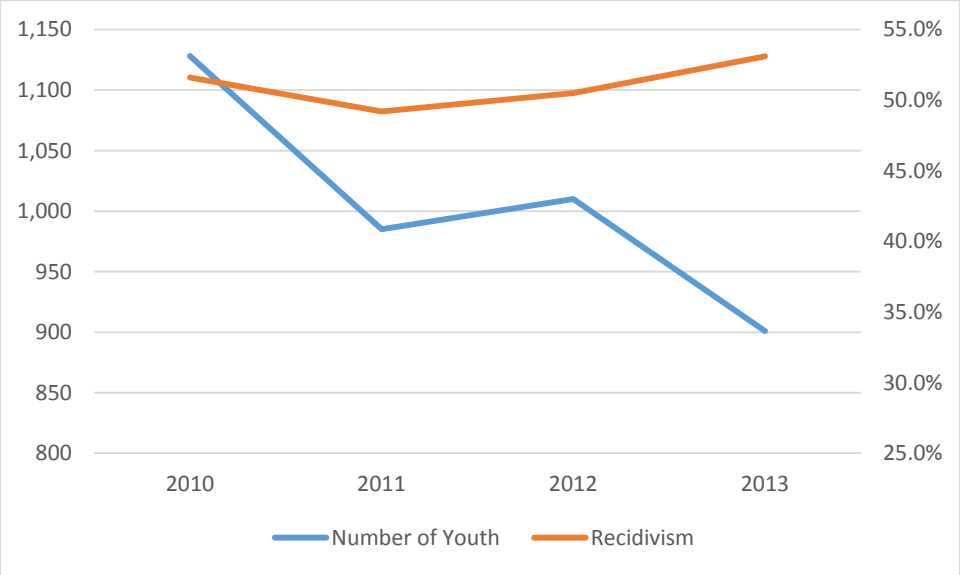
JJS Medicaid restructuring resulted in funding reductions of $9 million.

Because of Medicaid restructuring, the amount of revenue received for private community programming decreased during this period by approximately $9 million; legislative cuts affected the remaining $1.7 million. An additional $3.6 million that JJS was asked to pay in fiscal years 2012 and 2013 is not reflected under the expenditures. This programming is critical to behavioral changes in a youth. If a released youth reoffends, whether by misdemeanor or felony, within a year of his/her release from custody, that youth may be returned to JJS. This recidivism is costly to both the well-being of the youth and to the state.

Offender Recidivism Is Increasing

In 2013, JJS managed 901 youth offenders, divided between secure facilities and community programming. Figure 3.4 shows the combined population and the recidivism rates for community and secure programs from 2010 through 2013.

Figure 3.4 Youth Population and Recidivism from 2010 to 2013. Starting in 2012, a sharp increase in recidivism and a sharp decrease in JJS population occurred.



The number of JJS-supervised youth has decreased since 2010, however, recidivism exceeded 49 percent before the funding cutbacks and has further increased since 2011. The number of high, moderate, and low-risk youth has decreased, however, the percentage of high risk youth increased from 64 percent of the total population in 2010 to 70 percent in 2013. Thus, since the population is composed of a greater proportion of high-risk youth, they are more likely to recidivate.

Improved Program Monitoring Will Reduce Recidivism and Cost

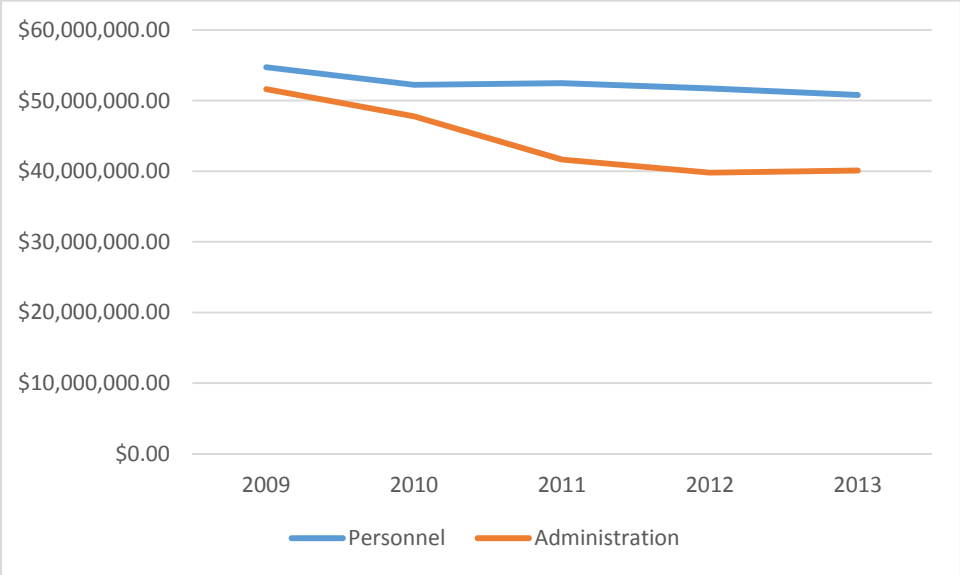
Recidivism is a primary cost driver for JJS, thus, decreasing it could potentially reduce annual costs by $6 million. Lack of program monitoring and not properly targeting high-risk youth offenders are possible contributors to the recidivism rate. Improving measurement of high-risk youth needs, such as examining risk factors and better identifying how to treat them, may provide JJS with the means to reduce recidivism. Implementing outcome measures may improve JJS's ability to efficiently allocate resources to effectively reduce recidivism.

Identifying youth needs and providing targeted treatment can reduce youth recidivism.

JJS expended approximately $91 million in fiscal year 2013; $51 million was spent for personnel and $40 million for non-personnel.

Figure 3.5 shows personnel costs and non-personnel costs from fiscal year 2009 through 2013.

