FINAL REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC)

Alcohol and Drug Treatment at Passages

1001 S. 27th St, Billings, MT 59101

By

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INTRODUCTION

Research has consistently shown that programs that adhere to key principles, namely the risk, need, responsivity (RNR), and fidelity principles, are more likely to impact delinquent and criminal offending. Stemming from these principles, research also suggests that cognitive-behavioral and social learning models of treatment for offenders are associated with considerable reductions in recidivism. To ensure that high quality services are being delivered, there has recently been an increased effort in formalizing quality assurance practices in the field of juvenile justice treatment and corrections. As a result, more legislatures and policymakers have requested that interventions be consistent with the research literature on evidence-based practices.

Within this context, under the direction of MCA 53-1-211, The Montana Department of Corrections (MDOC) completes an assessment of the Alcohol and Drug Treatment (ADT) program Passages using the Evidence-Based Correctional Program Checklist (CPC). The objective of the CPC assessment is to conduct a detailed review of the facility's practices and to compare them to best practices within the juvenile/criminal justice and correctional treatment literature. Facility strengths, areas for improvement, and specific recommendations to enhance the effectiveness of the services delivered by the facility are offered.

CPC BACKGROUND AND PROCESSES

The Evidence-Based Correctional Program Checklist (CPC) is a tool developed by the University of Cincinnati Corrections Institute (UCCI)[i] for assessing correctional intervention programs.[ii] The CPC is designed to evaluate the extent to which correctional intervention programs adhere to evidence-based practices (EBP) including the principles of effective interventions. Data from four studies[iii] conducted by UCCI on both adult and youth programs were used to develop and validate the CPC indicators. These studies produced strong correlations between outcome (i.e., recidivism) and individual items, domains, areas, and overall score. Two additional studies[iv] have confirmed that CPC scores are correlated with recidivism and a large body of research exists that supports the indicators on the CPC.[v]

To continue to align with updates in the field of offender rehabilitation, the CPC has been revised twice. A substantial revision was released in 2015 (CPC 2.0) and in 2019, minor revisions were made (CPC 2.1). Throughout this document, all references to the CPC are a direct reference to the revised CPC 2.1 version of the assessment tool.

The CPC is divided into two basic areas: content and capacity. The capacity area is designed to measure whether a correctional program has the capability to deliver evidence-based interventions and services for offenders. There are three domains in the capacity area including: Program Leadership and Development, Staff Characteristics, and Quality Assurance. The content area includes the Offender Assessment and Treatment Characteristics domains and focuses on the extent to which the program meets certain principles of effective intervention, namely RNR. Across these five domains, there are 73 indicators on the CPC, worth up to 79 total points. Each domain, each area, and the overall score are tallied and rated as either Very High Adherence to EBP (65% to 100%), High Adherence to EBP (55% to 64%), Moderate Adherence to EBP (46% to 54%), or Low Adherence to EBP (45% or less). It should be noted that the five domains are not

given equal weight, and some items may be considered not applicable in the evaluation process.

The CPC assessment process requires a site visit to collect various program traces. These include, but are not limited to, interviews with executive staff (e.g., program director, clinical supervisor), interviews with treatment staff and key program staff, interviews with offenders, observation of direct services, and review of relevant program materials (e.g., offender files, program policies and procedures, treatment curricula, client handbook, etc.). Once the information is gathered and reviewed, the evaluators score the program. When the program has met a CPC indicator, it is considered a strength of the program. When the program has not met an indicator, it is considered an area in need of improvement. For each indicator in need of improvement, the evaluators construct a recommendation to assist the program's efforts to increase adherence to research and data-driven practices.

After the site visit and scoring process, a report (i.e., this document) is generated which contains all of the information described above. In this report, your program's scores are compared to the average score across all programs that have been previously assessed. This report is first issued in draft form and written feedback from you and your staff is requested. Once feedback from you is received, a final report is submitted. Unless otherwise discussed, the report is the property of the program and/or the agency requesting the CPC and UCCI will not disseminate the report without prior approval. The scores from your program will be added to our CPC database, which we use to update scoring norms.

There are several limitations to the CPC that should be noted. First, the instrument is based upon an ideal program. The criteria have been developed from a large body of research and knowledge that combines the best practices from the empirical literature on what works in reducing recidivism. As such, no program will ever score 100% on the CPC. Second, as with any explorative process, objectivity and reliability can be concerns. Although steps are taken to ensure that the information gathered is accurate and reliable, given the nature of the process, decisions about the information and data gathered are invariably made by the evaluators. Third, the process is time specific. That is, the results are based on the program at the time of the assessment. Though changes or modifications may be under development, only those activities and processes that are present at the time of the review are considered for scoring. Fourth, the process does not take into account all "system" issues that can affect the integrity of the program. Lastly, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place.

Despite these limitations, there are a number of advantages to this process. First, it is applicable to a wide range of programs.[vi] Second, all of the indicators included on the CPC have been found to be correlated with reductions in recidivism through rigorous research. Third, the process provides a measure of program integrity and quality as it provides insight into the black box (i.e., the operations) of a program, something that an outcome study alone does not provide. Fourth, the results can be obtained relatively quickly. Fifth, it provides the program both with an idea of current practices that are consistent with the research on effective interventions, as well as those practices that need improvement. Sixth, it provides useful recommendations for program improvement. Furthermore, it allows for comparisons with other programs that have been assessed

using the same criteria. Finally, since program integrity and quality can change over time; it allows a program to reassess its progress in adhering to evidence-based practices.

As mentioned above, the CPC represents an ideal program. Based on the assessments conducted to date, programs typically score in the Low and Moderate Adherence to EBP categories. Overall, 14% of the programs assessed have been classified as having Very High Adherence to EBP, 20% as having High Adherence to EBP, 24% as having Moderate Adherence to EBP, and 42% as having Low Adherence to EBP. Research conducted by UCCI indicates that programs that score in the Very High and High Adherence categories look like programs that are able to reduce recidivism.

SUMMARY OF THE FACILITY AND SITE VISIT PROCESS

ADT, located in Billings, Montana, is a 55-bed program that serves adult female residents who have committed felony offenses in a secure wing of a former hotel. The majority of the participants are under the custody of the MDOC and have a history of substance use. Also located in the same building is an Assessment, Sanction, Revocation Center (ASRC) as well as a prerelease center; populations between these three programs are kept separate at all times. This program was originally a 60-day program but has increased its length to 90-days. Although their primary focus is on substance use, they have found that more people being referred to their program have co-occurring Substance Use Disorders (SUD) and mental health issues and are working to appropriately meet these specific needs. Referrals to this program come primarily from the MDOC's Probation and Parole Division, but also from the Montana Women's Prison (MWP) which is located only a couple of blocks from this facility.

