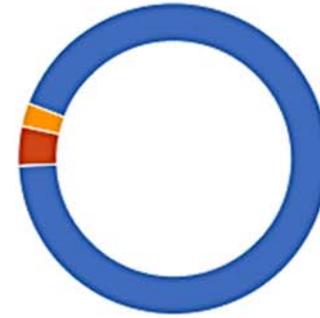


The Division of Juvenile Justice Services (DJJS) is a division within the Department of Human Services but is assigned to the Executive Offices and Criminal Justice Appropriations Subcommittee for legislative oversight. Prior to FY 2004, it was known as the Division of Youth Corrections.

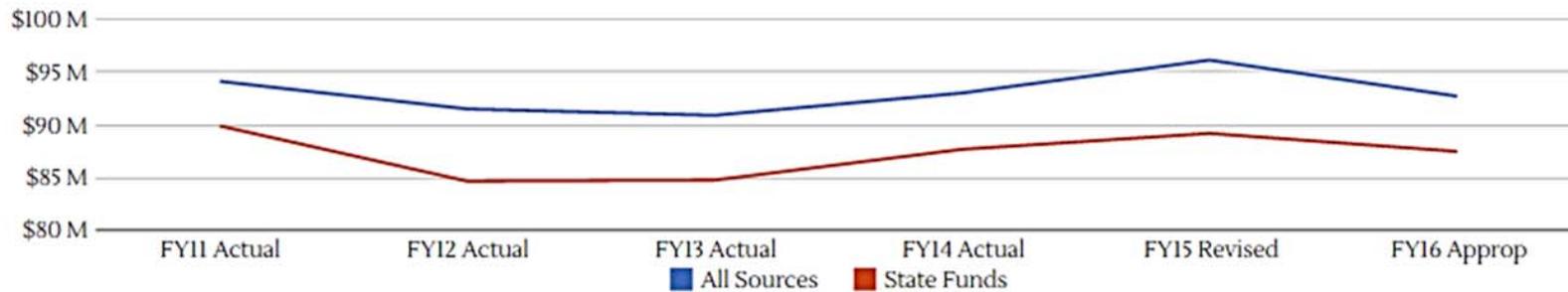


* Chart does not reflect (\$873,400) from Other Sources.

\$93 M

FY 2016 Appropriation

Funding History



- Overview
- Issues
- Performance
- Background
- Financials

Base Budget Recommendation

The Legislative Fiscal Analyst recommends a Fiscal Year 2016 base budget of \$92,726,200 from all sources for Juvenile Justice Services. This is a 2.2 percent reduction from Fiscal Year 2015 appropriated amounts from all sources. The total includes \$87,457,400 from the General/Education Funds, a reduction of 2 percent from current appropriations.

Funding Issues +

Related Publications +

Budget Effectiveness Review

The subcommittee might consider these options as a starting point in undertaking its budget effectiveness review:

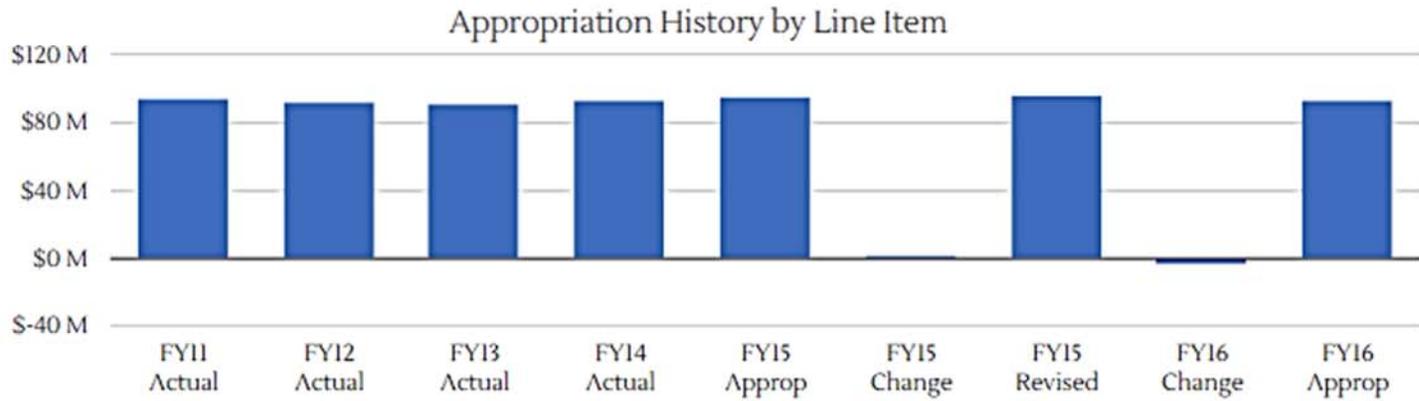
Description	Ongoing	One-Time
Juvenile Offender Capacity Reduction	(\$3,092,500)	\$0

Overview Issues Performance Background **Financials**

Intent Language +

The primary source of funding is state General Fund. The large difference in the 'Transfers - Medicaid' line below, beginning in FY 2011, is a result of the federal changes to Medicaid reimbursements; (see 'Background' section above for more detail). The Medicaid funding DJJS does qualify for is now recorded in the Department of Health. DJJS continues to record its state match portion for payments to service providers - this state match amount is shown as a negative revenue in the DJJS budget under Transfers-Health.

Appropriation Type: Operating and Capital Budgets ▼ Display By: Line Item Funding Source Expenditure Category



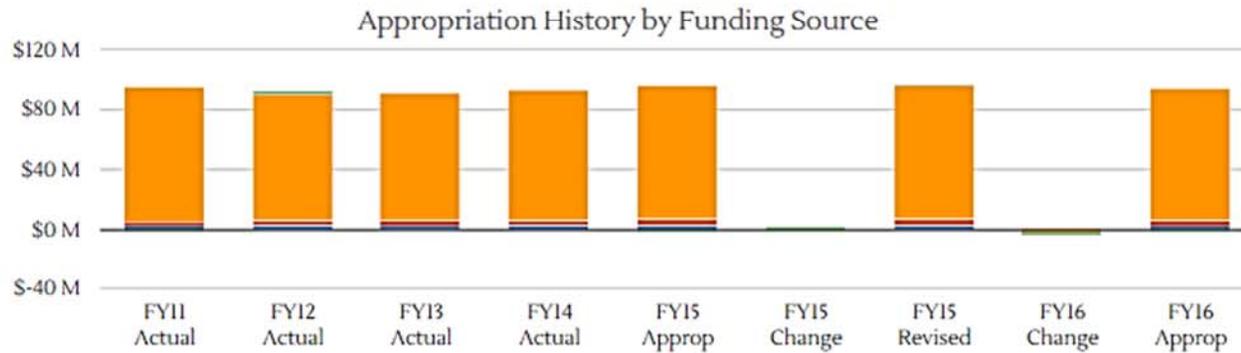
Show Table | Show Additional Information

Line Items	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual	FY15 Approp	FY15 Change	FY15 Revised	FY16 Change	FY16 Approp
Programs and Operations	94,107,100	91,497,300	90,872,500	92,959,100	94,775,700	1,282,800	96,058,500	(3,332,300)	92,726,200
Youth Parole Authority	0	0	0	0	0	0	0	0	0
Total	\$94,107,100	\$91,497,300	\$90,872,500	\$92,959,100	\$94,775,700	\$1,282,800	\$96,058,500	(\$3,332,300)	\$92,726,200

Intent Language +

The primary source of funding is state General Fund. The large difference in the 'Transfers - Medicaid' line below, beginning in FY 2011, is a result of the federal changes to Medicaid reimbursements; (see 'Background' section above for more detail). The Medicaid funding DJJS does qualify for is now recorded in the Department of Health. DJJS continues to record its state match portion for payments to service providers - this state match amount is shown as a negative revenue in the DJJS budget under Transfers-Health.