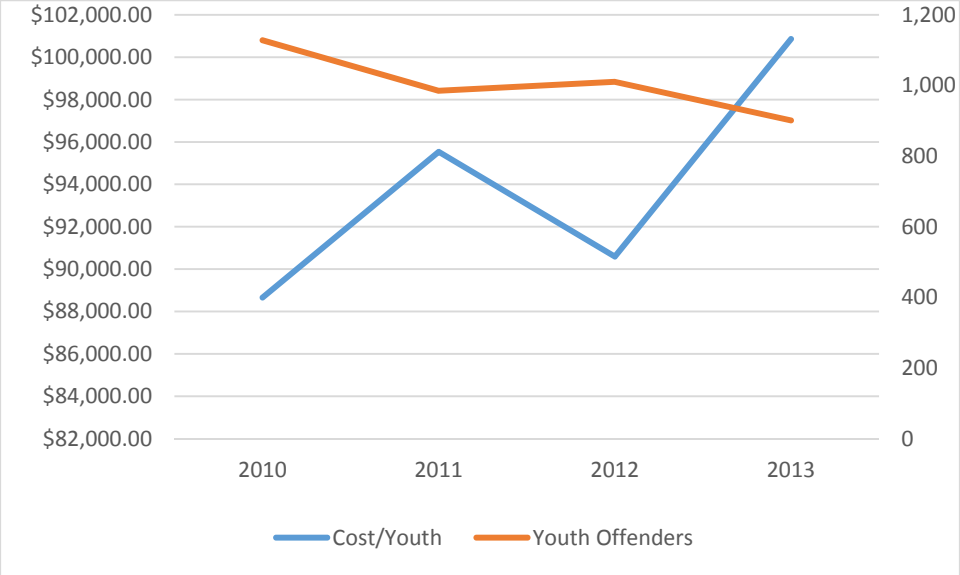
Figure 3.5 Personnel Costs and Non-Personnel Costs. Personnel costs have remained fairly static, whereas, administration costs have declined since fiscal year 2009.



Monitoring programming increases its quality, thus reducing recidivism.

Personnel costs have been mostly maintained during the cutbacks while non-personnel costs have declined. Program monitoring is a non-personnel function that provides oversight of the actual educational and behavioral programs. Providing quality programming is necessary to reduce recidivism. Figure 3.6 identifies the changes in the number of youth in custody, which includes those in secure facilities and private community programming, and cost per youth in custody since the funding cutbacks.

Figure 3.6 Cost Per Youth Compared with Number of Youth Offenders. The cost to treat and house youths has increased since fiscal year 2010.



The number of youth offenders has decreased and the cost per youth has increased. Since 2010, the cost per youth has increased by 14 percent, while the number of youth served has decreased by 20 percent. A higher percentage of youth being served are high risk, as mentioned above, thus they are more expensive to keep in secure care or to provide private programming.

Reducing Recidivism Can Lead To Savings

The average annual cost of recidivism to JJS is approximately $16.8 million, if all youth returned to JJS custody. Decreasing the recidivism rate for the secure care and community programming (which includes rural programming) to the level seen in the surrounding states could result in about $6 million in savings. Compared to other states, Utah has a much higher recidivism rate. However, recidivism comparisons can prove to be problematic since other states measure recidivism differently.

Recidivism costs JJS approximately $17 million annually.

Recidivism rates for JJS have averaged over 50 percent since 2010. Reducing recidivism reduces the cost to JJS of providing secure care and community programming, which also includes rural programming. We will discuss what JJS needs to do to improve

community programming in the next section. If the overall recidivism rate decreases by 10 to 20 percent, JJS can expect to see savings. Figure 3.7 shows projected cost savings from recidivism reductions for secure care and community programming.

Figure 3.7 Reduction of the 54 Percent Recidivism Rate Leads to Savings. A decline in youth recidivism can lead to significant savings.

Recidivism Cost Savings		
	44% Rate	**34% Rate**
Secure Care	$ 2,187,047	$ 4,374,094
Community Programming	905,541	1,802,115
Total	**$ 3,092,588**	**$ 6,176,209**

A 20% reduction in recidivism can lead to an approximate savings of $6 million.

The cost savings of $3 to $6 million illustrated in Figure 3.7 show the potential savings over time from the additional cost of secure care and community programming if fewer youth reoffend. This cost only reflects costs associated with housing youths in secure care and community costs, not any fixed costs. We also realize that this change in the recidivism rate will occur over a period of time. In the next section, we discuss how JJS can improve monitoring of youth who are more likely to reoffend; both of these rates are well within the rates identified by other states.

Other States Have Less Recidivism

Measuring recidivism rates requires a period of time to elapse before it can be measured, in this case, 12 months. Youth offenders must be tracked for 12 months to know whether or not they have reoffended. Utah's recidivism rate, when compared to other states, was higher. Figure 3.8 shows how Utah compares to some surrounding states.

Figure 3.8 2013 Youth Recidivism Comparison with Other States. Utah has a higher recidivism rate than three other states.

State	Recidivism Rate
*Colorado	28.7%
***Idaho	30.4%
**Arizona	33.4%
***Utah	53.1%

**Colorado rate for the year 2012.*
***Arizona rate for the year 2011*
****Idaho and Utah rate for the year 2013*

Utah's recidivism rates compared to other states is approximately 20% higher.

Compared to other states who measure recidivism similarly, Utah has a much higher recidivism rate. There are some proactive methods that these states use that JJS can replicate that may help reduce recidivism. These comparison states do the following:

- **Colorado**: Looks at domain risk levels, which are factors that can influence recidivism, such as school, relationships, attitudes, and behaviors. These factors are examined throughout the youth's time in the juvenile system and programming is tailored to address these needs.

- **Idaho:** Evaluates programming effectiveness by two methods: Performance-Based Standards (PbS) and Correctional Programming Checklist (CPC). The PbS's goal is to integrate best and research-based practices into daily operations, which gives them the ability to measure and track the success of individuals that, in aggregate, become key indicators of facility performance. The CPC is a tool developed for assessing correctional intervention programs, and is used to ascertain how closely correctional program meet known principles of effective intervention.

- **Arizona:** Measures effectiveness of programming through the Correctional Programming Checklist (CPC), which includes seven different items, such as observing groups, interviewing program directors, looking at the recidivism rate of each program. After assessing the seven areas, a score is tabulated and the program is rated as effective, in need of improvement, or ineffective.

As indicated in these examples, programming is key in positively changing behavior of youth offenders.