Women who enter this program typically come from the aforementioned ASRC floor conveniently located below this program or after receiving an ASAM Level 3.5 of recommended care. A number of the screeners used to measure motivation, drug of choice, intensity of addiction and other responsivity factors are completed on the ASRC floor, and the results of those assessments stored in the computer system utilized by the parent organization, Alternatives, as well as other private non-profits who contract with MDOC. In addition to secondary screeners, a Women's Risk and Needs Assessment (WRNA) is reviewed prior to acceptance by a designated screening committee.

Upon entering the ADT program, all participants must complete a three-week orientation phase in which staff evaluate individual characteristics, develop a treatment plan and assign the groups that will be mandatorily completed. There are a couple of groups that all participants must complete such as relationships (specific modules taken from Living in Balance curriculum), a substance use disorders group (also utilizes Living in Balance SUD specific modules) and recreation. Other groups assigned are decided based on the professional judgement of the Licensed Addiction Counselor (LAC) assigned to the participant derived from assessments, screeners and interviews, the WRNA, as well as the participant's input as to what they would find most useful.

It is important to acknowledge that operating an inpatient substance use program that specifically serves the criminal justice population during a global pandemic has been a challenge. The health and welfare of the participants was always the priority and for that reason, a number of

modifications were made that otherwise would not have been. For example, the ASRC and ADT floors were combined to allow for an entire floor to be used as quarantine beds. The mixing of these two populations has never occurred over the 14 years this program has been in operation. With this significant modification, the population of the program decreased significantly. With the decrease in the population, coupled with the need for social distancing in a congregate care facility and lack of large group spaces, group offerings occurred less frequently and had fewer participants. Alternatives worked closely with the MDOC throughout the pandemic to continue inpatient substance use treatment services for the greatly reduced offender population.

The assessment using the CPC took place on May 17th through 18th, 2021. The assessment process consisted of a series of structured interviews with the chief operating officer, program director, clinical staff, security staff, case management, and treatment assistant staff (other unit staff), and six residents.

For the purposes of this assessment, Jennifer Porter was identified as the Program Director as she oversees the programming and services on a daily basis as well as supervises staff. It should also be noted that for purposes of the CPC report, security staff were not considered direct service delivery staff as they provide supervision of the residents by enforcing rules and they neither provide any of the structured programming nor do they maintain a caseload. Additionally, data were gathered via the examination of 10 representative files (open and closed) as well as other relevant program materials (e.g., policy and procedure manuals, staff training information, assessments, curricula, resident handbook, etc.). Finally, 8 groups facilitated by both clinical and other staff were observed. These groups include Dialectical Behavioral Therapy (DBT), a DBT for Anger Management, Seeking Safety, two Moral Recognition Therapy (MRT) groups, and three different Substance Use Disorders (SUDS). Data from the various sources were then combined to generate a consensus CPC score and specific recommendations, which are described below.

FINDINGS

Program Leadership and Development

The first subcomponent of the Program Leadership and Development domain examines the qualifications and involvement of the program director (i.e., the individual responsible for overseeing daily operations of the facility), their qualifications and experience, their current involvement with the staff and the residents, as well as the development, implementation, and support (i.e., both organizational and financial) for the treatment services.

The second subcomponent of this domain concerns the initial design of the treatment services. Effective interventions are designed to be consistent with the literature on effective correctional services, and facility components should be piloted before full implementation. The values and goals of the facility should also be consistent with existing values in the community and/or institution, and it should meet all identified needs. Lastly, the facility should be perceived as both cost-effective and sustainable.

Program Leadership and Development Strengths

Ms. Porter is very experienced and has been working with adult female criminal justice populations within ADT/Passages approximately 7.5 years and has served as the clinical director for 3.5 years. She also has 5.5 years of experience with youth services and worked at Rimrock, a private substance use disorder treatment facility. Ms. Porter is a hands-on program director in four aspects. She is directly involved in selecting staff by conducting interviews and approves each new hire. She is involved in training new staff on the treatment curriculum. She has direct oversight of staff who are providing services to the program participants. Lastly, she is involved in providing direct services to program participants by facilitating two groups and filling in for her staff when they are absent from work.

Formal piloting of potential changes to the program or of facility level changes that can impact the program are consistently conducted. For example, the recent addition of a Gambling group, and Living in Balance (LIB) were formally piloted prior to implementation at ADT. ADT consistently has a formal pilot period where program logistics and content are sorted out for a period of at least seven months before a change or a new process begins. ADT also utilizes resident surveys when making determinations during a pilot period.

The ADT program has support from criminal justice stakeholders. For example, judges, the MDOC, and, specifically, probation and parole officers are all viewed as supportive of ADT. Judges continuously refer clients, probation and parole communicate well with staff and visit the site when needed, and Child and Family Services (CFS) works with the site to coordinate parental visitation. In addition, community stakeholders are supportive of ADT. ADT has support from many volunteers, including those who lead Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings and numerous volunteers from local religious groups.

Additionally, there have been no major decreases in funding that have significantly impacted the program within the past two years and funding has been stable. ADT increased the amount residents pay for room and board from $6 to $7. Finally, the ADT program has been offered at the facility for roughly 14 years, which exceeds the CPC criterion of being an established program.

Program Leadership and Development: Areas in Need of Improvement and Recommendations

Ms. Porter has multiple academic credentials. Ms. Porter possesses a bachelor's degree in Psychology and a minor in Addiction Counseling; is a Licensed Addiction Counselor (LAC) through the state of Montana; however, Ms. Porter did not complete any courses or specializations in working specifically with offender/delinquent populations (criminal justice, forensic psychology, etc.).

- **Recommendation:** Should ADT ever need to identify another clinical director or assistant clinical director, preference should be given to candidates with at least a bachelor's degree in a helping profession with classes/specializations in corrections (criminal justice, forensic psychology, etc.).

It is important the program be based on the effective correctional treatment literature and that all staff members have a thorough understanding of this research. A review of program materials indicated a formal literature search had begun to occur; however, changes to ADT are not made with the information gleaned from the literature reviewed. As such, staff are not formally and regularly utilizing the research on evidence-based practices when delivering services to the justice-involved population.

- **Recommendation:** The ADT and/or the program director should continue to conduct a literature search but moreover ensure that an effective program model is implemented consistently throughout all components of the program. Other examples of literature could include major criminological and psychological journals, as well as key texts. Some examples of these texts are: "Psychology of Criminal Conduct" by Don Andrews and James Bonta; "Correctional Counseling and Rehabilitation" by Patricia Van Voorhis, Michael Braswell, and David Lester; "Choosing Correctional Options That Work: Defining the Demand and Evaluating the Supply" edited by Alan Harland; and "Contemporary Behavior Therapy" by Michael Spiegler and David Guevremont. Journals to be regularly reviewed should, at a minimum, include: Criminal Justice and Behavior; Crime and Delinquency; and The Journal of Offender Rehabilitation. Collectively, these sources will provide information about assessment and programming that can be applied to groups and services delivered by the program. It is important that the core program and all of its components be based on a coherent theoretical model with empirical evidence demonstrating its effectiveness in reducing recidivism among criminal justice populations (e.g., cognitive behavioral and social learning theories). It should be noted that Ms. Porter does send out information and articles from corrections, however this does meet the above criteria.

