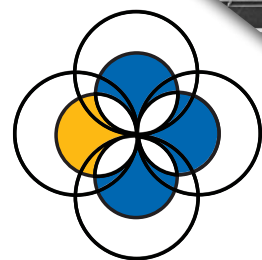CENTER FOR
Health &
Human Services
R E S E A R C H

FY 2020 ANNUAL REPORT

Dear Friends,

The Center for Health and Human Services Research (CHHSR) embraces the Talbert House mission of empowering children, adults and families to live healthy, safe and productive lives. We support this mission through research, analysis, and advocacy of science-based practices, and it is this shared mission that guides our selection of research and quality improvement projects that we undertake each year. Since we published our last Annual Report, we have continued to make progress with our research and technical assistance efforts related to individuals and communities disproportionately impacted by the opioid epidemic. We have assisted the agency in selecting psychometrically sound client assessment instruments, and added a new staff position to our growing team.

CHHSR staff are driven by the belief that integration of scientific evidence into daily program operations is necessary for social service agencies to fully achieve their missions of improving the lives and communities of those they serve. As researchers, we are fortunate to be embedded in a practice agency that shares this same belief. In fact, Talbert House has a long-standing commitment to scientific research that differentiates it from other social service agencies. From the addition of the first doctoral level Graduate Assistant in 1995 to the creation of a Chief Research Officer position in 2006 to the launch of the Center for Health and Human Services Research in 2013, Talbert House has continued to demonstrate and strengthen its investment in the power of science.

While we are proud of our accomplishments, we must acknowledge that our work would not be possible without key partnerships that are integral to our success. These partnerships include front line staff who are responsible for delivering evidence-based care, funders, policymakers, trade associations and academic research collaborators. We look forward to what more we can accomplish with these partners in the next fiscal year. In the meantime, we invite you to read on for highlights of this past year's achievements that help tell a story of a mission-driven research organization striving to harness the power of applied science to affect positive change.

Building a stronger community....one life at a time.

Sincerely,

Kimberly Sperber

Kimberly Sperber, Ph.D.
Director

CENTER FOR
Health &
Human Services
R E S E A R C H

Re-evaluating differences in Criminal Thinking Scales among men and women in community correctional service settings

Research shows that correctional interventions should target characteristics most predictive of recidivism. Endorsement of antisocial attitudes is one of the strongest dynamic criminogenic risk factors for criminal conduct, and empirical evidence has shown that cognitive-behavioral interventions that reduce procriminal cognitions significantly reduce recidivism. Consequently, valid assessments of antisocial attitudes can assist practitioners in: identifying antisocial thinking patterns of individuals, allocating treatment resources to address antisocial cognitions, and monitoring changes in antisocial attitudes over time. Talbert House community corrections programs assess antisocial cognitions at the beginning and end of treatment as both a measure of individual treatment progress through individual changes in scores and a measure of program performance through the aggregation of change scores.

Talbert House programs have used the How I Think Questionnaire (HIT) to assess antisocial cognitions for more than 15 years. Recently, however, program staff expressed an interest in examining and comparing other measurement options and enlisted the assistance of CHHSR to design a quality improvement project to assess and compare the performance of the 54-item HIT and the 36-item Texas Christian University Criminal Thinking Scales (TCU CTS) for use in the agency's community corrections programs. This project aims to examine the psychometric properties of the HIT and the TCU CTS in a sample of adult male and female halfway house residents to inform agency selection and use of these types of assessment tools for individual treatment planning and progress monitoring as well as ongoing program performance evaluation.