Appropriation Type: Operating and Capital Budgets | Display By: Line Item Funding Source Expenditure Category



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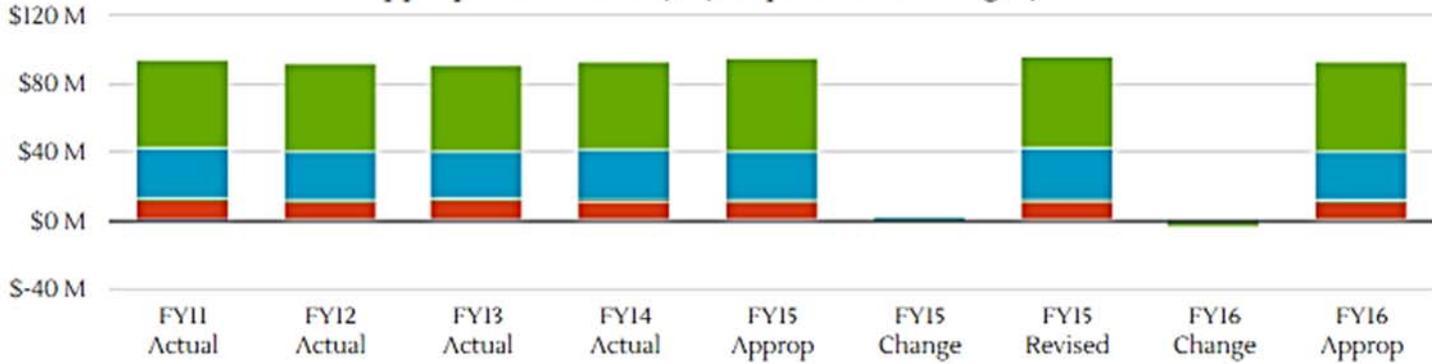
Sources of Finance	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual	FY15 Approp	FY15 Change	FY15 Revised	FY15 Change	FY16 Change	FY16 Approp
General Fund	82,143,100	81,669,500	82,749,100	85,904,100	87,457,400	0	87,457,400	0	87,457,400	87,457,400
General Fund One-time	7,740,000	3,000,000	2,021,500	1,776,600	1,760,900	0	1,760,900	(1,760,900)	0	0
Federal Funds	2,063,400	3,040,200	3,732,100	3,280,200	4,155,000	130,400	4,285,400	(442,200)	3,843,200	3,843,200
American Recovery and Reinvestment Act	703,500	0	0	0	0	0	0	0	0	0
Dedicated Credits Revenue	2,334,300	2,497,700	2,416,800	2,098,400	2,308,200	(9,200)	2,299,000	0	2,299,000	2,299,000
Transfers	0	0	0	500,000	0	(888,700)	(888,700)	15,300	(873,400)	(873,400)
Transfers - Child Nutrition	935,600	943,700	899,100	798,900	929,400	(929,400)	0	0	0	0
Transfers - Commission on Criminal and J	809,800	911,600	712,500	568,100	606,400	(606,400)	0	0	0	0
Transfers - H - Medical Assistance	0	(59,800)	0	(63,400)	0	0	0	0	0	0
Transfers - Health	0	0	0	0	(1,818,900)	1,818,900	0	0	0	0
Transfers - Medicaid	(800,200)	(1,540,900)	(1,851,500)	(1,556,100)	31,000	(31,000)	0	0	0	0
Transfers - Medicaid Admin	0	(18,900)	(62,200)	0	(62,200)	62,200	0	0	0	0
Transfers - Other Agencies	(29,900)	0	(2,800)	(1,500)	0	0	0	0	0	0
Transfers - Within Agency	(408,500)	(431,000)	(692,900)	(399,600)	(591,500)	591,500	0	0	0	0
Beginning Nonlansing	1,500,000	2,884,000	2,148,800	1,198,000	0	1,144,500	1,144,500	(1,144,500)	0	0
Closing Nonlansing	(2,884,000)	(1,398,800)	(1,198,000)	(1,144,500)	0	0	0	0	0	0
Lansing Balance	0	0	0	(100)	0	0	0	0	0	0
Total	\$94,107,100	\$91,497,300	\$90,872,500	\$92,959,100	\$94,775,700	\$1,282,800	\$96,058,500	(\$3,332,300)	\$92,726,200	

