FINAL REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC)

Passages Pre-Release Center

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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) completed an assessment of the Passages Pre-Release Center (PPRC) program 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 consider 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 several 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

Passages Pre-Release Center, located in Billings, Montana, is a 74-bed program that serves adult female residents who have committed felony offenses. The PPRC is housed in a secure wing of a formal hotel and began providing services in its current location and capacity in January 2007. 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 an Alcohol and Drug Treatment program (ADT). Populations between these three programs are kept separate at all times.

PPRC helps residents reintegrate into the community while learning necessary life skills to maintain a crime free lifestyle. Although their primary focus is on substance use, they also provide Moral Recognition Therapy (MRT), and co-occurring mental health and substance abuse programming. Referrals to this program come from the MDOC's Probation and Parole, the Montana Women's Prison (MWP), Federal Bureau of Prisons as well as their ASRC and ADT programs.

The assessment using the CPC took place on August 9th through 11th, 2022. The assessment process consisted of a series of structured interviews with the overall director of Passages, program director, clinical staff, security staff, case management staff, and several program residents.

For the purposes of this assessment, Karli Morris was identified as the Program Director as she oversees the program 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 20 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, four groups facilitated by both clinical and other direct service delivery staff were observed. These groups include Cognitive Behavioral Interventions for Substance Abuse (CBI-SA), Aftercare: Living in Balance, Aftercare: Matrix, and Moral Recognition Therapy (MRT) group. 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. As noted above, the Treatment Services Director, Karli Morris serves as program director for the purpose of the CPC.

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

The program director, Ms. Karli Morris, possesses a bachelor's degree in criminal justice. Although she is new to position, she has four years of correctional experience and has worked three years as a case manager. In addition to her providing direct supervision to service delivery staff, Karli Morris regularly carries a small caseload of residents ranging from eight to ten females.

Effective programs are based on the literature related to effective interventions. The program regularly conducts a literature review consisting of materials focusing on criminological and psychological journals. All literature is distributed to staff with easy access providing everyone with the ability to locate electronically and discussed in staffing.

PPRC regularly conducts pilots of new interventions before they are fully implemented in the program. For example, PPRC is currently piloting two groups within the program. The formal pilot period last for several months before officially being implemented with start and end dates. The formal pilot periods also utilize resident surveys when making determinations.

The facility has the support of the criminal justice community. Stakeholders include probation and parole, Montana Department of Corrections, local law enforcement and judges. Overall, their support for the program was rated as positive. The staff at the program also provide positive ratings when asked about support from the community-at-large. Community stake holders include local employers, landlords, a local college, outside community agencies and community clinics. While volunteers are welcomed into the facility, volunteer involvement has been temporarily paused due to the pandemic.

The facility is established and stable as it has been providing treatment services since 2007 in its current location. Furthermore, funding for the program has been stable in the recent past. The program has not experienced significant budget cuts in the last two years.

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

The research on program effectiveness asserts that program directors are more effective if they are directly involved in matters related to staffing. Consequently, the CPC recommends that program directors be involved in hiring, training, and all supervising staff who provide services to those served by the program. While the program director participates in the interview process and has the final say on the hiring for case management staff, there was no evidence of involvement in other delivery service staff hires. As discussed above, the program director is involved in supervising delivery staff; however, there was no evidence that she provides formal training for all new direct service staff. At the time of the assessment, Karli Morris was not involved in shadowing with all new delivery service staff, observing new staff offering feedback in day-to-day operations or involved in hiring all of the delivery service staff. Most of the service delivery staff training relied on other experienced staff.

- ***Recommendation:*** The program director should be involved in hiring direct service staff. This includes determining which candidates to interview. The program director should also be included in the interview process and decision-making process of choosing staff in service delivery positions.

- ***Recommendation:*** The program director should personally conduct formal training to direct service delivery staff. The director should have a clear role in providing some training to all new service staff delivering services/interventions (e.g., any staff targeting criminogenic need areas, individuals, treatment planning).

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 providers who conduct groups or provide direct services to the clients in this 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 they were assessed in the previous domain.