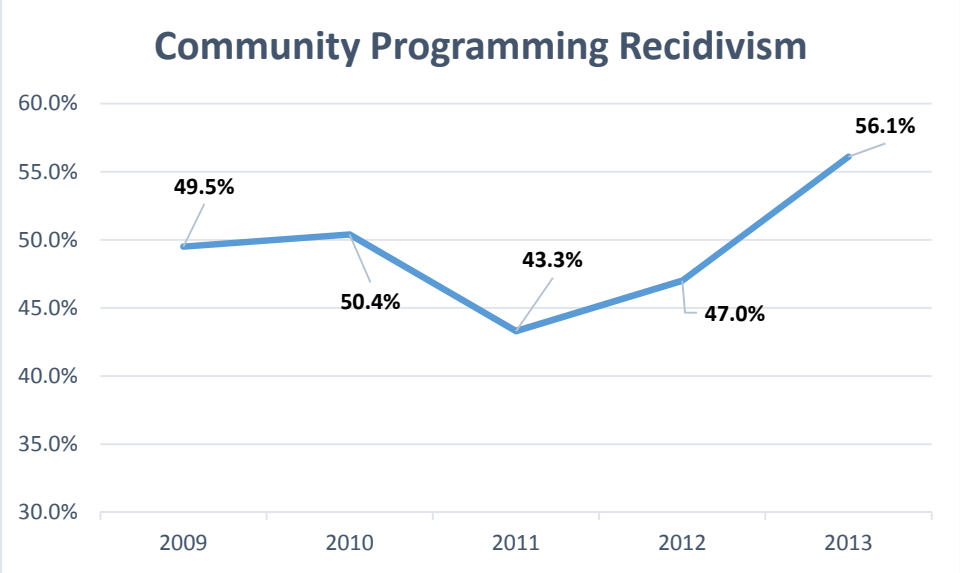
Programming Requires Greater Oversight To Potentially Increase Effectiveness

JJS needs to evaluate programming to ascertain the effectiveness of treatment.

Programming in Utah is not currently reviewed for effective treatment of youth offenders. JJS annually performs a quality assurance audit; however, this audit is done to ensure contract compliance, not to ascertain program effectiveness. JJS needs to provide greater control by monitoring programming to ensure it is meeting the needs of youth offenders.

The purpose of programming is to provide services in a residential or nonresidential environment that will eventually lead to the safe return of youth to their homes. Changing youth behavior is key to reducing the likelihood of reoffending. The community program recidivism rate for 2013 was approximately 56 percent, meaning 56 percent of youth who completed the community program committed a felony or misdemeanor and were charged within 365 days of their release. Figure 3.9 shows the recidivism rate for community programming from 2009 to 2013.

Figure 3.9 Youth Recidivism Rates from 2009 to 2013. Recidivism increased by almost 13 percent since 2010.



Since 2009, recidivism has increased, with the largest increase from 2011 to 2013 (13 percent). According to JJS management, a relatively

large number of high-risk youth were released during 2012, but this fact accounts only for a small part of the change in the recidivism rate. JJS could not fully explain why the recidivism rate increased and could not determine if the programming offered was effective in treating the youth who participated during 2013.

Increased costs can be a byproduct of recidivism. As demonstrated, the value of providing oversight to community programming is that oversight helps ensure proper services are provided to positively affect the behavior of youth offenders.

A representative of JJS stated that no one is auditing program elements of the community program, including the parts of the programming used to provide education and behavioral change tools. The contracts with private providers do not state that JJS can audit program elements. We recommend that JJS put language into future contracts that gives it the ability to audit programming elements.

Currently JJS has not written provisions in the contracts with private programming providers that JJS can audit the program elements.

Outcome Measurements Need to Be Implemented

Utilizing data to focus on the highest risk youth can help the agency allocate resources efficiently as well as improve its efforts to effectively reduce recidivism. The implementation and appropriate use of Evidence-Based Programming (EBP) are a key in evaluating the effectiveness of programming. University of Cincinnati Corrections Institute (UCCI) has worked with federal, state, and local governments to promote effective interventions and assessments for adult and juvenile offenders.

Targeting services to high-risk youth can lead to greater efficiency and effectiveness.

Youth offenders are administered a Protective and Risk Assessment (PRA) at the commencement of their time with JJS. The PRA collects information about behaviors and characteristics known to predict reoffending. Currently, this tool appears to be accurate, since the high-risk youth have reoffended at a much higher rate than medium- and low-risk youth. According to a UCCI representative, crucial factors for a more successful programming outcome include devoting a large portion of resources to the highest risk offenders. According to research provided by UCCI:

> …treatment programs that target higher-risk offenders produce better outcomes. Furthermore,

within treatment programs, the effects on recidivism are greatest for high-risk offenders and minimal, if not detrimental, for low-risk offenders. Finally, treatment programs that use risk assessment instruments to identify appropriate clients have been found to be more effective at reducing recidivism.

Lack of high-risk youth focus means medium- and low-risk youth receive equal attention.

Currently, JJS's case managers visit high-risk youth as much as medium- and low-risk youth in programming. JJS should look at focusing more visits on high-risk youth, since they are more likely to reoffend then medium- and low-risk youth.

JJS staff have stated that they use Evidence-Based Practices (EBP) and the Correctional Program Checklist (CPC), but were unable to determine if EBP is being used appropriately and effectively, while the CPC is being used in a limited basis. EBP uses a breadth of research and knowledge about processes and tools that can improve correctional outcomes, such as reduced recidivism. Tools and best practices are provided with a focus on both decision-making and implementation.

The CPC assesses how well correctional programs follow principles of successful intervention.

The CPC is designed to evaluate the extent to which correctional intervention programs adhere to the principles of effective intervention. Several recent studies on juvenile programs conducted by the University of Cincinnati developed and validated effectiveness indicators for the CPC. The following advantages for the CPC have been found:

- Criteria are based on empirically derived principles of effective programs
- All of the indicators included in the CPC are correlated with reductions in recidivism
- The process provides a measure of program integrity and quality
- The results can be obtained relatively quickly
- CPC identifies program strengths and weaknesses and what the program does consistent with research on effective interventions, as well as what areas need improvement
- It provides useful recommendations for program improvement

- CPC allows for comparisons with other programs that have been assessed using the same criteria and allows a program to reassess its progress over time

The use of Evidence-Based Practices can assist in the proper treatment high-risk youth.

JJS can improve programming by evaluating risk factors of high-risk youth and targeting those factors for treatment. Using EBP, JJS should be able to appropriately apply proper programming to high-risk youth. The CPC can be used to measure whether EBP is being used appropriately, as well as provide a basis to measure outcomes and show where enhancement may be needed to improve those outcomes.

Recommendations

1. We recommend that JJS do an in-depth review of all programming to determine if they provide the necessary services to meet the needs of youth offenders.

2. We recommend that JJS develop methodology to determine negative (criminogenic) behavior factors of high-risk youth.

3. We recommend that JJS target high-risk youth and tailor programming to address negative behavior factors.

4. We recommend that JJS fully implement the Correctional Program Checklist.

5. We recommend that JJS develop comprehensive outcome measurements to guide future improvements to programming and allow the division to make standardized comparisons across providers.

6. We recommend that JJS put language into contracts with private providers of community programming that allows JJS to audit program elements to ascertain whether programming is effective.

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Chapter IV
State Hospital Can Decrease Cost and Risk

The Utah State Hospital can reduce per-client costs and implement controls that would help manage risk. Many forensic patients occupy forensic beds longer than necessary. These extended stays reduce the number of patients that can be treated each year, increasing the cost per patient. In addition, the process for securing off-site medical treatment for patients lacks certain controls that could result in unnecessary costs for the hospital.