Intent Language +

The primary source of funding is state General Fund. The large difference in the 'Transfers - Medicaid' line below, beginning in FY 2011, is a result of the federal changes to Medicaid reimbursements; (see 'Background' section above for more detail). The Medicaid funding DJJS does qualify for is now recorded in the Department of Health. DJJS continues to record its state match portion for payments to service providers - this state match amount is shown as a negative revenue in the DJJS budget under Transfers-Health.

Appropriation Type: Operating and Capital Budgets | Display By: Line Item Funding Source Expenditure Category

Appropriation History by Expenditure Category

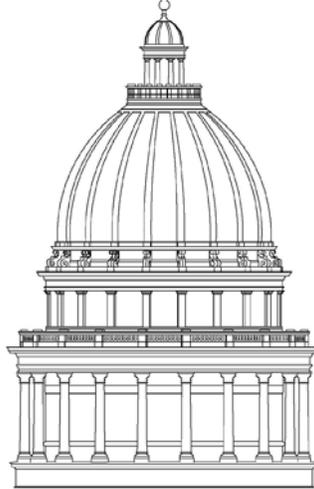


Show Table | Show Additional Information

Categories of Expenditure	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual	FY15 Approp	FY15 Change	FY15 Revised	FY16 Change	FY16 Approp
Personnel Services	52,445,900	51,699,800	50,786,700	52,267,600	54,430,300	(285,800)	54,144,500	(1,921,600)	52,222,900
In-state Travel	112,800	161,900	166,600	165,700	171,000	(100)	170,900	(1,200)	169,700
Out-of-state Travel	14,900	13,700	23,800	33,200	28,600	(3,200)	25,400	0	25,400
Current Expense	10,652,400	10,411,000	11,512,000	10,930,900	10,596,500	153,400	10,749,900	(365,300)	10,384,600
DP Current Expense	1,311,300	1,237,600	1,004,300	1,074,000	1,106,600	(47,900)	1,058,700	(22,900)	1,035,800
Capital Outlay	818,600	86,100	163,200	46,200	47,000	(37,000)	10,000	0	10,000
Other Charges/Pass Thru	28,751,200	27,887,200	27,215,900	28,441,500	28,395,700	1,503,400	29,899,100	(1,021,300)	28,877,800
Total	\$94,107,100	\$91,497,300	\$90,872,500	\$92,959,100	\$94,775,700	\$1,282,800	\$96,058,500	(\$3,332,300)	\$92,726,200

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

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.

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.

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

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

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.