During FY20, the HIT and the TCU CTS were administered by program staff to 142 men (58%) and 101 women (42%) under real-world conditions between October 2019 and July 2020. Completed instruments were submitted to CHHSR staff for analyses. Residents were assessed with the HIT and the TCU CTS within two days of their arrival to the participating programs. Preliminary results provide general support for the internal consistency of subscales contained in each instrument (Figures 1 and 2). Overall Cronbach's alphas ranged from 0.63 to 0.93. Values on the HIT indicate excellent or highly acceptable internal consistency on each subscale, with Cronbach's coefficient alphas ranging from 0.81 to 0.93 among groups of men and women. Behavioral indicators such as Physical Aggression (PA) and Stealing (S) showed higher internal consistency than cognitive indicators. On average, values on the TCU CTS indicate acceptable to high levels of internal consistency, with alphas ranging from 0.63 to 0.92 among men and women. Although the overall alphas were in an acceptable range, the Cold Heartedness (CH) and the Personal Irresponsibility (PI) scales were at or below the 0.70 level indicating further research is warranted. Alphas showed relatively low levels of internal consistency for CH and PI compared to other subscales among men and women. Correlation matrices indicated that all the HIT subscales were statistically significantly correlated with each other (range: 0.75 to 0.92), while TCU CTS subscales were less intercorrelated (range: 0.09 to 0.88). Two subscales with low correlations among groups of men and women (Cold Heartedness and Criminal Rationalization) contained the instrument's only negatively-worded items which should be further examined. Planned future analyses include confirmatory factor analysis for convergent and discriminate validity, pre-post reliability, and predictive validity testing.

Figure 1. Internal Consistency of How I Think Subscales among Men and Women

Scale	Overall (N = 174)	Male (n = 95)	Female (n = 79)
SC	0.84	0.83	0.83
BO	0.85	0.84	0.84
MM	0.87	0.84	0.90
AW	0.90	0.91	0.88
OD	0.83	0.81	0.83
PA	0.90	0.88	0.91
L	0.87	0.86	0.86
S	0.92	0.90	0.93

Note. Cronbach alpha coefficients are reported for the How I Think (HIT) Questionnaire using 46 items and 8 subscales defined as Cognitive Indicators: Self-Centered (SC), Blaming Others (BO), Minimizing/Mislabeling (MM), Assuming the Worst (AW); and Behavioral Indicators: Opposition-Defiance (OD), Physical Aggression (PA), Lying (L), Stealing (S). Anomalous Responding (AR) subscale (8-items) were excluded.

Figure 2. Internal Consistency of Criminal Thinking Subscales among Men and Women

Scale	Overall (N = 239)	Male (n = 142)	Female (n = 97)
EN	0.88	0.86	0.89
JU	0.85	0.85	0.83
PO	0.83	0.81	0.83
CH	0.69	0.72	0.65
CN	0.79	0.78	0.78
PL	0.70	0.73	0.63
Total	0.92	0.92	0.90

Note. Cronbach alpha coefficients are reported for the Texas Christian University Criminal Thinking Scale (TCU CTS) using 36 items and 6 subscales: Entitlement (EN) Justification (JU), Power Orientation (PO), Cold Heartedness (CH), Criminal Rationalization (CN), and Personal Irresponsibility (PI).

practitioner highlight

Ashley Fox has worked at the Engagement Center as a Licensed Practical Nurse (LPN) since May 2019, and has six years of experience in the nursing field. As a member of the Engagement Center nursing staff, Ashley serves as a key component in of the continuum of patient care, working with clients receiving withdrawal management (WM) services and residential Substance Use Disorder (SUD) treatment services. In this role, Ashley has acted as a liaison between the Engagement Center staff, clients, and CHHSR staff conducting GPRA assessments with clients at the Engagement Center.

A vital step in the GPRA assessment is determining client SOR-GPRA eligibility, which requires timely information on clients' drug use history, drug overdose history, and SUD/OUD diagnostic codes. Ashley has consistently worked closely with the CHHSR staff to ensure that this information is shared with staff in a timely manner while maintaining client privacy. Through this collaboration,

Ashley has proven to be an important component of staff partnerships needed for success in facilitating the GPRA assessments required by SOR grant recipients such as the Engagement Center. In addition to working with CHHSR staff to screen clients for GPRA eligibility, Ashley has also been proactive in working with CHHSR staff to recruit eligible clients for the GPRA assessments by providing clients with brief introductory information about the GPRA assessment and by working with CHHSR staff to determine the optimal time to approach clients for a GPRA assessment.

Ashley and the medical team have been diligent in establishing and maintaining a strong practitioner-researcher collaboration throughout this project. Her participation in this partnership continues to support CHHSR staff in developing best practices for conducting GPRA assessments. We'd like to extend our thanks to Ashley and all the staff at the Engagement Center!