Staff Characteristics Strengths

The program currently meets the CPC criterion for staff educational and experience. The criterion indicates that 70% of direct service delivery staff have at least an associate's degree in a helping profession. At the time of the assessment, PPRC staff exceeded this recommendation. In fact, 100% (11 of 11) of PPRC staff met the CPC indicator for education and 100 % (11 of 11) of direct service delivery staff at PPRC had a bachelor's degree.

The CPC recommends that 75% or more of direct service delivery staff have worked with criminal/juvenile justice populations for at least 2 years. At the time of the assessment, PPRC staff exceeded this target with 81% (9 out of 11) of direct service delivery staff had at least 2 years of experience working with criminal/juvenile justice populations. It is commendable that both the staff educational requirements and experience requirements are exceeded at PPRC.

When hiring, it appears that staff are selected based on certain skills and criteria beyond solely education or experience. The assessment found that PPRC staff are selected based on factors such as empathy, a belief that offenders can change, an openness to learn, and accountability.

Programs where all staff meet at least twice a month to discuss all cases demonstrate better outcomes than programs that lack this feature. Currently, PPRC professional staff meet three times per month on Wednesdays for approximately 2.5 hours. These staff meetings include case review for clients, trainings, discussions of research articles, and "6-minute trainings."

PPRC direct service delivery staff are formally assessed annually with a performance evaluation. These evaluations include a formal interview, a self-rating, and a supervisor rating. Their performance is assessed based on their effective use of authority and their direct service delivery skills (e.g., modeling skills, redirection techniques, behavioral reinforcements, etc.).

Programs where clinical supervision is provided to professional staff at least once a month by a licensed clinical supervisor shows a reduction in recidivism. Formal clinical supervision by a licensed clinical supervisor is provided to all direct service delivery staff at PPRC. As indicated by the professional staff at PPRC, a supervisor regularly observes groups and individual sessions with those direct service providers on a monthly basis.

At the time of the site visit, the PPRC has a training process in place that requires all staff to receive training on the treatment model and interventions before delivering the service. Additionally, each new staff member has one week of training conducted by HR, followed by a six-month training checklist. During this time, staff are assigned a mentor to assist with on-the-job shadowing.

Programs that have a formal mechanism in place for which staff are able to provide input into how the program runs, demonstrate better outcomes than programs that lack this feature. The totality of the site visit indicated that staff feel comfortable offering input into the program. Staff have informal opportunities to provide feedback such as sending an email to their immediate supervisor or offering suggestions during weekly staff meetings. An example of a program change based on employee suggestions was cutting down a resident's barriers to obtaining a cell phone. In addition, staff are supportive of the offenders at PPRC. Staff expressed support for the offender's rehabilitation throughout the site visit.

Staff Characteristics Areas in Need of Improvement and Recommendations

At the time of the site visit, PPRC training records were provided for review. Based on the training records, PPRC staff are earning less than 30 hours of training per year. The CPC criterion for on-going training recommends that programs receive 40 hours a year of on-going training related to evidence-based practices. The CPC recommends a minimum of 40 hours of formal training directly relevant to program and service delivery.

- ***Recommendation:*** All staff should receive at least 40 hours of on-going training each year. The majority of these hours should be directly related to delivering services and 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.

OFFENDER ASSESSMENT

The extent to which offenders 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 factors for each resident and provide services and interventions accordingly. The Offender Assessment domain examines three specific areas: 1) selection of program residents, 2) the assessment of risk, need, and personal characteristics, and (3) the manner in which these characteristics are assessed.

Offender Assessment Strengths

The majority of the residents in the PPRC were appropriate for the services offered. Staff indicated, however, that between 2- 10% of the residents may not be well suited for the program due to medical or mental health issues. The facility should continue to monitor these concerns and ensure that it does not exceed the 20% limit outlined in the CPC. If the percentage of inappropriate residents surpasses the 20% threshold, the staff should communicate those concerns to the referral source.