USH Offers Long-Term Mental Health Treatment for Severely Mentally Ill Patients

The Utah State Hospital (USH) falls under the authority of the Division of Substance Abuse and Mental Health (SAMH). It is the only intermediate care facility in the state. Adult, adolescent, and child patients must meet very specific admissions criteria and must be referred through a local authority. When a patient is released, the local authority resumes responsibility for the patient.

The hospital has five distinct populations: Adult, Forensic, Adolescent, Children, and the Adult Recovery Treatment Center (ARTC). The adult program serves civilly committed individuals, 18 years of age or older. The forensic population houses accused offenders who have been found incompetent to proceed to trial and offenders who have been adjudicated and but are mentally ill. Children between the ages of 6 and 12 are placed in the children's program. Older youth are placed in the adolescent program. The ARTC has five beds available to rural counties who do not have reliable access to inpatient services. The length of stay is much shorter than the other programs (a median length of stay of 15 days) but the care is acute and 24 hours a day.

USH's Budget Has Remained Stable

The state hospital budget has decreased slightly over the past four years. Much of this decrease in spending can be attributed to a

reduction in beds (through the elimination of a civil, adult unit) and the resulting reduction in full-time equivalent employees (FTE) and patient-related expenditures. In fiscal year 2012, USH cut 30 adult beds, reducing the overall number of beds to 329. Figure 4.1 shows funding sources over time.

Figure 4.1 Total Expenditures Have Remained Fairly Stable. Expenditures include pediatric, adolescent, adult, forensic, and ARTC patients (in millions).

Fiscal Year	2010	2011	2012	2013	Percent Change
State Funds	$38.2	$39.5	$37.3	$38.2	0%
Federal Funds/Other	$15.9	$15.7	$14.5	$15.4	-3%
Total Cost*	**$54.2**	**$55.2**	**$51.8**	**$53.5**	**-1%**

** Total does not include depreciation*

The majority of funding from the state hospital comes from the state. A little over a quarter of the total budget comes from the federal government, including Social Security and Medicaid transfers. USH receives a 30 percent match from Medicaid for the population under 22 or over 65 years old. The figure also includes some revenue from dedicated credits. Much of the dip in federal funding can be attributed to the elimination of ARRA funds in 2012.

Figure 4.2 Reductions in FTEs and Number of Beds Has Coincided with Reductions in the Number of Patients Served. The number of patients that the hospital is able to serve has decreased slightly more than the reduction in beds.

Fiscal Year	2010	2011	2012	2013	Percent Change
FTEs	758	754	743	747	-1%
Number of Beds	359	359	329*	329	-8%
Patient days	116,122	115,653	107,588	108,297	-7%
Patients Served	740	725	678	674	-9%
Median LOS**	199	216	214	214	7%

** The elimination of a 30 bed, civil adult unit*
***Median length of stay, excluding ARTC*

USH reduced the number of FTEs and beds between 2010 and 2013. At the same time, the median length of stay increased. However, it is important to note that median length of stay has fluctuated historically. These factors led to a decrease in the number of patient days and total patients served.

Figure 4.3 Despite Minimal Change to Total Expenditures, USH's Cost Ratios Have Increased Moderately. Cost per patient day and cost per bed have increased as admissions have decreased and lengths of stay have increased.

Fiscal Year	2010	2011	2012	2013	Percent Change
Annual Cost Per FTE	$71,491	$73,222	$69,650	$71,673	0%
Annual Cost Per Bed	$150,948	$153,788	$157,295	$162,734	8%
Total Cost Per Patient Day	$467	$477	$481	$494	6%

While the budget has remained fairly stable, ratios such as total cost per patient day and annual cost per bed have all increased from 2010. USH cut beds, thus reducing the number of patient days. These reductions were disproportionate with the 1 percent decrease in total costs. Cost per FTE has increased negligibly. USH states this increase occurred due to a rise in the number of occasions that FTEs provided intense one-on-one care for patients.

Utah State Hospital Tracks Many Patient Outcome Measures

Utah State Hospital tracks numerous indicators of quality, efficiency, and effectiveness. These numbers are reported back to DHS as well as monitored and compared longitudinally. Efficiency measures include: cost per patient day, occupancy rate, cost per bed per day/year, total patient days, and payroll hours. Quality and effectiveness measures include: readmissions, rapid readmissions (within 30 days), total seclusion hours and number of incidents, total restraint hours and number of incidents, admission and discharge and scores for the Brief Psychiatric Rating Scale (BPRS). Most of the above-mentioned measurements are separated by population (adult, adolescent, youth and forensic).

USH measures indicators of quality, efficiency, and effectiveness.

Two statistics that USH should consider tracking are the average days a patient is on the waitlist for a bed and the percent of patients ready for discharge who have barriers to discharge. Barriers usually occur when USH and the local mental health authority responsible for the patient after discharge cannot find an acceptable place to send the patient to transition out of the hospital setting. Colorado monitors both these statistics monthly and reports them quarterly.

Utah is only somewhat aware of the number of individuals on its waitlist. Local authority liaisons keep track of patients who are in need of beds, but there is no one at USH who has access to an overall waitlist that incorporates all 13 local authorities. Similarly, the forensic unit can only produce an estimate of the number of people waiting for a bed. The ability to state an actual number to the division or policymakers may help all parties determine whether a policy change is warranted to address demand.

Administrators have mentioned challenges with placing patients who are ready to be released from the hospital. USH clinicians and local authorities are supposed to work together to establish a plan to transition the patient, often including residential or supported housing. Specific parts of the state are more challenging to establish transitional services due to demand or lack of resources. If the hospital cannot find an appropriate place to send a discharged patient, the patient may have to wait at the hospital for a placement, increasing hospital costs and decreasing efficiency. Tracking these incidents may help identify under what circumstances they are likely to occur and help reduce them, as well as reduce the likelihood of readmissions, if a patient is not provided with suitable transitional care and supervision.

Utilization Is Close to Full Occupancy for Most Populations

UHS tracks utilization through an average daily census and the number of admissions. USH administrators state that they prefer to keep the children and youth units at about two-thirds full, in order to provide optimal care and avoid having children wait for beds. Overall, they consider 92 to 93 percent, between all populations, to be full occupancy. The hospital does not operate at 100 percent occupancy because there is a necessary lag between discharges and admissions.

Beds are allocated to local authorities based on population. There is occasionally a wait for an adult bed. However, local authorities are usually willing to share available beds. The forensic program often has a long waitlist, indicating a higher demand for beds than the hospital can typically meet.