Ashley Fox, LPN
Licensed Practical Nurse, Engagement Center

Delivering Withdrawal Management services at the Engagement Center: Opening year trends in length-of-stay and successful discharge, (2018-2019 retrospective chart review)

In 2018 the CHHSR was awarded funding for a Single Site Retrospective Study of Clinically Managed Withdrawal Management Services (WM 3.2). In FY19-FY20 we completed data abstraction and preliminary analyses including all Electronic Health records with the Engagement Center (EC) service code recorded during the first 13-months of operations. Administrative Datasets were also abstracted, including a Clinical Tracker where referral, intake, and discharge dates, and related progress notes were recorded by EC clinicians and/or administrators. Records included discharge dates coded as "Successful" or "Unsuccessful." During this period the EC definition of successful discharge included clinician confirmation of both [A] follow-up treatment provider (medical prescriber appointment or SUD treatment alternative) and [B] verified supportive place to live (home, recovery housing, or alternative).

Understanding the relationship between EC accessibility, length-of-stay, and successful discharge is important for communities continuing to develop and deliver ASAM Level-3 service models (ASAM Level 3.1-3.7) including WM 3.2 beds and networks of providers. In practical contexts there are no predetermined lengths-of-stay for overdose survivors or other individuals admitted to the EC or comparable open-public-access WM service centers, where evidence-based buprenorphine induction and non-agonist treatment options

are available. In practice this could mean large numbers of discharges occur much earlier than anticipated (e.g., against medical advice), later than anticipated (e.g., beyond the 3-14 day period recommended for buprenorphine induction), and related phenomena (generally attributable to edge cases) may occur more often than clinicians are prepared to manage. We conducted initial analyses of successful discharge rates and lengths of stay to aid in clinical research and quality improvement initiatives. Discharge analyses were limited to administrative data sets collected during the first year of operations (May 14, 2018 to May 31, 2019).

Initial results of retrospective analyses included records abstracted from 588 unique admissions during the first year of EC operations. There were 14 admissions during the very first 2-weeks of operations, and length-of-stay ranged from 1 to 26 days among all cases. Average length-of-stay (ALOS; mean= 8.9, SD=9.6) was significantly greater for successful compared to unsuccessful cases admitted to the EC during the first 2-weeks cohort. Analyses indicated this trend continued in cohorts admitted throughout the first year of operations. Excluding the first 2 weeks of cases and examining the next 12 months of admissions by 3-month quarter (Q1-Q4) the ALOS ranged from 9 to 11 days (median 7 to 9 days) for successful cases. ALOS ranged from 3 to 5 days (median 2 to 3) for unsuccessful cases. Length-of-stay distributions are represented in Figure 3 including medians, standard deviations, range, and statistical outliers. Across graphs there is a slight upward trend in length of stay for successful discharges, and very few cases approached the 31-day length-of-stay recorded in the dataset. Given the right skewed distributions, medians with 95% Confidence Intervals (CIs) for successful

and unsuccessful cases are represented in Figure 4 for cohort comparisons. Median days for successful cases decreased to 7 days in Q1 and remained between 8 and 9 days from Q2 to Q4 with CIs narrowing around 9 days in Q2-Q4 for cases coded as successful. The ALOS trend for unsuccessful cases is relatively flat with a Median 3 days in Q1, Q2 and Q4. In next steps, we plan to model differences in outcomes by sex and prescribed treatment modality. We may summarize open-ended reasons for 'unsuccessful' discharge, as some were noted in the Clinical Tracker, and related in-depth interviews were recorded with EC staff and affiliated providers in FY20.

Of course, length of stay and successful discharge are expected to be highly interrelated. As expected the number of admitted cases increased from Q1 (n=109), Q2 (n=147), Q3 (n=137), to Q4 (n=180) and the proportion of first-time admissions declined over time. This may indicate dynamics in referral sources, referral rates, relapse rates, and possible shifts in the composition of cases including more complex clinical presentations such as difficult to house overdose survivors

or others dealing with recidivism and housing difficulties in structurally underserved areas. Ultimately readmissions rose to 30% of all admitted cases in Q4. Thus far, significant improvements in successful discharge status have not been observed during Q1-Q4, wherein 47-62% did not meet the criteria of both having a supportive place to live upon discharge and a follow-up treatment provider. It is important to note that nearly all cases were classified as residential admissions and most were uninsured or Medicaid insured during the period of investigation. The few non-residential cases and some other cases may be removed from future analyses of discharge planning and outcomes. Future analyses may address patterns in referral sources and housing availability post-discharge as structural determinants of MAT uptake and survival in Greater Cincinnati. Future multi-site research should include WM, treatment maintenance, and survival outcomes across WM-3.2 facilities and make comparisons with traditional inpatient clinics and ambulatory options. Ongoing research will be important in the context of changing availability of telemedicine and other innovations precipitated by the SARS-COVID-19 pandemic.