Standardized risk and need assessments are a cornerstone of effective service delivery. Risk assessment tools are a crucial piece of evidence-based correctional programming as these scores assist in determining suitability for services, and the duration and intensity of treatment services, based on risk level. Need assessment tools are also crucial as they identify the criminogenic needs of the individual. Treatment should be individualized to target the most severe criminogenic needs of each resident. All residents at PPRC have a risk and needs assessment at placement in the center. PPRC utilizes the WRNA to identify risk levels and criminogenic needs of the residents. The WRNA is a validated, standardized, and objective assessment instrument that produces a level of risk.

Responsivity assessments assist in determining residents' possible barriers to treatment (i.e., mental health concerns, trauma histories, low motivation for treatment, or learning/education barriers, to name a few). Effective correctional programs assess a minimum of two responsivity characteristics to ensure that individual-level factors that can interfere with interventions are addressed. The PPRC staff currently conduct responsivity assessments such as the Women's Risk Needs Assessment for trauma responsivity needs, housing and mental health, the General Anxiety Disorder-7 (GAD-7) for anxiety, and the Patient Health Qeustionnaire-9 (PHQ-9) for depression. These tools are validated, standardized, and objective instruments. The responsivity assessments chosen are relevant to the services offered by the program. For example, the PPRC utilizes a system in which residents are referred to a case manager for the duration of stay based on responsivity specific areas. The program utilizes case managers who specialize in supporting specific case load needs.

The program provides an environment where the majority of their residents are classified as moderate to high risk. Specifically, more than 70% of resident at PPRC are either categorized as being moderate or high risk of recidivating. This was verified through electronic records gathered from the Offender Management Information System (OMIS).

Offender Assessment Areas in Need of Improvement and Recommendations

While the program has some exclusionary criteria for certain types of participants, such as severe mentally illness and disqualifying medical conditions, these criteria are not explicitly documented. PPRC recognizes the Montana DOC's recommendations on programming placement, but do not have their own exclusionary criteria. Furthermore, those recommendations are not always followed as evident by the facility providing services to low-risk offenders.

- ***Recommendation:*** PPRC should have set exclusionary criteria (e.g., some relevant clinical, demographic, legal criteria) to ensure that program residents are appropriate for the services offered. The facility administration should work with the department's central office to set these criteria and once set, they should be written and followed by staff. Possible exclusionary criteria that should be examined include level of addiction, mental health, and risk to recidivate.

PPRC serves specialized populations, including substance abuse and domestic violence offenders. Beyond the WRNA, however, tools used to assess these domain specific needs were not regularly found in client files during the file review. That is, no tools designed to objectively assess key issues such as substance abuse, addiction, or domestic violence are used to decide placement into groups or duration of treatment.

- ***Recommendation:*** In addition to the WRNA, the program should utilize a validated, standardized needs assessments to determine placement in and duration of treatment services for substance abuse and domestic violence offenders. Examples of these include ASI for substance abuse, PCL-R/V-RAG for domestic violence, or the URICA for motivation.

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 residents in new prosocial thinking and skills, and the provision and quality of aftercare services. Other important elements of effective intervention include matching the resident's risk, needs, and personal characteristics with appropriate programs, intensity, and staff. Finally, the use of relapse prevention strategies designed to assist the resident in anticipating and coping with problem situations is considered.

Treatment Characteristics Strengths

To reduce the likelihood that residents will recidivate, characteristics associated with recidivism (criminogenic needs) must be targeted. The program offers services that target criminogenic needs in several areas, including attitudes, education, employment, substance abuse, peers, communication skills, decision making skills, impulsivity, goal setting, and transition planning. Overall, PPRC is targeting at least 50 percent of their treatment efforts on criminogenic need areas.

PPRC is utilizing some evidence-based interventions and their primary treatment model utilized is cognitive behavioral therapy (CBT). Staff demonstrate modeling through CBI and have residents' role play their target behaviors.

Research suggests that programs should provide services between three and nine months in length and should not exceed 12 months (not including aftercare). The average length of stay at PPRC is 180 to 200 days.