STAFF CHARACTERISTICS

The Staff Characteristics domain of the CPC concerns the qualifications, experience, stability, training, supervision, and involvement of the staff. Certain items in this domain are limited to full-time and part-time internal and external providers who conduct groups or provide direct services to the women in your Passages/ADT Program. Other items in this domain examine all staff that work in the program. Excluded from this section in totality is the program director, as she was assessed in the previous domain. In total, eight staff were identified as providing direct services, including the case management staff, Licensed Addiction Counselors (LAC), and a treatment assistant. Additionally, Ms. Porter also provides direct services to the clients in the program.

Staff Characteristics Strengths

Programs where 70 percent of their direct service delivery staff have at least an associate degree in a helping profession are more successful in helping effectuate change. Additionally, having 75 percent of staff with at least two years' experience working with the criminal justice population have a greater impact. At the time of the assessment, Passages ADT staff exceeded this requirement. In fact, 100 percent of the staff facilitating groups met the CPC indicator for education. Staff facilitating groups met this requirement as indicated in traces observed, years of

experience, belief in behavior change, personal characteristics and values are taken into consideration when hiring staff at Passages ADT.

Research shows that successful programs have their professional staff attend staff meetings at least twice per month. ADT direct service delivery staff meet once per week and there is an all staff meeting once per month. An agenda is followed for both meetings. Other means of feedback to staff regarding service delivery skills, behavioral reinforcements and other qualities important to effective treatment occurs through annual evaluations.

Programs where clinical supervision is provided to professional staff at least once a month by a licensed clinical supervisor show a great reduction in recidivism. As indicated by all professional staff at ADT, Ms. Porter sits in/observes groups, holds individual sessions with those direct service providers, and holds group sessions at least once per month. Additionally, Ms. Porter also provides initial training, where she ensures everything on the new hire checklist/40-hour initial training is completed. She also provides ongoing training for the first six months to one year with new hires.

It was indicated that all staff have input into the program and with supervisorial approval components of the program can be modified. There is a staff board where suggested changes can be placed for review and staff surveys also allow for suggested modifications. For example, the idea to revamp the phase system used at ADT was proposed. The changes proposed wanted to implement were how the women in the program progressed through the phase system; was previously based on time in the program and was changed to how the clients are doing/progressing in the program/with their treatment.

Passages ADT has an employee handbook that is provided to all employees. This handbook provides ethical guidelines, staff boundaries/how they should interact with the clients in the program, and the programs policies and procedures. These guidelines and boundaries are a part of their initial and ongoing staff training.

Staff Characteristics Areas in Need of Improvement and Recommendations

Equally important to ADT is the ongoing training of staff. Programs that have at least 40 hours of annual training for all direct service delivery staff relevant to program and service delivery are more successful in reducing recidivism. Although ADT staff receive 40 hours of initial training, they do not receive 40 hours of formal ongoing training per year. Across the board, most of the training staff receive annually is not dedicated to service delivery skills and focuses more on safety and security of the facility.

- **Recommendation:** All staff should receive at least 40 hours of ongoing training each year. These hours should be directly related to delivering criminogenic services to women involved in the justice system and should include a review of the principles of effective intervention, behavioral strategies such as modeling and role play, the application of reinforcers and punishments, risk assessment, group facilitation skills, case planning, and updates to the field of offender rehabilitation. ADT should consider delivering booster

trainings to staff throughout the year and collaborate with their administrative staff to help provide regular formal training opportunities for all staff.

OFFENDER ASSESSMENT

The extent to which women are appropriate for the services provided and the use of proven assessment methods is critical to effective correctional programs. Effective programs assess the risk, need, and responsivity of women, and then provide services and interventions accordingly. The Offender Assessment domain examines three areas regarding assessment: 1) selection of women; 2) the assessment of risk, need, and personal characteristics; and (3) the manner in which these characteristics are assessed.

Offender Assessment Strengths

ADT accepts women into their program with an appropriate MDOC referral. Those referred are then screened by a screening committee where that team discusses the referrals and then votes on their acceptance into the program. Members of that screening committee include ADT administration, two Probation and Parole Officers from the community, a Disciplinary Coordinator, and a Law Enforcement Official. As a result, ADT accepts appropriate clients, as determined by their screening committee. Of the 33 women in the ADT program ten to twenty percent were considered inappropriate due to their mental health concerns, physical health concerns, or willingness to change. ADT should continue to monitor this to ensure that they remain under the 20 percent limit outlined in the CPC.

Risk factors should be identified and measured with a validated, standardized, and objective risk assessment instrument that produces a level of risk. Furthermore, needs assessment scores are also crucial as they determine which criminogenic need areas offenders have, whereas responsivity assessments assist in determining offenders' possible barriers to treatment (i.e., mental health concerns, trauma histories, low motivation for treatment, learning or education barriers, to name a few). ADT uses the WRNA to identify risk levels and criminogenic needs for their clients. Additionally, ADT uses secondary assessments to address additional domain specific needs and responsivity; those assessments include Patient Health Questionaire-9 (PQH-9), Adverse Childhood Experience (ACE), South Oaks Gambling Screen (SOGS), Generalized Anxiety Disorder-7 (GAD-7), and the Stages of Changes Readiness and Treatment Eagerness Scale 8D and 8A (SOCRATES 8D and 8A).

Programs that are most successful in reducing recidivism have 70 percent or higher moderate or high-risk offenders served by their program. Through file review and electronic records gathered from both the Offender Management Information System (OMIS) and Total Offender Management (TOM) it was determined that of the 33 women in the ADT program 1 was high risk, 9 were moderate, 20 were medium, and 1 was low. This data shows that over 90 percent of the women in their program meet the CPC requirement.

Offender Assessment Areas in Need of Improvement and Recommendations

Although ADT has a screening committee to determine acceptance, there is no exclusionary criteria explicitly documented. Often times denial criteria is based on an "unacceptable level of risk for future criminal activity" which is ambitious and subjective. Research suggests that programs such as ADT should accept residents with an elevated WRNA score.

- **Recommendation:** ADT should have set exclusionary criteria (e.g., some relevant clinical, demographic, legal criteria). The facility/program administration should have a set and documented exclusionary criteria, and once set, they should be written and followed by staff. Possible exclusionary criteria that should be examined include ASAM Level, risk to recidivate score (low), and any other criteria that would exclude an individual from entering the program. Although it is acknowledged that they exclude participants who do not meet the minimum of ASAM Level 3.5 level of care there are other criteria that should be written into the exclusionary criteria.