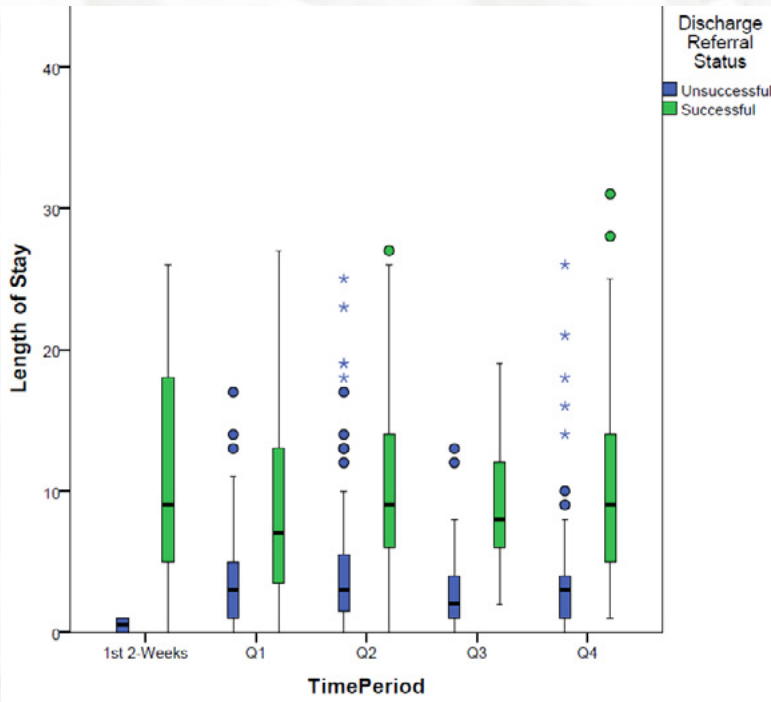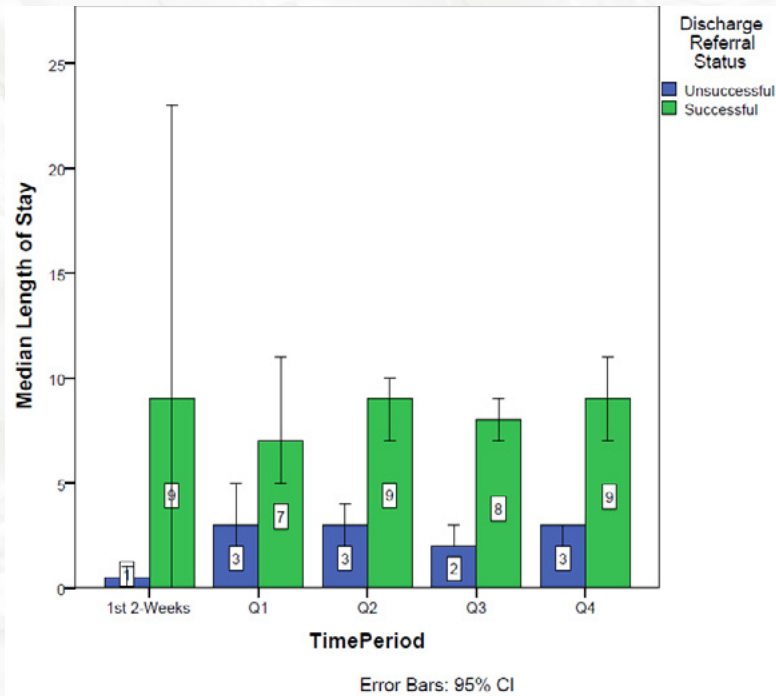**Figure 3.** Length of Stay by Period of Admission (May 2018 to May 2019) and Discharge Outcomes