The program has detailed manuals which specify all major aspects of the program. Evidence suggests that these manuals were consistently followed by staff. There is also a resident handbook that is available for residents in the Total Offender Management (TOM) system. Group manuals for CBI, Living in Balance, and MRT were available to delivery service staff for groups.

Residents spend at least 40 percent of their time per week in structured tasks. The program requires that their residents to work at least 40 hours per week. If they are in school and/or attending Intensive Outpatient (IOP) in the community, the amount of time spent is subtracted from 40 hours. Residents who are on SSDI and unable to work full-time are expected to work part-time and find other ways to proactively use their time. Structured tasks identified are the following: self-help meetings, treatment groups, house chores, IOP, and outside appointments.

All groups are facilitated and monitored by staff from beginning to end. PPRC is encouraged to continue to have staff-only facilitated groups and not have clients facilitate or co-facilitate programming. Furthermore, research indicates that groups should not exceed 8-10 clients (residents) per active facilitator. The PPRC currently meets the CPC group size criterion.

The program assigns residents to case managers based on the residents' risk level and the case managers specialty (e.g., sex offending, inmate workers, federal residents, and mental health). Facilitation of treatment groups offered by treatment staff and case managers are rotated every six months.

The program values the residents' input. They gather this information through exit interviews, staff/program evaluations, group evaluations, resident government, and grievances. It is reiterated to each resident that they can always talk to staff. PPRC has made changes based off resident feedback with treatment programing by discontinuing Moving On and offering a pilot program with CBI-Substance Abuse and Living in Balance.

PPRC has developed a range of rewards including positive incident reports, phase system, Big Sisters, resident of the month. With the positive IRs, residents are able to choose a prize after turning in four positive IRs they have received.

A good behavioral management system consists of rewarding prosocial behaviors that will sustain behavior in the long term, as well as sanctioning unwanted behaviors. At the time of assessment, PPRC had an appropriate range of punishers available to promote behavioral change in the future by showing the residents that behavior has consequences. These punishers included verbal disapproval, extra duty with chores, apology letters, incident report classification system (Class 1 Rules, Class 2 Rules, and Class 3 Rules), and ASRC Sanctions.

The successful program completion rate should be a range between 65 percent and 85 percent, indicating that clients do not indiscriminately complete the program or that too few clients progress through the program. Based on file review and interviews with staff members, the current successful completion percentage was roughly between 80 percent and 85 percent, meeting the CPC criterion.

Formal discharge plans are developed upon program completion. These plans include goals, objectives, and notes regarding specific individualized need areas. The process of developing the plan begins at intake and is reviewed during weekly case management sessions (case manager and resident). The discharge plan includes successful completion of mandatory requirements, release plan detailing housing, employment, and continuing support and goals. Once the discharge plan has been established, it is presented to the Conditional Release Screening Committee or BOPP.

Offender Assessment Areas in Need of Improvement and Recommendations

To further reduce the likelihood that residents will recidivate, the ratio of criminogenic needs targeted to non-criminogenic needs should at least be 4:1 (80 percent criminogenic). Although the program targets a number of criminogenic needs, it also targets a number of non-criminogenic needs. These include mental health, housing, trauma, self-care, and parenting. While the number of services and interventions provided at PPRC 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, PPRC staff members should enhance the topics in the treatment groups and individual sessions to focus on the already identified core criminogenic needs and reduce the time spent on non-criminogenic needs.

In developing a case plan, there should be evidence that case plans are derived from the WRNA. Case plans should be individualized for each resident. The case planning process should include identification of targets for change, goals and objectives, time frames for completion, and performance indicators.

- ***Recommendation:*** All case plans should be tailored to the resident's needs and consistently address two or three major criminogenic needs identified from the formal assessments utilized. The case plan should have a beginning date and an end date.

PPRC provides reentry and transitional services to residents that are returning into the community. While residents are in the community, it was determined that client advisors (CAs) do not regularly engage in agenda checks by phone and physical checks. Due to short staff concerns within the facility, physical agenda checks have not been an ongoing practice. It was reported that residents are able to pay for a phone app identified as "Intouch" to locate their whereabouts at all times but due to the financial obligation, this is not a reasonable request.