TREATMENT CHARACTERISTICS

The Treatment Characteristics domain of the CPC examines whether the facility targets criminogenic behavior, the types of treatment (or interventions) used to target these behaviors, specific intervention procedures, the use of positive reinforcement and punishment, the methods used to train participants in new prosocial thinking and skills, and the provision and quality of aftercare services. Other important elements of effective intervention include matching the participant's risk, needs, and personal characteristics with appropriate programs, intensity, and staff. Finally, the use of relapse prevention strategies designed to assist the participant in anticipating and coping with problem situations is considered.

Treatment Characteristics Strengths

To reduce the likelihood that women will recidivate, characteristics associated with recidivism (criminogenic needs) must be targeted. ADT offers services that target needs in numerous areas, including peers, attitudes, substance use, the lifestyle of substance users, criminal attitudes, emotional regulation, coping skills, leisure time, empathy, victim impact, decision making skills, mental health, trauma, anger management, and impulsivity. Overall, the facility is targeting at least 50 percent of their treatment efforts on criminogenic need areas.

Treatment planning is a key part of the change process. On the first one to one session with their clinician, the LAC assigned to the participant is responsible for creating and managing the case plan. They establish approximately three to four goals from the WRNA, and other assessment/screening instruments, as applicable (e.g., ACES, SOGGS). Next, three to six objectives are developed to effectively meet the goals within the 90 days stay. Additionally, the participant is asked what they want to learn and if they have already taken a recommended group, if it would be useful to attend again. Prior to finalization, the plan is reviewed with the participant, and they sign off demonstrating their agreement with the requirements. LAC staff routinely

document progress and completion of the goals and objectives during their weekly individual meetings with the participant.

ADT is developing case plans based on the WRNA. The LAC creates a case plan for the 90 days the participant will be in ADT, but the participant typically comes with a transition plan that has been approved by the supervising officer in the community. These time-based logistics make it difficult for the facility to work with participants on an individual needs basis in that there is the set length of stay and upon successful completion, they move onto the next step in their plan be it a prerelease, sober living, or back to a community. The next placement has an expectation that the bed date will work as established prior to beginning treatment at ADT. The minimum length of 90 days that a participant will be in the ADT program does meet the minimum, research-driven standard.

Every participant on the ADT floor is in some form of treatment to include both groups and one-to-one sessions with an LAC. It is only for an extreme circumstance that they would leave the treatment floor (e.g., funeral or emergency medical need) and if they do, they are always escorted and monitored by staff.

The CPC requires that while incarcerated, participants spend at least 40 percent of their time per week in structured tasks (i.e., 35 hours). Participants at ADT exceed this minimum as they are busy during the day Monday through Friday engaged in various therapeutic activities, with approximately 1 to 2 hours of free time each day. While there is more flexibility on the weekends, there are structured activities of which the participants are expected to attend that are always supervised by a staff.

As indicated in the development of the case plans, the WRNA is used to drive the specific programmatic groups in which participants are assigned. Not all participants engage in every program curricula offered. Further, because the program is so small, if there are specific needs an individual has, the LAC assigned will work to provide supplemental assignments or focus the one-to- one session on areas that are not covered in groups.

Staff at ADT are being matched to the specific services they deliver both in terms of training in the curricula as well as skill set and preference. For example, licensed clinical staff facilitate the SUD groups and individual one-to-one sessions. Because MRT is a curricula in which you must be trained by the publisher, only the qualified staff facilitate this program. Further ADT uses the WRNA, and other screening assessments as appropriate, to match the participant with the most appropriate LAC. For instance, there is only one LAC who is also a candidate for licensure in an LCPC capacity and for this reason, the participants who have more pronounced mental health needs are matched with this staff member.

ADT gives participants multiple opportunities to provide input and demonstrate the value placed on such by adapting some program modifications. The current process is to submit a request slip indicating the participants suggested updates or changes that is then brought to the staff meeting to vet. If approved, the change is implemented. This is a process shift from verbally suggesting ideas in the morning meetings, which then became a ‘complain session.’ A second option is to offer candid feedback after a group session. The facilitators formally request feedback

anonymously or verbally when asked. Notably, the program has changed their process. An example is during their exercise time, participants requested to use both the north and south dining areas and alter the times in which they are offered. A few other examples are the incentives for phase advancement, extra phone calls on holidays, and getting to use crafty gel pens.

The facility has developed a range of rewards—verbal praise, the positive incident report (PIR) which can be exchanged for a tangible item, and both privileges and prizes for phase advancement. For example, orientation phase is the most restrictive with regards to where participants may be and for how long. From Phase 1 to Phase 2 maintain three phone calls from orientation and receive an extra, fourth call, plus additional free time, optional movie night, obtain one additional PIR prize and engage in a monthly phase up celebration. Phase 3 includes everything from Phase 2 as well as an additional optional movie night with other Phase 3 residents, and weekly they may obtain two additional prizes from the PIR box.

Leadership at ADT has made a significant effort to improve the ratio of the use of reinforcers compared to punishers. There was initial resistance in the significant increase of the application of reinforcers but after training, presenting research and exercising the application, there was buy in due to the observable increase in moral and positive behaviors from participants and the formal disciplinary process utilized less often. Specifically, from January to May, there were 99 writeups with 45 participants compared to 1,392 documented rewards applied. ADT is to be commended to reaching the goal of using reinforcers to punishers in a 4:1 ratio, and as a result, have seen improvement in resident's mood and behavior especially during a difficult time of combined ASRC and ADT participants.

ADT has developed some appropriate punishments, ranging from verbal warnings, room restrictions, to incident reports, and the formal disciplinary process that involves MDOC staff decisions. Between the time of the behavior and the disciplinary hearing, the participant is referred to their assigned LAC who will do worksheets, behavior chains, and cost/benefit analyses on the specific behavior in which they have been sanctioned.

Because the participants are not allowed to facilitate groups, and ADT staff is always present from start to finish, the program is adhering to the research suggesting the need for consistent monitoring. Additionally, the number of participants in the groups also falls within the most effective size. The program has made appropriate efforts to ensure group sizes did not get too small during the pandemic which would diminish the value that is gleaned from the interactions and feedback among participants.

The discharge planning begins at the beginning of the program. When a participant is screened and approved for treatment at ADT, typically they come with the location in which they will discharge already determined. This assists in the ability for the case manager assigned to the participant make appropriate referrals for continuity of care. Areas in which referrals are typically made include target areas of case plan not yet met, medication needs, ongoing substance use treatment after care, or care for treating mental health issues. All this information is summarized in the discharge summary of the progress/summary report (PSR) provided to MDOC.