Figure 4.4 Total Occupancy Has Stayed Around 88 Percent for the Past 4 Years. Demand for forensic beds has increased in recent years.

	2010	2011	2012	2013
Pediatric/Youth (72 beds)	69%	71%	67%	64%
Adult (182/152 beds)*	96	92	95	92
Forensic (100 beds)	92	94	98	97
ARTC (5 beds)	60	80	80	80
Total	**89%**	**88%**	**89%**	**87%**

**30 beds cut in 2012*

Overall, USH has stayed close to full occupancy for the past four years. In the next section, we look at how USH can improve its forensic programming.

Key Controls in Forensic Program Are Lacking

USH has limited influence on the length of stay of its forensic population. USH administrators are responsible for informing the courts when a patient is restored, but it is ultimately up to the courts to decide when to see the patient and what to do. Some of these decisions contradict the law. The hospital has made policy changes to address this issue, but more can be done.

The forensic program has 100 beds. Forensic adults are adults who have been adjudicated and found not competent to stand trial. These patients are held in a secure facility (regardless of the severity of the crime they are accused of committing) until competency can be restored. In addition to adults deemed incompetent to stand trial (about 80 percent of all forensic patients), the forensic unit also holds and treats patients who have been adjudicated and been found guilty

Forensics houses USH's highest cost patients.

or not guilty and mentally ill. However, the majority of patients are there solely for competency restoration. Forensic patients cost more than civilly committed adult patients. Over the past four fiscal years, the average cost for forensic patients was $475 per patient day. The average cost for a civilly committed adult was $434 per patient day.

Some Forensics Patients Are Held Significantly Longer than the Median Length of Stay

Each year, a number of patients are held for competency restoration much longer than the reported median length of stay. The median length of stay for the forensic population is about 162 days. Over the past five years, 64 patients have been held for competency restoration longer than 365 days. Charges for these patients range from Class C misdemeanors to first-degree felonies. Thirty-three patients committed third-degree felonies or less. Overall, the hospital has a competency restoration rate of about 68 percent. For patients held longer than one year, the restoration rate is about 56 percent.

Length of competency stay rests with the judge's decision.

While state hospital clinicians can offer guidance regarding the progress of a patient held for competency restoration, what happens with the patient's case is ultimately the judge's decision. If the judge finds that the patient has been restored to competency, the patient will go to trial. If the patient is convicted, time spent for competency restoration does not diminish the sentence. Maximum lengths of stay are outlined in Title 77, Chapter 15, Section 6 of the ***Utah Code***. The statute includes the following guidelines for patients found to be incompetent:

- All patients can be held for up to one year (once determined incompetent) at which point, a new competency hearing must be held.

- Unless the patient has been charged with a capital offense, a first-degree felony, or manslaughter (a second-degree felony), and if the patient is still incompetent after the one-year hearing, he or she is either released or temporarily detained pending civil commitment. Patients accused of capital offenses, first-degree felonies, and manslaughter can be held an additional 18 months and then another 36 months, if warranted. After the one-year hearing, a hearing is held every 18 months, at which point, if the patient is still incompetent,

the judge must believe that he/she is still making reasonable progress towards competency.

- Capital, first-degree felony, and manslaughter patients who are still incompetent after the additional 36 months have expired, must be released or civilly committed.

- The amount of time a patient is held for competency restoration cannot exceed the maximum sentence the patient would have received if tried and convicted.

Based on these statutory provisions, no patient can be held for longer than five-and-a-half years (one year plus 54 additional months) for restoration after being found incompetent, regardless of the charges. Moreover, patients who are charged with less serious infractions and determined to be incompetent can only be held for the lesser of one year or the maximum sentence for the charges.

The law does provide up to two, 90-day maximum evaluation periods for a clinician (not involved in treatment and competency restoration) to determine whether the patient is incompetent and in need of restoration. Due to limitations in the state hospital's data, we were unable to determine if the evaluation period was included in the lengths of stay for competency restoration numbers provided to us. Therefore, our findings are reported as a range of potential savings.

Many Patients Have Been Held for Competency Restoration for Longer than Allowed by State Law. Over that past five years, the forensic program held over 30 patients with misdemeanors or third-degree felonies (as the most serious charge) for over one year. Several patients were civilly committed within one year of admission or pled guilty and mentally ill (in compliance with state stature) but the majority of patients did not. The longest stay was just over two-and-a-half years.

Some competency stays exceed the time intended in state statute.

Misdemeanors include, but are not limited to, the following:

- Theft
- Assault
- Resisting arrest
- Possession of marijuana under one ounce
- Possession of drug paraphernalia
- Trespassing

- Public intoxication
- Public nuisance

Third-degree felonies include, but are not limited to, the following:

- Burglary of a non-dwelling
- Theft more than $1,000 but less than $5,000
- Aggravated assault
- Possession of controlled substances (excluding marijuana)

It is possible that some of these offenders may have multiple misdemeanor or third-degree felony charges stemming from one incident. In this case, judges may only be applying the section of the law addressing maximum sentences – that an offender cannot be held for competency restoration longer than the maximum sentence that he or she can receive if convicted. Maximum sentences for misdemeanors range from 90 days to one year. The maximum sentence for a third-degree felony is zero to five years. It is possible for a convicted misdemeanor offender to serve longer than one year, if the sentences are assigned consecutively. In practice, however, most restored individuals who are actually convicted serve their sentences concurrently.

More importantly, ***Utah Code*** 77-15-6 states that only very specific offenses allow a restoration confinement in excess of one year. Subsection 7 states:

> At the hearing held pursuant to Subsection 6 (one year hearing) except for defendants charged with the crimes listed in Subsection 8 (aggravated murder, murder, attempted murder, manslaughter, or a first degree felony) a defendant who has not been restored to competency shall be ordered released or temporarily detained pending civil commitment proceedings.

Based on the language of the statute, the most serious charge directive (if the most serious charge is less than manslaughter) should supersede the maximum sentence if convicted directive, for which the likely intent was to safeguard offenders who committed minor infractions from long confinements for competency restoration. In application, the courts may be using this safeguard as a justification for holding offenders in the forensic program for longer periods of time.

The content of the above law corresponds with the 1972 US Supreme Court case *Jackson v. Indiana (406 U.S. 715)* which created precedent for competency restoration practices. The court found that a defendant "…cannot be held for longer than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future," regardless of mental capacity. Doing so violates the defendant's due process rights. As a result of this ruling, many states (including Utah) created specific requirements with regard to competency restoration time limits.

Utah joins 70 percent of states in creating some limit to the time for which a defendant can be held for restoration. Utah's statutory severity falls somewhere in the middle of neighboring states. The following chart details the applicable laws from other western states, ranging from least to most severe.