- ***Recommendations:*** The whereabouts of residents and peer associations should be closely monitored by staff or other means. Utilization of physical random home, work and/or school checks, random drug testing, electronic monitoring, checking of itineraries, and phone calls on a regular and frequent basis will ensure adequate monitoring of residents.

The program does not utilize the WRNA to identify risks and needs of the resident and to separate them in treatment groups. Treatment duration is not varied based on risk and need level. It is recommended that the range in dosage should be approximately 100-150 hours for moderate risk and 200+ hours for high risk. Residents that are high/moderate risk are placed into Matrix and those with mental health needs are placed in CBI. The process in which residents are assigned to different programing that is offered at PPRC is unclear.

- ***Recommendation:*** With effective programs, low risk residents are not to be placed in groups with moderate to high-risk residents. Residents that are assessed as being low risk should be offered individual sessions or placed in programing that is strictly low risk.

- ***Recommendation:*** Residents that have been assessed as being high risk and moderate risk should receive the highest intensity or duration of service that assist in reducing criminal behaviors. Methods utilized to address target behaviors criminogenic need areas should be evidence-based (e.g., cognitive behavioral).

- ***Recommendations:*** Based off assessment results, residents should be assigned to programing and/or services that best meet their needs or other responsivity factors. For example, residents who are highly anxious should not be placed in highly confrontational groups. Likewise, residents who lack motivation may need their motivation issues to be addressed first before being assigned to programing that targets their beliefs and teaches skills. PPRC should develop and establish guidelines when assigning residents to programing and staff.

Reinforcement is most effective when the reinforcer occurs immediately following the desired behavior and when the behavior is clearly linked with the reinforcer. The research is also clear the rewards need to outweigh negative consequences (punishments) by a ratio of 4:1. When reviewing PPRC Screening/Disciplinary/Incident Reports that was provided, there was 577 positive incident reports and 587 Class I, II, and III incident report for the pre-release. These data indicate that the ratio of rewards to consequences is closer to 1:1.

PRRC offers training in punishers during new hire training. New staff starting employment with Alternatives, Inc., receive 40 hours of initial training that includes agency policies and procedures, PREA and other required trainings. There is an overview of punishers (Class I, Class II, and Class III) that PPRC utilizes when targeting unwanted negative behaviors. Program 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

The CPC recommendations regarding a behavior modification system are designed to help the facility fully use a cognitive-behavioral model. Punishers should be impossible to escape, be consistent, and administered immediately and not spread out based off the inappropriate behavior shown. Staff should be trained to look for negative effects after administering punishers.

- ***Recommendation:*** Reinforcers should be monitored to ensure they are being consistently applied, 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 towards residents.

- ***Recommendations:*** PPRC should strive and continue to work towards achieving a 4:1 ratio of reinforcers to punishments to work towards desirable behavior from their residents.

- ***Recommendation:*** PPRC staff should be trained in a behavioral management system to ensure that it is being used consistently and accurately. The training should include core correctional practices of effective reinforcement, effective disapproval, and effective use of authority. Staff members should understand that punishment may result in certain undesirable outcomes beyond emotional reactions and be trained to monitor and respond to these responses.

Interviews and group observation indicated that groups using the CBI curricula utilized modeling by staff and skill building through role plays. It was identified that other groups that offenders participate in do does not utilize modeling, skill building and graduated practice.

- ***Recommendation:*** PPRC residents should consistently be taught to observe and anticipate risky thinking and problem situations through staff modeling. Incorporating modeling during groups and individual sessions allow the resident to observe and address deficits towards their criminogenic behavior. Staff should be trained to follow the basic approach to teaching skills, which includes, 1) defining skills to be learned; 2) obtaining client buy-in as to the importance of the skill; 3) staff teaching the steps of the skill; 4) staff modeling the skill for the client; 5) resident 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).

- ***Recommendation:*** Residents should engage in role-playing, which assist and allow the residents to practice new thinking, skills, and behaviors. There needs to be consistent and routine practice of skill building in programing offered to residents.