Treatment Characteristics Areas in Need of Improvement and Recommendations

To further reduce the likelihood that participants will recidivate, the ratio of criminogenic needs targeted to non-criminogenic needs should at least be 80 percent criminogenic. As mentioned above, although the program targets a number of criminogenic needs, it also targets a number of non-criminogenic needs. To name a few: life skills, self-care, housing, parenting/ motherhood, healthy sexuality, grief, and loss, trauma, meditation, recreation, empathy, victim impact, mental health. As a result, the ratio of criminogenic to non-criminogenic needs is 22 to 14. As such, while the amount of services and interventions provided in ADT surpasses the 50 percent ratio of criminogenic to non-criminogenic needs, the amount of time does not meet the 80 percent ratio. The emphasis of programming should greatly favor criminogenic needs as these are most likely to reduce recidivism.

- **Recommendation:** To increase the emphasis on criminogenic targets, ADT staff should enhance the topics in the group and individual sessions to focus on the already identified core criminogenic needs and reduce the time spent on non-criminogenic needs. Skills group should be run regularly and as designed and residents should be practicing prosocial skills during these groups. The ancillary groups could be refocused to target the top tier of criminogenic need areas (i.e., attitudes, values, and beliefs; peer associations; and personality characteristics like impulsivity and coping skills) through a core curriculum like Thinking for a Change (T4C). Finally, residents who require intensive treatment should be provided advanced practice opportunities throughout their length of stay. These advanced practice opportunities should focus on high-risk situations that residents may face in the community when they are released.

The most effective programs are based on behavioral, CBT, and social learning theories and models. ADT staff reported using CBT and social learning. At the time of the assessment, the primary modality of treatment was observed to be a combination of psychoeducational, and process, with limited CBT or social learning. In addition to what was reported and available in the manuals, the assessors observed multiple group sessions where the primary treatment approach was unclear and/or did not follow the curriculum the facility has adopted. To illustrate some of the concerns with the current treatment, we offer the following observations:

1. Groups did not take advantage of the full time to provide quality programming to the residents.
2. There were no role models utilized and thus no role plays utilized to practice skill development. In fact, there is an expectation that residents will only participate in one role play throughout the entire course of the program.

To ensure that effective interventions are being used throughout all ADT components, an overarching evidenced-based intervention modality should be adopted, and all group and individual sessions should be consistent with the program model. Modalities such as cognitive-behavioral or structured social learning have been shown to be effective at reducing recidivism among offenders involved in the justice system. ADT should make enhancements to include regular cognitive restructuring and structured skill-building throughout a resident's length of stay. We offer several recommendations to help ensure a coherent treatment approach is used throughout all of the services delivered.

- **Recommendation:** The evidence-based curricula that are already in use should adhere to the structure in which it should be delivered, and staff should be provided feedback and coached to enhance their fidelity to service delivery. Groups should run the entire length of time that it is scheduled.

- **Recommendation:** There is a strong foundation for effective CBT and social learning to occur, however there needs to be more consistent ties to the ways in which these thoughts and behaviors will impact their futures.

- **Recommendation:** Current curricula could be supplemented to ensure that CBT and social learning is included. This would require developing CBT activities to supplement the curriculum where they are not already included. For example, sessions that deal with motivation for change could include teaching, practicing, and the application of a cost-benefit analysis. Sessions that explore how thinking drives behavior can include teaching, practicing, and applying the ABC model. Sessions that deal with triggers and coping skills can include specific social skills from the core correctional practices list. By the end of active treatment, residents should have mapped out their high-risk situations and developed new thinking and new coping skills. This is referred to as a success plan or relapse prevention planning. As part of the phase progression, residents are expected to demonstrate that new thinking and behavior in group, on the unit, and in individual sessions.

The staff at the ADT program have ensured that information that staff need (e.g., mission and vision, assessment, scheduling, case planning, behavior management, phase advancement, and some treatment interventions) is accessible. Furthermore, these policies are routinely followed. However, as noted above, treatment curricula are not followed. Additionally, there are no clear expectations about how the LACs should conduct their individual sessions with the resident to which they are assigned. Overall, staff have leeway in what they do in group, especially the SUD group, (e.g., staff can pick which parts they want to use and supplement with any activities you want).

- **Recommendation:** All individual and group sessions should be manualized to ensure consistency in delivery. For the individual sessions, this should include expectations for the length of sessions, topics of sessions, approved teaching techniques, and homework activities. Once all components are manualized, staff should be monitored for their adherence to the manuals (i.e., policy and procedure, curriculum, and manualized interventions).

Although there are not a substantial number of low-risk residents in ADT, the few low-risk residents are in services with others who are at medium- to high-risk to recidivate. Effective correctional programs inform service delivery using the risk, need, and responsivity levels of the resident. For example, effective programs are structured so that lower-risk residents have limited exposure to their higher-risk counterparts. Research has shown that mixing low-risk residents with medium- to high- risk residents can increase their risk of recidivism. Low-risk residents may be negatively influenced by the behavior and criminal thinking of high-risk residents, thereby

increasing their risk of recidivism. The structure of ADT is difficult to obtain this objective while still accepting low-risk residents.

- **Recommendation:** By using formal risk assessments, ADT should give preference to medium- and high-risk residents. When low-risk offenders are accepted into the facility, they should be provided separate housing areas and separate treatment groups. They should not be mixed with medium to high-risk residents. If ADT continues to accept low-risk residents, they should provide individual sessions for these residents if the number of low-risk participants is too small to warrant separate groups.

ADT should also vary the dosage (i.e., the number of hours of services) and duration of services according to the resident's risk level. We know that people who are at higher risk for recidivism by definition have more criminogenic needs, and these residents should be required to attend additional services, informed by the needs identified on the risk and need assessment tools. Types of services that can count toward dosage include interventions targeting a criminogenic need area using an evidence-based approach. Based on the treatment groups observed, very little of the current hours of services would currently count toward dosage. To demonstrate, groups do not use CBT/follow the manualized curricula, groups end early, every resident who shows up at some point receives an attendance certificate no matter how much they learned or participated. In the current treatment structure (i.e., SUDS group four times a week, Seeking Safety and DBT once and both offered at the same time, MRT twice, and individual sessions with LAC staff), this equates to a maximum of 9.5-12 hours per week for dosage that could take place.