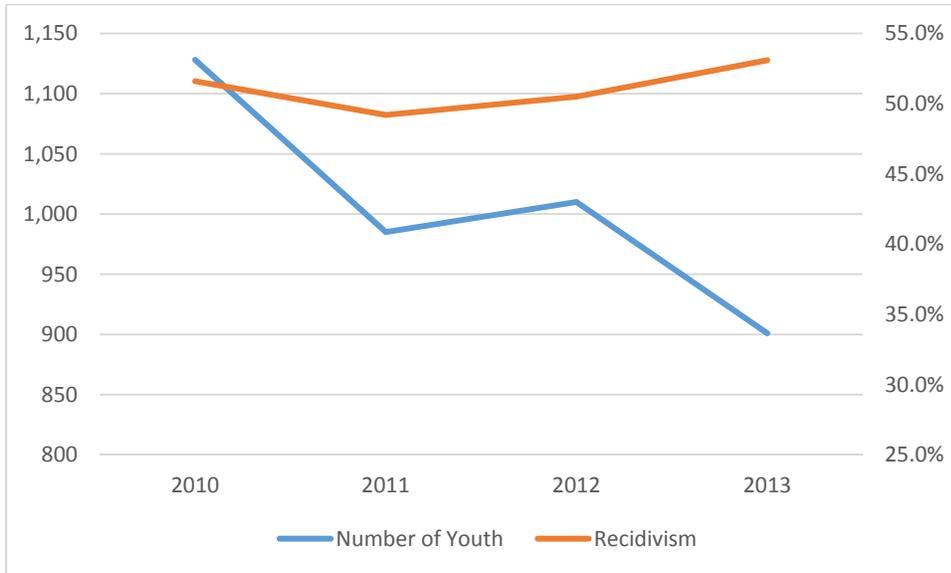
Offender Recidivism Is Increasing

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.

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

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

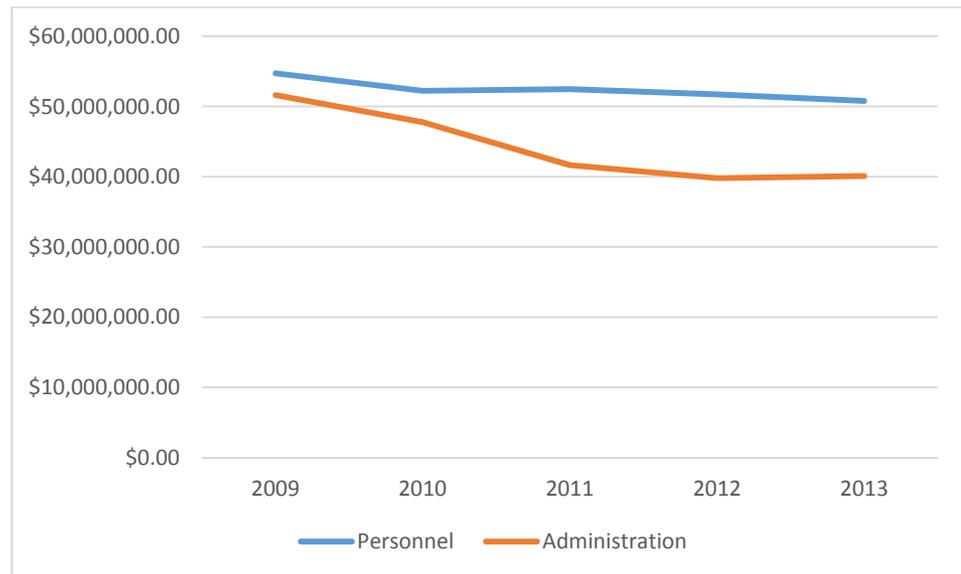
Recidivism is a primary cost driver for JJS, thus, decreasing it could potentially reduce annual costs by \$6 million. Lack of program monitoring and not properly targeting high-risk youth offenders are possible contributors to the recidivism rate. Improving measurement of high-risk youth needs, such 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.