Figure 4. Differences in Median Length of Stay by Period of Admission and Confidence Intervals

partner investigator highlight

Dr. Winstanley is an Associate Professor at West Virginia University, Department of Behavioral Medicine and Psychiatry. Dr. Winstanley received her doctoral degree from The Johns Hopkins Bloomberg School of Public Health and she has more than 18 years of experience as a behavioral health services researcher. Dr. Winstanley has partnered with CHHSR investigators on numerous funded studies and projects related to the opioid epidemic, serving as a Collaboration Board member on all OCJS-funded projects, co-authoring conference presentations, consulting on study methodologies, and designing an introductory training on the opioid epidemic for agency staff. Dr. Winstanley's current research is focused on reducing the morbidity and mortality associated with the opioid epidemic, as well as the use of technology to improve access and quality of behavioral health services.

Dr. Winstanley

Ongoing evaluation for State Opiate Response [SOR] Projects in Hamilton County: screening for trauma and related exposures among men and women (preliminary 2019-2020 outcomes from the Engagement Center)

In 2019-2020, Talbert House continued to operate the Engagement Center (EC) and CHHSR research staff continued to support evaluation activities required by State Opiate Response (SOR) grant recipients. Activities included intake and follow-up assessments guided by SAMHSA (Government Performance and Results Modernization Act, GPRA), the Hamilton County Mental Health and Recovery Services Board, and the Ohio Department of Mental Health and Addiction Services. During this period of time CHHSR staff were assigned to the EC and four additional Talbert House locations set to begin enrolling GPRA eligible clients, defined as individuals with diagnosed opioid use disorder or recent overdose experience. As part of internal quality improvement processes, staff abstracted preliminary intake screening results from SOR-GPRA assessments to better understand baseline histories of trauma and related symptoms reported by men and women served at the EC during FY 2020.

Data collection for SOR Grant Year 1 at the EC began on April 8, 2019 and ended on September 30, 2019. During this period there were 1,006 client intakes recorded at the EC. In order to characterize SOR-GPRA participants from Year 2 only we removed records of services beginning during Grant Year 1 (n=378). We also removed (a) those assigned to the Burnet Intensive Services (BIS) and Alcohol and Drug Abuse Prevention and Treatment (ADAPT) programs (n=27), (b) those screened for intake but not admitted to treatment (n=6), and (c) those not completing a GPRA assessment and not yet discharged from services at the EC as of September 30, 2020 (n=3). Included were all other intake records from EC during SOR Grant Year 2 (n=592). Of the recorded cases included in Grant Year 2, 448 (76%) were eligible to participate in a GPRA

Figure 5. Trauma and Related Symptom Screening, Engagement Center SOR-GPRA Year 2 (n=230)

	Total (N)	n (%)	Male (%)	Female (%)	X^2
Depression	223	201 (90.1%)	151 (91.5%)	50 (86.2%)	1.360
Anxiety	224	211 (94.2%)	155 (93.7%)	56 (96.6%)	0.794
Memory / Concentration	221	141 (63.8%)	100 (61.3%)	41 (70.1%)	1.616
History of Trauma	227	170 (74.9%)	119 (71.3%)	51 (85.0%)	4.433*
Nightmares	168	126 (75.0%)	80 (67.8%)	46 (92.0%)	10.972***
Avoidance	168	136 (81.0%)	89 (75.4%)	47 (94.0%)	7.859**
Hypervigilance	168	147 (87.5%)	102 (86.4%)	45 (90.0%)	0.407
Detachment	168	135 (80.4%)	90 (76.3%)	45 (90.0%)	4.194*
Level of Stress	228				1.876
Not at All		5 (2.2%)	4 (2.4%)	1 (1.7%)	
Somewhat		11 (4.8%)	8 (4.8%)	3 (5.0%)	
Considerable		39 (17.1%)	32 (19.0%)	7 (11.7%)	
Extremely		173 (73.8%)	124 (71.7%)	49 (81.7%)	
Emotional Problems	225				7.396
Not at All		5 (2.2%)	4 (2.4%)	1 (1.7%)	
Somewhat		20 (8.9%)	17 (10.3%)	3 (5.0%)	
Considerable		39 (17.3%)	34 (20.6%)	5 (8.3%)	
Extremely		161 (71.6%)	110 (66.7%)	51 (83.3%)	
Quality of Life	228				7.261
Very Good		10 (4.4%)	8 (4.8%)	2 (3.3%)	
Good		43 (18.9%)	36 (21.4%)	7 (11.7%)	
Neither		78 (34.2%)	55 (32.7%)	23 (38.3%)	
Poor		63 (27.6%)	49 (29.2%)	14 (23.3%)	
Very Poor		34 (14.9%)	20 (11.9%)	14 (23.3%)	
Arrests - Last 30 Days	230	31 (13.5%)	24 (14.2%)	7 (11.5%)	0.286
Incarceration - Last 30 Days	230	29 (12.6%)	23 (13.6%)	6 (9.8%)	0.579