- ***Recommendation:*** Residents should practice new prosocial thinking and behaviors in increasingly difficult situations, and difficult role-playing scenarios. There needs to be consistent and routine practice of graduated practice in programing offered to residents.

Completion criteria for the program needs to be clearly outlined and defined by progress in acquiring prosocial behaviors, attitudes, and beliefs. The determination of program completion should not be based on time or solely on the non-behavioral indicators (e.g., completion of court requirements, pay all fines). In other words, definitions of treatment success should be competency-based rather than time-based or completion-based. Current requirements do not measure resident change, skill acquisition, or progress in treatment.

- ***Recommendation:*** Completion of PPRC should be defined by progress in acquiring prosocial behaviors, attitudes, and beliefs while in the programs, and not engaging in behavior that seriously jeopardizes the safety of staff and other program residents.

The program does not offer groups and/or training for family members of the residents to provide support, taught the same skills and techniques as the resident. All family member services are referred out to different agencies within the community.

- ***Recommendation:*** PPRC should include a formal family component. The family members (or other prosocial supports) should be formally trained to provide support to the resident. These individuals should learn the skills and techniques that the resident acquired while in the program to understand the language of the curricula and support the resident's progress in the community. They should also learn how to communicate effectively with the resident and to identify risky situations and triggers to aid in reintegration.

PPRC does not offer aftercare for their residents after they successfully complete the program. Due to aftercare not being provided to the discharged residents, the quality of aftercare cannot be determined.

- ***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.

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

Effective programs have a management audit system in place that includes the quality assurance processes of file review, regular observation of staff delivering services/groups with feedback provided, and a mechanism to provide participants feedback on their progress in the program. The PPRC has a number of different staff, including the program director, that conduct file reviews, observe groups/staff delivering services, and provide feedback to those facilitating groups. Additionally, the case managers at the PPRC consistently provide feedback to the residents on their caseloads with weekly one-on-one meetings.

Programs that collect formal participant feedback on service delivery and use that data to inform programming have a greater impact on reducing recidivism. This can include quarterly surveys, exit surveys/interviews, post release surveys, phone calls, etc. PPRC has a formal process to collect client satisfaction within the program. PPRC collects surveys from program participants after completing any groups or classes as well as just prior to their completion of the program. This information is completed in writing. PPRC then uses this information to determine any problems with service delivery, curriculum, or the program as a whole. This information is reviewed and utilized by administration staff to make appropriate changes deemed necessary. Programs that collect formal client feedback on service delivery have better programmatic outcomes than programs who lack this process.

Quality Assurance Areas in Need of Improvement and Recommendations

More effective programs have a management audit system in place to evaluate external service providers to ensure that the services being provided are of high quality. This may include periodic site visits, monitoring of groups, regular progress reports, file review, audits, etc. These must also be completed on a regular basis and written reports should be available. The PPRC does rely on outside providers to deliver some treatment and programming services. For example, drug and alcohol providers from the community have been tapped to provide direct care. Unfortunately, the information, including the progress of each resident, is not consistently shared with the staff at the PPRC.

- ***Recommendation:*** The program director, or their designees, should be allotted time to formally oversee these outside providers to ensure that the services being provided are of high quality. This can be conducted by monitoring the groups/sessions regularly, by requiring that each provider submit a regular progress report that is reviewed, or through a regular and consistent file review process. Whichever format is chosen, it must be done on a regular basis, and a summary report of the findings should be developed.

Programs that have a periodic, objective, and standardized reassessment process in place to determine if offenders are meeting target behaviors are more effective. Indicators my include pre and post testing on target behaviors, reassessments using standardized instruments, or monitoring the progress through a detailed treatment plan and making changes in the plan on a regular basis.

In conducting a file review of closed files there was no tangible evidence found to support that a standard reassessment process takes place.

- ***Recommendation:*** PPRC should develop a policy and/or procedure outlining a standardized reassessment process for when a resident should receive a reassessment to determine if they are meeting the targeted behaviors identified on their case/treatment plans. This policy and/or procedure should include sections identifying case management, criminogenic needs, current and reassessments timeframes, and life-altering events.