Figure 4.5 Most Neighboring States Have Created Laws Regarding Maximum Time Periods for Competency Restoration. California's law is most similar to Utah's law.

State	Statutory Summary
Idaho	270 day maximum
Arizona	The lesser of 21 months or the maximum sentence
California	Felony: lesser of 3 years or maximum sentence Misdemeanor: lesser of 1 year or maximum sentence
Utah	Felony: lesser of 5½ years or maximum sentence Misdemeanor/3rd Degree Felony: lesser of 1 year or maximum sentence
Nevada	Lesser of 10 years or maximum sentence
Colorado	Maximum sentence
Wyoming	Not specified

Most of these states utilize the maximum sentence if a defendant were convicted as a guideline for how long competency restoration can continue before the person is released or committed. Four of these states, including Utah, have also created an upper limit that can supersede the maximum sentence clause. The upper limits range from 21 months to 10 years. In practice, Utah is not enforcing this upper limit for their misdemeanor and third-degree felony populations.

The State Can Free Up Funds by Following the Intent of the Law. Five misdemeanor patients and up to 22 third-degree felony or third-degree felony/misdemeanor patients were held for longer than allowed by law. According to the law, if these patients were still incompetent at the end of the one year competency restoration period, they should have been released or civilly committed based on the discretion of the treating clinicians and the court. One patient, charged with one Class B misdemeanor, was held for just under one year before being civilly committed. However, since the maximum number of days held for competency restoration cannot exceed the maximum sentence if the person is convicted (180 days for a Class B misdemeanor), this confinement is still in violation of the law.

Even if the data provided to us by the hospital included the evaluation periods that could take up to 180 days (two 90 day periods), they would still be out of compliance for 13 third-degree felony patients and all five misdemeanor patients. The numbers in the following chart take both possible scenarios into account.

Figure 4.6 Up to Twenty-Seven Patients Were Held Longer than the Maximum Length of Stay Allowable by Law. Potential savings could have been as high as $3.3 million.

Misdemeanor Patients	5
Third-Degree Felony Patients	13-22
Total Patients	27
Total Days Past Maximum LOS*	2,723-7,042
Average Cost per Patient Day - Forensic	$475
Average Cost per Patient Day - Civil	$434
Potential Savings from Release	$1,293,344 to $3,344,917
Potential Savings from Civil Commitment	$111,636 to $288,719

**Length of Stay*

Combined, these patients may have been held up to 7,000 days longer than allowed by law. If these patients had been released by the statutory maximum, USH could have freed up to $3.3 million. If these patients were civilly committed after the statutory maximum, USH could have freed up to $289,000. These funds could have been applied to additional patients who could have been admitted as a result of shorter competency restoration periods.

Additional savings could be realized with second-degree felony cases in which the defendant is not accused of manslaughter. These patients must be released, tried, or committed after the one-year period (after the initial evaluation) as well. Unfortunately, time and data quality and availability did not permit us determine the detailed charges of any patient or the eventual outcomes for the patients discussed above.

The decision of how long to leave a patient in competency restoration is guided by clinicians, but ultimately dictated by the presiding judge. USH does not inform judges when a patient's length of stay is in violation of the law, however, they have gone to the DHS Attorney General in the past.

Reduction in Length of Stay May Lead to Positive Outcomes. Best practices state that for misdemeanor offenders, the initial restoration period should not exceed 120 days or the maximum sentence that the offender could have received if tried and convicted. For felony offenders, an additional 245 days (one year total) may be necessary. If a mental health professional believes that the individual is making progress towards restoration, the judge may order an additional 60 days in addition to the one-year restoration period, provided the time for restoration does not exceed the maximum potential sentence.

Shorter competency restoration lengths of stay may result in better outcomes.

Utah's median length of stay of 162 days for forensic patients is higher than several of its peer states. The state hospital in Idaho had a median length of stay of 46 days. According to published annual reports, Oregon had a median length of stay of 72 days (2012) and Arizona had a median length of stay of 105 days. If USH aligns its length of stay with legal requirements, it would likely have a comparable median with its peers.

USH Often Has a Waitlist for Forensic Services. There is usually a waitlist for forensic beds. Offenders who require competency restoration must wait in jail until a bed becomes available. The current waitlist is about 40 people. Administrators tell us that this number is double what it was this time last year, despite comparable admissions and discharge statistics.

Community treatments for non-violent offenders may be a better option than USH stays.

There Are Options that May Help Reduce Demand for Beds. In response to the high demand for forensic beds, some states have considered other options for competency restoration for non-violent offenders. A study conducted for the Ohio Department of Mental Health suggests that the state could free up beds and save money by diverting non-violent offenders, hospitalized for competency restoration, to a civil hospital or community treatment. These lower-risk patients may not require a maximum-security facility. The civil adult units at USH are semi-secure and have fairly high occupancy, but are full less often than the forensic unit. Additional options in the community may exist as well.

USH administrators have also considered the option of beginning the restoration process while the offender waits for a bed. Offenders on the waitlist for USH forensic services are housed by the jail facilities of the judicial district in which they were charged. This change could expedite the restoration process for patients on the waitlist and eventually reduce the average length of stay at the hospital. However, it may require additional training for staff. Potential savings should ultimately be weighed against the reduction in the average length of stay for forensic competency patients.

Longer stays increase time on waitlists, further increasing costs.

Previous Audit Findings Identified that the Delay in Discharging Patients Impacts the Waitlist. The forensic program has carried a waitlist in the past as well. An audit performed by the Legislative Auditor General in 2008 found that USH could reduce this waitlist if they were able to reduce the lag time between clinicians determining that a patient is competent and the patient actually being discharged to the courts. At the time, patients were staying an additional 52 days, on average, before being discharged. The waitlist ranged from 3 to 15 patients and the waits could last as long as 2 to 3 months for a bed.

Waitlist times have decreased since 2008.

We have been told by forensic administrators that this lag time continues to be an issue. However, the hospital has had some success in reducing this delay through a policy change in 2011. USH can now charge individual jurisdictions for patients who continue to occupy a forensic bed after they have been restored to competency. Currently, all district courts have a delay of less than the reported average for all district courts in 2008, when the problem was at its height. However, the Third District Court and the Fifth District Court still have relatively long delays, at 47 days and 32 days, respectively.

Off-Site Medical Visits Lack Financial Controls

On a fairly regular basis, patients committed to USH need outside medical attention. USH is the secondary payer for these patients, after private health insurance and Medicaid or Medicare. Since many of these patients have limited to no coverage, off-site medical visits can be very costly for USH. Despite the significant cost, USH does not take adequate steps to control costs.