- **Recommendation:** Overall, the research indicates that residents who, based on the WRNA, are at medium risk to reoffend need approximately 100 to 150 hours of evidence-based services to reduce their risk of recidivating, and moderate-risk residents need over 200 hours of services to reduce their risk of recidivating. High-risk may need 300 hours of evidence-based services. Only individual sessions, case management sessions, and groups targeting criminogenic need areas (e.g., antisocial attitudes, values, and beliefs, antisocial peers, anger, self-control, substance abuse) using an evidence-based approach (i.e., cognitive, behavioral, cognitive-behavioral, or social learning) can count toward the dosage hours. As stated above, the facility can proactively plan for different treatment dosages based on risk level to ensure that service intensity varies upon risk and need levels. To illustrate, **Track A** could be reserved for those who are low risk. The women in Track A would have less requirements for treatment services, and ADT should ensure that these residents receive as little services as possible while still addressing key need behaviors (e.g., if the youth is high need for substance abuse treatment). The overall hours and the time spent in ADT should ideally be shorter for these individuals as well. **Track B** could then be reserved for moderate-risk residents. ADT would then design this track to provide group and individual sessions at ADT for approximately 6 months and aim to deliver between 100 to 150 hours. Finally, **Track C** could be reserved for high-risk residents. These individuals would receive the highest intensity and length of services—over 200 hours and over the course of 9 months. ADT should work with the MDOC central office to develop these parameters and educate stakeholders about the new processes if contract parameters provide for these adjustments.

As noted in the strengths section above, ADT has identified good rewards. They are also being applied consistently, as a result of a prosocial behavior. Reinforcement is most effective when the reinforcer occurs immediately following the desired behavior, when that behavior is clearly linked with the reinforcer and there is an explanation as to how the prosocial behavior will positively impact their life in the future. While staff do immediately point out desired behavior, they do not link the behavior and the reinforcer. Finally, the research is also clear that rewards need to outweigh negative consequences (i.e., punishments) by a ratio of 4:1.

In addition to appropriate rewards, a good behavior management system has a wide range of negative consequences or punishments available to promote behavioral change. At the time of the assessment, ADT had established a range of punishments (see above in strengths). However, there was a lack of consistency and clarity in meting out punishment for specific behaviors. Outside of treatment hours, is physically impossible for the one security staff to observe and intervene in antisocial behaviors. Of note is that most punishments available to staff focus on compliance and control, and do not focus on long-term behavioral change. ADT is dependent on the disciplinary hearings process through MDOC making it very difficult to implement these steps effectively. Staff are also not trained on how to properly administer effective negative consequences. For example, there is no formal policy concerning negative effects that may occur after the use of punishment. Policy and training should alert staff to issues beyond emotional reactions such as aggression toward punishment, future use of punishment, and response substitution.

The CPC recommendations regarding a behavior modification system are designed to help the facility fully use a cognitive-behavioral model.

- **Recommendation:** Reinforcers should be monitored to ensure they are being consistently applied (e.g., PIR), administered as close in time to the desired behavior as possible, and that staff link the reward to the desired behavior. All staff, regardless of their role, should administer rewards as appropriate.

- **Recommendation:** For negative consequences or punishments to achieve maximum effectiveness, the following criteria should be observed : 1) escape from the consequence should be impossible; 2) applied at only the intensity required to stop the desired behavior; 3) the consequence should be administered at the earliest point in the deviant response; 4) it should be administered immediately and after every occurrence of the deviant response; 5) alternative prosocial behaviors should be provided and practiced after punishment is administered; and 6) there should be variation in the consequences used (when possible).

- **Recommendation:** All staff should be trained in the behavior management system and be monitored to ensure they are using the system consistently and accurately. This training should include the core correctional practices of effective reinforcement, effective disapproval, and effective use of authority. Staff should understand that punishment may result in certain undesirable outcomes beyond emotional reactions and be trained to monitor and respond to these responses. Policy and training should alert staff to issues beyond emotional reactions such as aggression toward punishment, future use of punishment, and response substitution.

The facility has not yet established criteria that clearly outline the completion criteria for the treatment program and rather is based on the 90-day length of stay unless formal disciplinary action has occurred. ADT termination is currently based on mostly length in the program and as a byproduct, progress in acquiring prosocial behaviors, attitudes, and beliefs is not evaluated as part of this process and residents are not differentially discharged from the facility. There is no distinction between residents who are successful in treatment, residents who reach maximum benefit (one to date), or residents who are unsuccessful with their treatment. As a result, the successful completion rate for residents in the facility is extremely high. Because the emphasis is a successful completion so the resident can move onto the next phase of their release plan in a timely fashion, the completion rate is above the 65 percent-85 percent range required by the CPC.

- **Recommendation:** As the program continues develop its comprehensive treatment program, benchmarks should be set as to when someone can move from orientation to active treatment (e.g., when they demonstrate base knowledge about the thought–behavior link). Clear standards should also be set as to when individuals can complete their active treatment phase and can move from active treatment to aftercare. Currently, the handbook states 'all tasks/assignments in group and individual sessions must be *on track*' which is vague. ADT has moved to a phase system, which will assist in this effort of establishing criteria. When a residents advance in phases, it is important to clearly outline the reasons she has advanced. Benchmarks can include attendance and participation standards, scores on pre- and post-testing, meeting a certain percentage of objectives from their case plan, or demonstrating prosocial behaviors and attitudes. If a resident is not demonstrating change, they should not be advanced. Further, if there is not an extension of the 90-day program for these individuals, they should not be considered successful completers.

- **Recommendation:** Once ADT delineates completion status, it should monitor its successful completion rate, which should range between 65 percent and 85 percent, indicating that residents do not indiscriminately complete or get terminated from the program.

If correctional programming hopes to increase participant engagement in prosocial behavior, participants must be taught skills in how to do so. At the time of the site visit, very little of the group and individual services incorporated cognitive restructuring or structured skill building (i.e., skill modeling, participant practice, graduated practice, and constructive feedback). These should be a consistent practice in ADT and used in one-to-one LAC sessions, group treatment sessions, and unit-based skills groups.

- **Recommendation:** Residents should be taught to restructure their antisocial or unhelpful thinking to help them make prosocial decisions. Specifically, they should be taught how to identify, challenge, and replace their unhelpful thinking across program targets. Various tools exist to help achieve this, including *rules tools, thinking reports, cost–benefit analysis, and behavior chains*. All staff should incorporate cognitive-restructuring techniques in their discussions/meetings/sessions/groups even if the curricula do not already call for them. Furthermore, added techniques should be documented in the program/facilitator manuals to ensure consistency between staff and groups offered at ADT.

- **Recommendation:** Structured skill building should be routinely incorporated across the service elements. Staff should be trained to follow the basic approach to teaching skills, which includes 1) defining skills to be learned; 2) obtaining resident buy-in as to the importance of the skill; 3) staff teaching the steps of the skill; 4) staff modeling the skill for the ladies; 5) residents rehearsal of the skill (role-playing); 6) staff providing constructive feedback to residents on their use of the skill; and 7) generalizing the skill to other situations (e.g., homework or advanced role plays). Following this, residents should practice the skill in increasingly difficult situations, which forms their graduated skills practice. The identification of high-risk situations and subsequent skill training to avoid or manage such situations should be a routine part of programming. All staff members should use these steps consistently and provide constructive feedback to the residents.