Alternatives tracks recidivism of both male and female offenders on a success/fail system, however there is no data that shows rearrests, returns to prison, or returns to facilities. The data provided did not meet CPC criteria. Additionally, the PPRC also has not undergone a formal evaluation comparing its treatment outcomes 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. While MDOC compiles some information related to a number of issues, and OMIS allows for some reports to be run, the facility has not identified a process to ensure that available data are examined to help the facility make data-driven decisions

- ***Recommendation:*** Recidivism, in the form of rearrest, reconviction, or reincarceration, should be tracked at six months or more after release from the PPRC. The program can do this on their own, work with MDOC to obtain the data they collect, or work with a third party to collect and review recidivism data for all residents who are released from their facility. There should be evidence the program receives and understand the data. This data should then be examined over time to identify trends.

- ***Recommendation:*** A comparison study between the facility's recidivism rate and a risk-controlled comparison group should be conducted. A report should include an introduction, methods, results, and discussion section. Alternatives Inc. should explore if PPRC has the ability to complete such a study. If not, the facility should 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). Local colleges and universities to consider include Montana State University (Billings), University of Montana (Missoula), or Montana State University (Bozeman). Departments that could assist with such a project include fields like criminal justice, sociology, and psychology.

- ***Recommendation:*** Similarly, Alternatives Inc. should identify an evaluator who is available to assist with data. If this is an internal position, evaluation must be the main focus of their position, and they should have appropriate credentials. Alternatively, the facility could partner with a local college or university 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 the facility) so that fiscal remuneration is limited to payment for analysis and reporting.

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 20 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.

Passages Pre-Release Center received an overall score of 61.5 percent on the CPC. This falls into the High Adherence to EBP category. In the capacity domain, PPRC scored a 69.6 percent which falls into the Very High Adherence category. In the content domain, PPRC scored a 55.5 percent which is High Adherence to EBP.

PPRC 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 PPRC want assistance with action planning or technical assistance, MDOC or UCCI can provide or recommend others to help in these endeavors. Evaluators note that PPRC staff are open and willing to take steps toward increasing the use of EBP within the facility. This motivation will no doubt help PPRC to maintain alignment with effective correctional programming while making further modifications to improve services.