Off-Site Medical Expenditures Are Unpredictable And Vary Greatly Year to Year

Over the past five years, expenditures by USH for off-site medical visits have varied dramatically. This variation is understandable as USH cannot anticipate the non-psychiatric medical needs of its residents. USH is obligated to provide patients with any and all necessary medical care. Patients with chronic or severe physical ailments can be especially costly.

Figure 4.7 USH Off-Site Medical Expenses Are Unpredictable. While costs have nearly doubled since 2009, growth was not constant or steady.

Year	2009	2010	2011	2012	2013
Off-Site Medical Costs	$509,919	$784,302	$674,626	$597,107	$904,124

This variation in necessary expenditures makes it difficult to budget for the following year. However, there are three operational changes that can be made that may help increase predictability of off-site medical expenditures.

USH Does Not Maintain Contracts With Outside Providers

USH does not have contracts with any of the outside medical providers to whom they send patients for treatment and they also do not follow a fee schedule when approving providers and medical services. In addition, USH does not keep fully standardized records of outside medical expenditures and thus, has no means to analyze costs. The lack of written agreements with providers means that the hospital cannot anticipate individual expenses. The absence of a fee schedule

(providing a standard cost for most medical procedures) means that USH does not know if it is being charged a reasonable rate for services provided.

While some providers offer USH discounts, USH has not formalized any agreements.

USH works with numerous providers each year. While it is not reasonable to expect that the hospital would develop formal agreements with each provider, some providers are used on a regular basis. Some of these providers offer discounts to USH between 5 and 30 percent. However, without a fee schedule, USH cannot confirm that the discounted rate is truly a cost savings in comparison to the standard rate.

The Utah Department of Corrections has contracts with providers to deliver outside medical services. When a medical service is necessary and a contracted provider is not available, the ***Utah Code*** (64-13-30) requires that the department establish and utilize a fee schedule based on the non-capitated state Medicaid rate. Using service contracts and a fee schedule would help USH control costs for outside medical care.

USH should form contracts with the largest (by volume) providers of off-site medical care. These contracts should establish rates and have a monetary cap. For smaller providers and less common medical needs, USH should be able to compare specific costs to standard, medical industry rates. The ability to compare to standard rates will help administrators choose more cost-effective providers.

USH could benefit from fully standardizing how it documents outside medical expenditures each year. Doing so would allow them to compare costs for similar procedures across providers. This comparison should help them determine which providers offer the most affordable medical care and with which providers the hospital may want to form contracts.

Recommendations

1. We recommend that the Legislature review ***Utah Code*** 77-15-6 and monitor compliance of maximum lengths of stay by all relevant entities, including the courts and the Utah State Hospital (USH).

2. We recommend that USH consider the costs and benefits of additional options to reduce the forensic waitlist and/or the demand for forensic beds.

3. We recommend that USH administrators institute a fee schedule for off-site medical procedures.

4. We recommend that USH establish contracts with the regularly used providers of off-site medical services.

5. We recommend that USH standardize recordkeeping, especially with regard to outside medical expenditures.

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Agency Response

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State of Utah

GARY R. HERBERT
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Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

ANN SILVERBERG WILLIAMSON
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October 7, 2014

Mr. John M. Schaff, CIA
Auditor General
State of Utah - Office of the Legislative Auditor General
W315 Utah State Capitol Complex
Salt Lake City, UT 84114-5315

RE: **Report No. 2014-09**

Dear Mr. Schaff,

Thank you for the work of your office. Please find the Department of Human Services response to Legislative Audit No. 2014-09 herein.

CHAPTER 2

Recommendation 1

We recommend that the Department of Human Services develop reports that identify how state funds have been expended.

DHS agrees; the Department will create regular reports for the purpose of reviewing prioritized expenditures that are most significant, large or of high risk, as well as analyzing trends to inform decision making.

Recommendation 2

We recommend that the Department of Human Services evaluate state funding to ascertain if it is being used efficiently and effectively.

DHS agrees, and the Department will actively pursue coordination between divisions to ensure that care for shared clients is unduplicated to avoid unnecessary costs. The Department will also use expenditure reports referenced above to evaluate appropriate use of state funds, including but not limited to the appropriate leverage of federal dollars.

CHAPTER 3

The Division of Juvenile Justice Services (JJS) appreciates how this chapter captures the complexity and importance of the work to turn around young lives. The JJS mission is to improve the social competency of the youths who have contact with the juvenile justice system by holding them accountable to their victims and the community, and by teaching them new skills.

JJS agrees with the focus on reducing recidivism and has been implementing measures to influence the recidivism rate. The complexity of recidivism tracking was recently highlighted in a National Reentry Resource Center publication. The Division calculates recidivism by tracking youths for 360 days after their release from JJS custody to determine if they have been charged with a new misdemeanor or felony. JJS accounts for charges in both the juvenile and the adult system. Most states only track recidivism if it occurs in the juvenile system; therefore, state-by-state comparisons are difficult.

The audit's proposed savings to JJS if the recidivism rate declines is based on the presumption that every youth committing a new misdemeanor or felony offense returns to JJS custody. Preliminary data indicates; however, that only about 25 percent of youths who recidivate receive a new JJS custody disposition. Further, as the report acknowledges, the proposed savings do not take into account the fixed costs of operating a secure facility. Thus, the $6 million figure may be an overestimate of the Division's direct cost savings.

Recommendation 1

We recommend that JJS do an in-depth review of all programming to determine if they provide the necessary services to meet the needs of youth offenders.

JJS agrees with the need to expand evaluation of programming effectiveness for a.) alignment with youths criminogenic needs upon placement b.) demonstrated progress throughout the service, and c.) beneficial outcomes for the youths upon program completion.

The Division's ability to match youths to program services relies on the private provider network and the availability of specialized services. JJS currently examines data monthly to coordinate effective programming supply with the demand.

Revised contract language and an updated sanctions model will strengthen accountability for program results.

Recommendation 2

We recommend that JJS develop methodology to determine negative (criminogenic) behavior factors of high risk youth.

JJS is utilizing the Protective Risk Assessment (PRA) to determine a youth's risk level and criminogenic needs. In early 2014, the Division launched a new version of a case planning tool and trained all staff on its use. The tool applies the principles of evidence-based practices in case planning, and incorporates the results of the PRA into a plan of action with the youth.

Recommendation 3

We recommend that JJS target high risk youths and tailor programming to address negative behavior factors.