intake assessment, while 144 (24%) were not eligible. Of the 448 eligible, 230 (51%) completed an intake assessment and 218 (49%) did not. Those who were GPRA-eligible but did not complete an intake assessment were coded as leaving treatment prior to completing the assessment (n=158, 35%), refusing to consent to an assessment (n=27, 6%), medical symptoms too severe to complete an assessment and a small number of other reasons clients may have been unavailable for intake assessment (n=33, 7%).

Results of preliminary Year-2 intake data revealed numbers participating in GPRA assessment were not significantly different among men (38%) and women (36%) ($X2=2.631$, n=448, p=0.452). Additional comparisons involved chi-square tests of independence among only those GPRA-eligible men and women who completed assessments. Most participants identified as men (n=169, 73.5%) and as white/Caucasian (n=191, 83%), with white/Caucasian men comprising 59% (n=136) of the sample. The next largest group was white/Caucasian women (n=55, 24%); Black or African American women were 14% (n=33) of the sample, and American Indian women were 2% (n=4) of the sample. There was a small non-significant difference in age and some of the trauma related risk-factors captured in the GPRA. As reported in Figure 5, recent (past 30-day self-reported) symptoms of Depression, Anxiety, Cognitive and Emotional

Problems, drug related Stress Level, and overall Quality of Life were similarly distributed among men and women. Women in the sample had significantly greater exposure to Violence or Trauma (reported from any setting including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief). Among men and women exposed to Violence or Trauma, there were significant differences in associated symptoms, with women significantly more likely to report Nightmares, Avoidance, and Detachment. In contrast, Hypervigilance was not significantly different. Recent exposures to incarceration and arrest were similarly distributed among men and women.

Exposures to violence and trauma are known risk factors for addiction severity, and associated symptoms may be treated differently among groups engaged in short versus long-term therapy. Next steps in research may develop clinical treatment recommendations based on EC experiences with men and women who may be prescribed buprenorphine, antivirals, and other treatment regimens including individualized and group therapeutic services. More robust research will require additional cases and repeated measures that may be included in datasets stemming from SOR-GPRA and associated service partnerships promoted and supported by SAMHSA and local governments.

summary and practical implications

This year's findings from correctional settings compare the How I Think Questionnaire and the TCU Criminal Thinking Scales to inform agency decision making related to performance measurement. Findings from non-correctional settings demonstrate relatively high levels of trauma reported by women screened in residential withdrawal management settings. Clinicians may be able to address related symptoms as part of buprenorphine induction counseling and other forms of medication assisted treatment. Longitudinal analyses of withdrawal management records revealed very short periods of time (1-3 day lengths of stay) where residential discharge planning and linkages to service providers may be improved.

CRIMINAL JUSTICE & PUBLIC HEALTH COLLABORATION

During FY20 Dr. Vissman served as an Intervention Design Team member on the HEALing (Helping to End Addiction Long-term) Communities Study funded by the National Institutes of Health (NIH). This work has included development of curricula and recommendations for community coalitions selecting evidence based practices and strategies in southern Ohio and other parts of the United States. The impacts of this project are designed to reduce rates of opioid overdose deaths across a 4-state community randomized controlled trial. Results will be borne out through FY21-FY22 in justice-involved communities and other populations disproportionately affected by opioid overdose epidemics.