Figure 1: Passages PRC CPC Scores

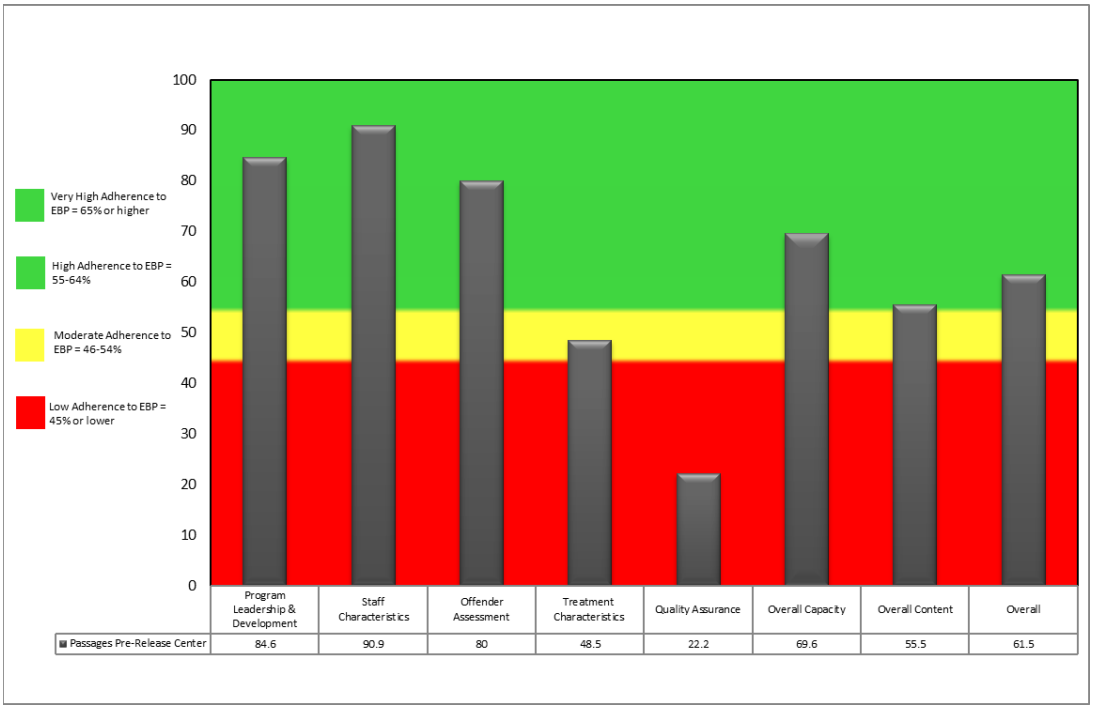
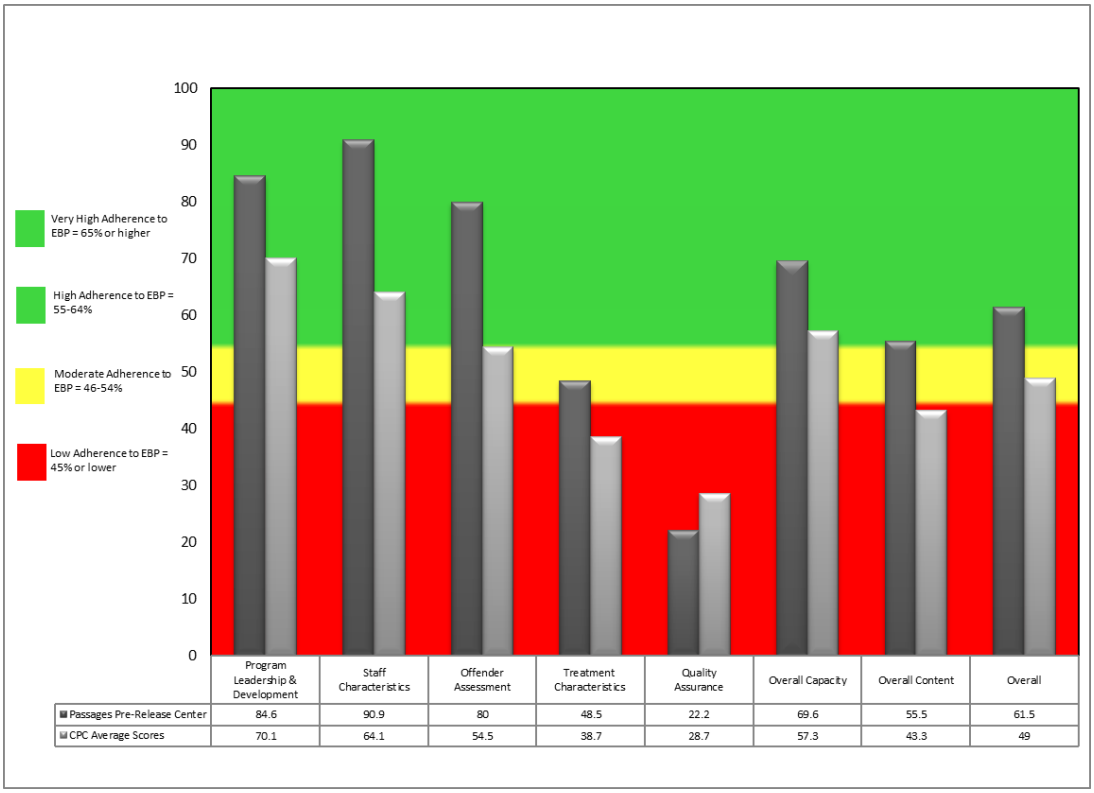


Figure 2: Passages PRC CPC Scores compared to national average scores*



*National Average based on 660 program evaluations completed 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.