Juvenile Court probation officers and JJS case managers are jointly trained on the use of the Protective Risk Assessment (PRA) and both agencies use the tool to inform decision making and placement. Judges issue the orders for placing youth into JJS custody; some youths who are lower risk, yet high need, may be ordered into JJS custody for services. The Division's case planning model and training emphasizes that services and supervision should be proportionate to the youth's risk level, with higher risk youths requiring greater intensity and duration. JJS uses data-based reports to scrutinize the separation of high and low risk youths in care.

JJS agrees with the need for more visits with high risk youth because they are more likely to reoffend than medium and low risk youth. The Division is evaluating the feasibility of hiring a highly qualified treatment and clinical services director. Attracting highly skilled and educated staff will improve the Divisions' ability to tailor programming and improve outcomes, which will ultimately reduce recidivism.

JJS has contracted with the University of Utah Criminal Justice Research Center to conduct a literature review of effective community-based residential programs. JJS will use the results to implement effective practices and eliminate ineffective practices.

Furthermore, Utah is one of three states working with the Council of State Governments Justice Center to reduce juvenile recidivism and apply the findings from their recently released white paper, "Reducing Recidivism and Improving Other Key Outcomes for Youth in the Juvenile Justice System." This pilot project will support our goal of improving the outcomes for our state.

Recommendation 4

We recommend that JJS fully implement the Correctional Program Checklist.

JJS agrees with the audit's recommendation that the Correctional Program Checklist (CPC) should be expanded and applied to all custody programs. Expansion would require additional staff dedicated to this effort, as well as changes to contractual language requiring its use.

In 2012, the Division began contracting with the University of Utah to apply the CPC. Last year, the CPC was applied to Salt Lake and Ogden Case Management offices to evaluate the application of evidence-

based practices in case management services. Results indicated that case plans should more effectively focus on criminogenic needs of youths. A follow-up evaluation next year will measure progress in adhering to the recommended practice.

Recommendation 5

We recommend that JJS develop comprehensive outcome measurements to guide future improvements to programming and allow the division to make standardized comparisons across providers.

JJS agrees and is piloting a new quality assurance audit tool that incorporates CPC elements to assess adherence to evidence-based practices. The tool has been vetted with a group of private providers and will be implemented in a three-month pilot phase between October and December 2014. The pilot will include ten programs representing a different service specialty (e.g., Proctor Care, Sex Offender Group Home, Mental Health Group Home). CPC components include staff competency, use of evidence-based principles, fidelity to programming, and safety.

The Division is revising contracts to require providers to adhere to evidence-based practices.

Recommendation 6

We recommend that JJS put language into contracts with private providers of community programming that allows JJS to audit program elements of programming to ascertain whether programming effective.

The Division agrees that current contractual language is weak in requiring programs to account for, and report on, youth outcomes. JJS is strengthening contract language and requiring programs to report on specific, measurable outcomes, such as reduction in youth risk and attainment of new skills.

Conclusion

The Division of Juvenile Justice Services is charged with keeping our communities safe by turning around the lives of at-risk and delinquent youths. Recidivism is one measure of the JJS mission. The Division tracks and reports on other performance measures including in-program performance and youth delinquency rates, negative drug test results, work hours performed, educational attainment, and other similar outcomes which are all critical to ensuring a youth's long-term success.

CHAPTER 4

Recommendation 1

We recommend that the Legislature review Utah Code 77-15-6 and monitor compliance of maximum length of stays by all relevant entities, including the courts and the USH.

The Utah State Hospital (USH) agrees that there are individuals with a length of stay at the Hospital longer than outlined in statute; therefore, attention needs to be given to this matter.
USH submits that some data clarification is needed particularly regarding individuals included in the report with dual commitment status' (civil commitment) or other legal status changes that made them exempt from the guidelines in UCA 77-15-6.

The Department of Human Services has custody of individuals receiving competency restoration until the court terminates the order. In regard to persons charged with third degree felonies, Utah statute allows a maximum restoration period up to 18 months, depending on the circumstances of the case. The courts and the parties to the criminal proceedings routinely set hearings and make orders based on the 18-month timeframe set forth in statute.

When taking into account all factors the actual number of individuals who remained at the Hospital outside of statutory guidelines is less than four percent of the total persons served during the five-year study period. In all cases, USH consistently provided reports to the courts as required by statute.

Recommendation 2

We recommend that USH consider the costs and benefits of additional options to reduce the forensic waiting list and/or the demand for forensic beds.

The Hospital agrees that a strategic plan is necessary to accommodate the growing demand for forensic services and that the Hospital and the State need to consider options for most effectively and efficiently addressing the increase.

USH has piloted the use of existing staff to deliver competency restoration work in local correctional facilities. Furthermore, the Hospital has worked diligently to implement the most current and effective treatment approaches for competency restoration. These practices inform our recommendation for solutions to address the growing demand for forensic competency restoration, which is a national trend.

To diminish the waiting list and affect the length of stay, potential statutory influences are:

1. The prescriptive standards required in Utah's statute for finding a person 'Competent to Proceed' (UCA 77-15-5).

2. Lowering the maximum time frame for competency restoration in statute for individuals charged with misdemeanor crimes.

3. Supporting alternative community-based restoration programs for individuals with misdemeanor charges.

Although decreasing length of stay for patients committed to the USH may not actually save money due to the current demand for services, it would result in a cost-efficiency by allowing USH to admit and treat more individuals.

The Hospital has proposed the following four options with estimated costs to address the growing forensic population:

- Provide pre-admission jail-based competency restoration services. (300K)
- Privately contracting to provide jail-based competency programming. (2M)
- USH staff a step down unit at USH for forensic overflow (4M)
- Build additional beds at USH (20M) plus staff (4M per unit of 26 beds)

The most cost efficient option is providing pre-admission jail based competency restoration services with USH staff.

Recommendation 3

We recommend that USH administrators institute a fee schedule for off-site medical procedures.

USH is addressing this recommendation and is in the process of preparing a fee schedule based on established rates with Current Procedural Terminology (CPT) codes. USH has already negotiated discounted rates with 70 percent of our 63 current off-campus medical providers. Off-campus medical costs have dropped by 38 percent from FY2013 to FY2014.

Recommendation 4

We recommend that USH establish contracts with the regular used providers of off-site medical services.

USH will begin the procurement process to seek contracts with off-campus medical providers.

Recommendation 5

We recommend that USH standardize record keeping, especially with regard to outside medical expenditures.

USH is in compliance with the accounting requirements of the Department of Health, State Finance and Governmental Accounting Standards. The Hospital will review recommendations from the audit to enhance our ability to monitor year-to-year off-campus medical expenditures to "compare costs for similar procedures across providers" in an effort to maximize any savings.

With Warm Regards,

Ann Silverberg Williamson, Executive Director