Research demonstrates that aftercare is an important component of effective programs in order to help clients maintain long-term behavior change. The ADT program does not currently have an aftercare component for all clients. While some do go to pre-release, or acquire other outpatient services, others do not.

- **Recommendation:** All residents should be required to attend a formal aftercare period in which continued treatment and/or supervision is provided. High quality aftercare includes planning that begins during the treatment phase, reassessment of offender risk and needs, requirement of attendance, evidence-based treatment groups or individual sessions, and duration and intensity is based on risk level. Since some individuals remain in the facility and others leave, the program should determine different protocols for each population concerning what aftercare should look like.

QUALITY ASSURANCE

This CPC domain examines the quality assurance and evaluation processes that are used to monitor how well the program is functioning. Specifically, this section examines how the staff ensure the program is meeting its goals.

Quality Assurance Strengths

ADT has a mechanism to provide resident feedback on their progress in the program. The program director consistently monitors groups and the staff delivering these services. Further, there is a file review process in place to ensure that all necessary forms, assessments and documentation is in the client's files.

ADT has a formal process to collect client satisfaction within the program. ADT collects surveys from program participants prior to their release, after they have completed a class, and after their completion of the program. This information is completed in writing. ADT then uses this information to see if any areas identified as criminogenic needs decreased or increased. ADT utilizes this information to see if there are continuous problems with service delivery and/or the curriculum. Programs that collect formal client feedback on service delivery have better programmatic outcomes than programs who lack this process.

ADT licensed staff meet with residents on a weekly basis and monitor their progress in a detailed treatment plan. Modifications, changes and updates are regularly made to this plan, and it is updated in the TOM system.

Quality Assurance Areas in Need of Improvement and Recommendations

The program does not track recidivism of its participants after completion of the program. While the program had data dated from 2014-2017 it does not meet the CPC criteria. Additionally, the program has not undergone a formal evaluation comparing its treatment outcomes (recidivism) with a risk-control comparison group. Finally, the program does not work with an internal or external evaluator that can provide regular assistance with research/evaluation.

- **Recommendation:** Recidivism—in the form of re-arrest, re-conviction, or re-incarceration—should be tracked at 6 months or more after release from prison. ADT should develop a process to collect post release recidivism data for offenders that have completed the program. When possible, this information could be provided with the assistance of MDOC or other law enforcement agencies. Staff should all understand where this data comes from and use it to help evaluate program effectiveness.

- **Recommendation:** In relation to the formal evaluation, a comparison study between the program's outcome and a risk-controlled comparison group should be conducted and include an introduction, methods, results, and discussion section. This study should be kept on file.

- **Recommendation:** ADT could partner with a local college or university who is available to analyze available data for research purposes to limit the cost. While conversations could center on having a faculty member responsible for this task, part of the conversation should relate to the possibility of using undergraduate or graduate interns to assist with data collection activities (at no cost to ADT) so that fiscal remuneration is limited to payment for analysis and reporting. Another option is to determine whether there is a possible research project that would meet the requirements for a student's master's thesis or dissertation (in order to provide another no-cost/low-cost option for evaluation).

OVERALL PROGRAM RATING AND CONCLUSION

As mentioned previously, the CPC standards represent an ideal program. No program will ever score 100% on the CPC. Based on the assessments conducted to date, programs typically score in the Low and Moderate Adherence to EBP categories. Overall, 7% of the programs assessed have been classified as having Very High Adherence to EBP, 17% as having High Adherence to EBP, 31% as having Moderate Adherence to EBP, and 45% as having Low Adherence to EBP. Research conducted by UCCI indicates that programs that score in the Very High and High Adherence categories look like programs that are able to reduce recidivism.

ADT received an overall score of 64.5 percent on the CPC. This falls into the High Adherence to EBP category. In the capacity domain, ADT scored a 78.1 percentage, the Very High Adherence.

In the Content domain, ADT scored a 54.5 percentage which is in the Moderate Adherence to EBP category.

ADT staff should commend themselves for the work they have done to date to make treatment a facility focus. Furthermore, recent changes to the program have increased the score both in certain domains and overall. It is often difficult to make changes to existing programs.

Certainly, care should be taken not to attempt to address all recommendations at once. Facilities that find the assessment process most useful are those that prioritize need areas and develop action plans to systemically address them. Should ADT want assistance with action planning or technical assistance, MDOC or UCCI can provide or recommend others to help in these endeavors. Evaluators note that ADT staff are open and willing to take steps toward increasing the use of EBP within the facility. This motivation will no doubt help ADT to maintain alignment with effective correctional programming while making further modifications to improve services.