Other partnership developments from FY20 include increased cooperation with SAMHSA supported projects to monitor outcomes of buprenorphine induction (including SOR-GPRA). CHHSR staff also began collecting data on state funded Quick Response Teams (QRTs) as part of externally supported addiction services research (OCJS). During FY20 Dr. Calvert left the CHHSR for a university appointment and we recruited his (pending) replacement as Senior Research Associate. We added a new staff position to our interdisciplinary research team to serve growing needs of SOR-GPRA and QRT related projects in FY20-21.
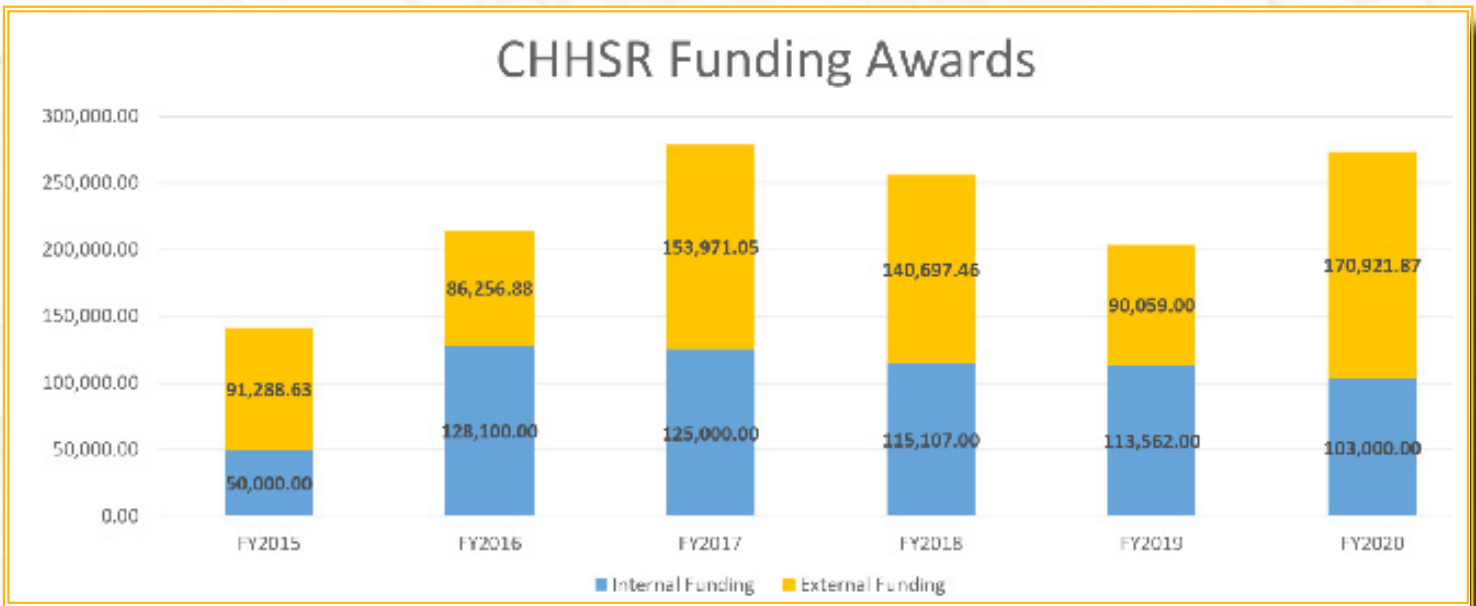
During FY20 we did not accept new student interns. In FY21 we will continue collaborating with Schools of Criminal Justice and Schools of Public Health. We will continue developing practicum experiences for a broader set of undergraduate and graduate students enrolled for credit hours in BS, MS, MPH, or PhD programs.

FUNDING

The graph below shows new funding awarded during FY2020. Funding amounts do not reflect continuation of FY2019 funds from previous awards.

FY 2020 Funders:

- Hamilton County Mental Health and Recovery Services Board, State Opioid Response (SOR) Grants
- Ohio Office of Criminal Justice Services (OCJS), Edward Byrne Memorial Justice Assistance Grant (JAG)
- National Institute on Drug Abuse (NIH), University of Cincinnati HEALing Communities sub award

CHHSR Funding Awards

	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
External Funding	91,288.63	86,256.88	153,971.05	140,697.46	90,059.00	170,921.87
Internal Funding	50,000.00	128,100.00	125,000.00	115,107.00	113,562.00	103,000.00

PUBLICATIONS

Sperber, K. G. & Whitton, S. (2021) "Engaging mothers in coparenting services with the nonresidential fathers of their children via fatherhood programs: Insights into barriers and solutions." In J. Fagan & J. Pearson (Eds.), New research on programs that help low-income fathers become better parents. Routledge Press.