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

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

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

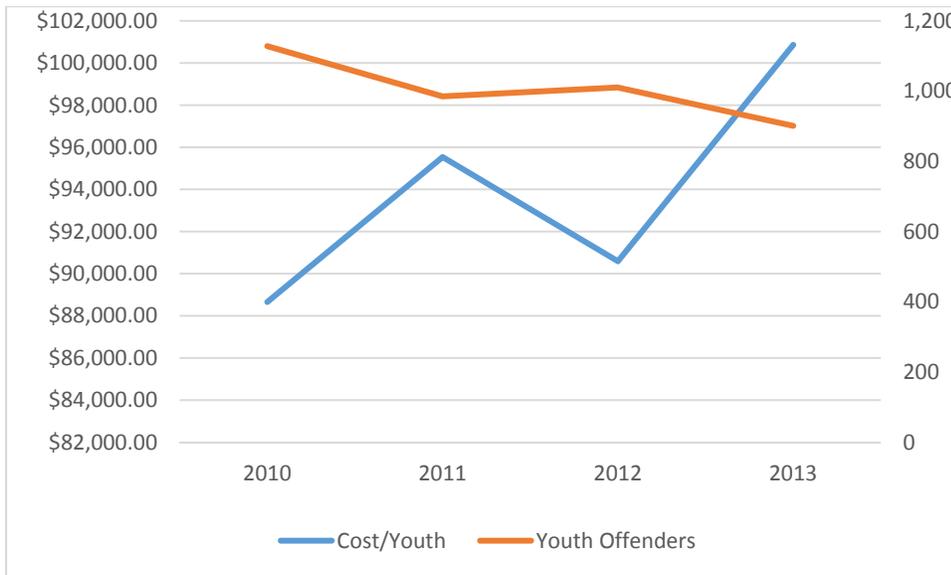
Figure 3.5 Personnel Costs and Non-Personnel Costs. Personnel costs have remained fairly static, whereas, administration costs have declined since fiscal year 2009.



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.

Monitoring programming increases its quality, thus reducing recidivism.

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 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

Recidivism costs JJS approximately \$17 million annually.

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

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.

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

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

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.

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

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

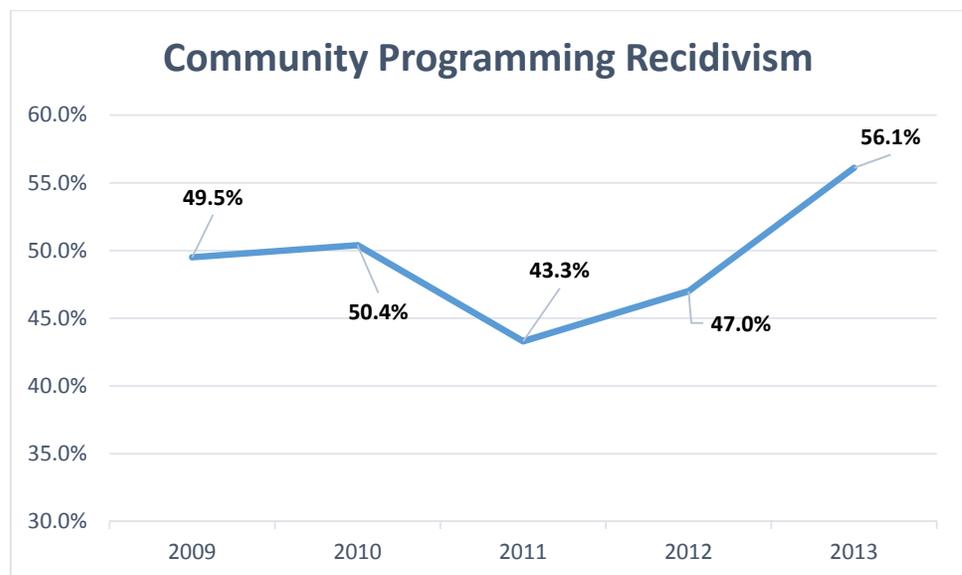
Programming Requires Greater Oversight To Potentially Increase Effectiveness

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.

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

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.

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.

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,

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

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

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

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

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.

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 than 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 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

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.

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

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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 statute) but the majority of patients did not. The longest stay was just over two-and-a-half years.

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

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

Some competency stays exceed the time intended in state statute.

- 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/3 rd 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.

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.

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

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.

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.

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.

Longer stays increase time on waitlists, further increasing costs.

Waitlist times have decreased since 2008.

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

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

(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.

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.

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.