Figure 1: ADT CPC Scores

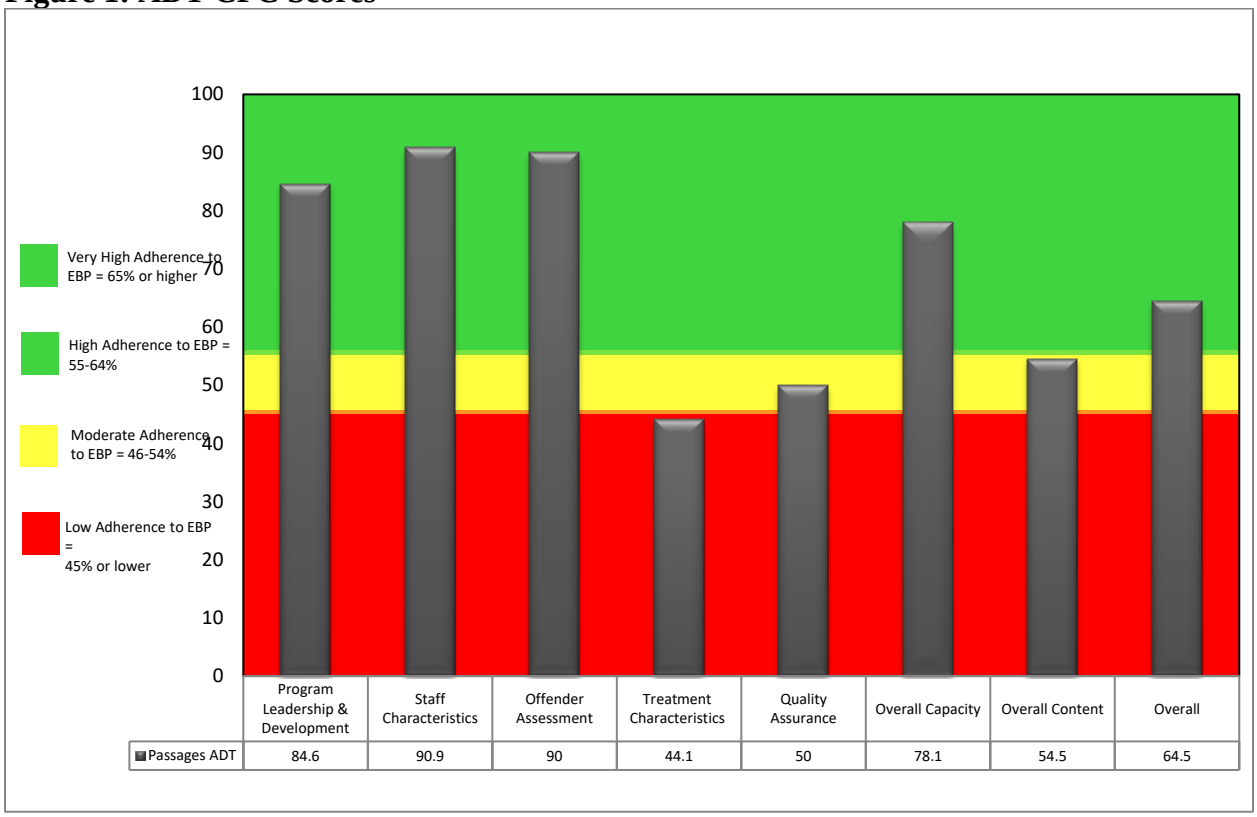
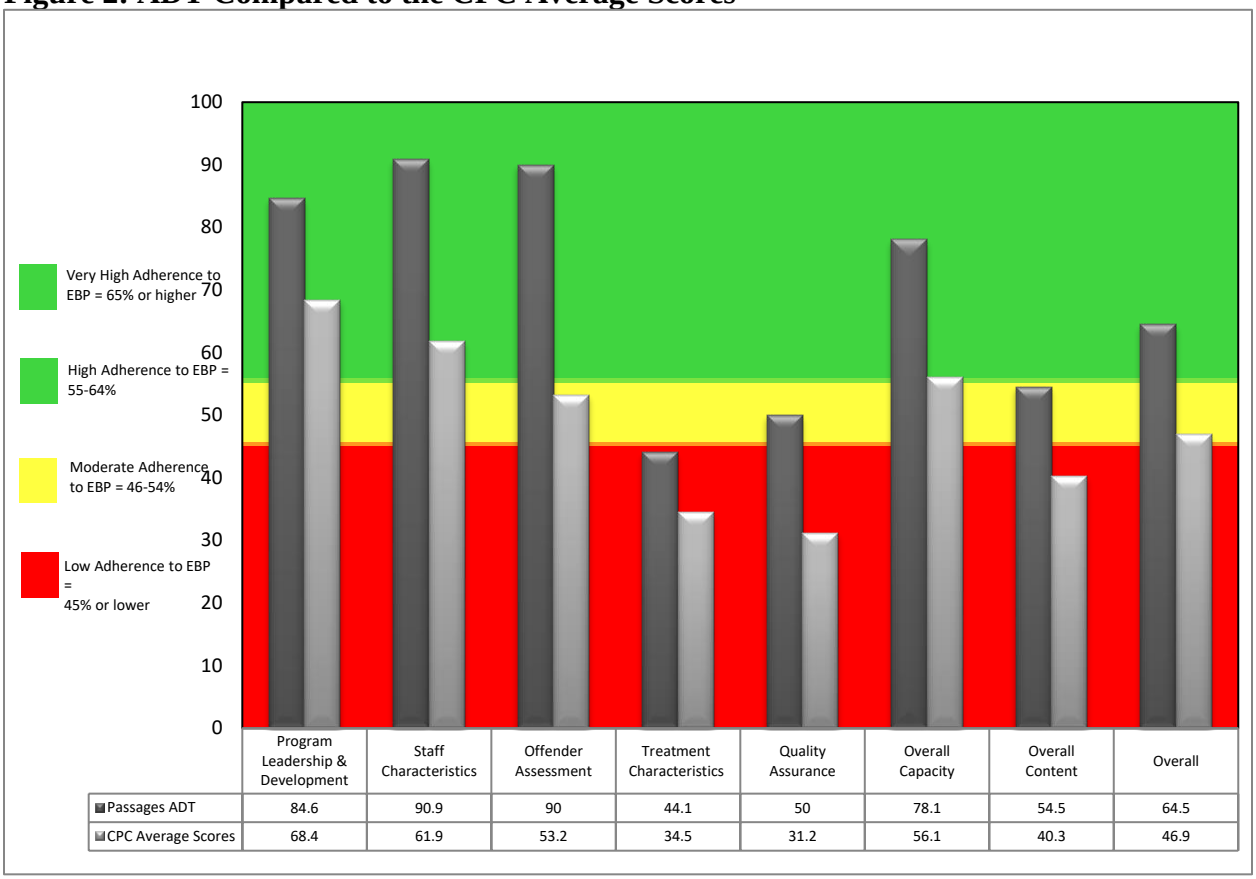


Figure 2: ADT Compared to the CPC Average Scores*



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
Passages ADT	84.6	90.9	90	44.1	50	78.1	54.5	64.5
CPC Average Scores	68.4	61.9	53.2	34.5	31.2	56.1	40.3	46.9

**CPC average scores are based on 607 assessments performed between 2005 and 2019.*

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

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

[iii] A large component of this research involved the identification of program characteristics that were correlated with recidivism outcomes. References include:

1. Lowenkamp, C. T., & Latessa, E. J. (2002). Evaluation of Ohio's community-based correctional facilities and halfway house programs: Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice.
2. Lowenkamp, C. T., & Latessa, E. J. (2005a). Evaluation of Ohio's CCA funded programs. Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice.
3. Lowenkamp, C. T., & Latessa, E. J. (2005b). Evaluation of Ohio's RECLAIM funded programs, community corrections facilities, and DYS facilities. Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, Division of Criminal Justice.
4. Latessa, E., Lovins, L. B., & Smith, P. (2010). Follow-up evaluation of Ohio's community-based correctional facility and halfway house programs—Outcome study. Final report. Cincinnati, OH: University of Cincinnati, Center for Criminal Justice Research, School of Criminal Justice.

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

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

[vi] Programs we have assessed include: male and female programs; adult and juvenile programs; prison-based, jail-based, community-based, and school-based programs; residential and outpatient programs; programs that serve prisoners, parolees, probationers, and diversion cases; programs that are based in specialized settings such as boot camps, work release programs, case management programs, day reporting centers, group homes, halfway houses, therapeutic communities, intensive supervision units, and community-based correctional facilities; and specialized offender/delinquent populations such as sex offenders, substance abusers, drunk drivers, and domestic violence offenders.