Sperber, K. (2020). Contemplating the role of community corrections at the intersection of public health and public safety. Journal of Community Corrections.

Sperber, K. (2020). Fidelity to evidence-based practice: Our obligation to effective supervision and service delivery. Federal Probation.

PROFESSIONAL PRESENTATIONS

Vissman AT. Educational Outcomes from a Standardized Overdose Prevention Intervention in southern Ohio Community Correctional Facilities. Appalachian Translational Research Network Annual Conference, Columbus OH; October 14, 2019

Calvert JC. Participant reflections on an overdose prevention curriculum addressing fentanyl in Ohio community correctional settings. Appalachian Translational Research Network Annual Conference, Columbus OH; October 14, 2019

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Kimberly Gentry Sberber, Ph.D., *Director*

Dr. Sperber received her Ph.D. in Criminal Justice from the University of Cincinnati in 2003 and has worked in the field for more than 25 years. In her role, Dr. Sperber oversees research in the areas of addiction, mental health, corrections and implementation science. She also assists Talbert House to implement, monitor and respond to Continuous Quality Improvement metrics that assess the agency's performance in terms of process, outcomes and treatment fidelity. Her most recent research has focused on: appropriate applications of risk-based treatment dosage for criminal justice clients; identifying and addressing barriers to Medication Assisted Treatment and opioid overdose prevention in community-based programs; implementation of opioid withdrawal management services in community settings; and identifying barriers to engagement in co-parenting services for non-residential fathers and their co-parenting partners.

Aaron T. Vissman, Ph.D., MPH, *Associate Director*

Dr. Vissman joined Talbert House in 2016 after completing his Ph.D. in Behavioral Sciences and Health Education at Emory University. He has extramurally funded NIH, CDC, and other research experience investigating public health disparities and multi-level intervention outcomes. He directs ongoing research and serves as grant writer and investigator for interdisciplinary health research projects. Recent projects focus on health education, HIV/AIDS, viral hepatitis, naloxone distribution and mortality in justice-involved populations. He directs the Public Health—Prevention and Policy—Internship Program and serves as a member of the Executive Committee on Continuous Quality Improvement at Talbert House. He teaches classes and workshops available for open registration via the ITD website including: Implementation of PEER-OPS –standardized opioid overdose prevention programs for community correctional facilities; HIV/HCV Policy and Advocacy; and Survey Research Methods.

Cherie Carter, M.S., CDCA, *Research Associate*

Cherie joined Talbert House as research intern in 2018. Prior to joining Talbert House, Cherie worked at UC's Corrections Institute and UC's Institute of Crime Science. She has a background in teaching and training, and has experience with Core Correctional Practices, Motivational Interviewing, Trauma Informed Care, EPICS, Thinking for a Change, Continuous Quality Improvement, and Cognitive Behavioral Interventions for Substance Abuse. Currently, she is managing a State Opioid Response data collection project, and assists with data collection and data analysis for CHHSR. Cherie is a doctoral student in the School of Criminal Justice at the University of Cincinnati.

Jee Yearn Kim, M.S., *Graduate Research Assistant*

Jee Yearn Kim is a doctoral student in the School of Criminal Justice at the University of Cincinnati. Her research interests center on psychology of criminal conduct, principles of effective intervention, correctional rehabilitation, and has published on violence against women, and related issues. Jee Yearn assists with literature reviews and data analysis for several projects at the CHHSR. She currently is working on examining effects of treatment enrollment on changing depression and social functioning among community based mental health clients at Talbert House.

Paige Adkins, BA., *Research Assistant*

Paige Adkins joined the Research Department at Talbert House in February 2020. Prior to joining Talbert House, Paige was a recent graduate from the University of Kentucky with a Bachelor's degree in Sociology and Gender and Women's Studies with a minor in Criminology. During her undergraduate work, she worked on numerous research projects gaining experience in criminal reentry, gender performance in prisons, power differentiations in race, and proper interview techniques with vulnerable populations. Currently, Paige is assisting in data collection and data entry for multiple projects including a State Opioid Response data collection project and the Texas Christian University/How I Think research project for CHHSR. In the future, Paige plans to attend graduate school with hopes of obtaining her PhD.