DRAFT REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC)

Butte Pre-Release Center and Women's Transition Center

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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, per Montana Code Annotated (MCA) Section 53-1-211, the Montana Department of Corrections (MDOC) was directed to complete an assessment of the Butte Pre-Release Center and Women's Transition Center (BPRC) 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 adult/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) for assessing correctional intervention programs. 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 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 confirmed that CPC scores are correlated with recidivism and a large body of research exists that supports the indicators on the CPC.

To continue to align with updates in the field of offender rehabilitation, the CPC has been revised twice. A substantial revision was release 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 wight, 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 date-driven practices.

After the site visit and scoring process, a report (i.e., this document) is generated which contains all 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 reason 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. 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

The BPRC, located in uptown Butte, Montana, is a comprehensive, community-based correctional program (subsidiary of Community, Counseling, and Correctional Services (CCCS) Inc.) serving adult male and female felony offenders referred by the MDOC staff. Accredited by the American Correctional Association (ACA) since 1998, the BPRC is a 180-bed capacity facility (120 male and 60 female) designed to assist adult male and female offenders with their transition back into the community as well as to provide a cost-effective, program-intensive alternative to incarceration. The BPRC describes themselves as providing residents with a full range of correctional programming, chemical dependency treatment, life skills development, and employment skills.

BPRC is designed to serve offenders who were/are inmates at the Montana State Prison, the Montana Women's Prison, a Regional Prison or Jail, or any other contract secure correctional facility who are within two years of their parole eligibility or discharge date. While at these locations, a screening packet is completed by both the facility and the potential resident for review by a screening committee. The composition of the committee includes six members to include: 1) the Program Administrator for the BPRC/WTC; 2) an at-large Community Representative; 3) a local Parole & Probation Officer representative; 4) two members of CCCS' Board of Directors (one sitting in the capacity as an "alternate"); and 5) the Sheriff (or designee) of Butte-Silver Bow County. A majority approval vote of the Local Screening committee members is required and assures the offender applicant is eligible for placement in the BPRC. According to the CCCS website, approval is based on a number of factors to include risk to reoffend, number and type of offenses, previous community placement, behavior in other institutions, desire, and motivation to change and medical or psychological limitations that could prevent participation.

Within the first ten days of admittance, the residents complete a Treatment Plan with their case manager using the previously completed risk assessment. If a risk assessment has not been completed, they will complete one at that time. All residents are enrolled in Criminal Addictive Thinking (CAT). The other group provided by BPRC is Anger Management (AM) for male residents. If Parole Board or their judgment recommends Batterers Intervention (BI) they are referred to an outside provider for that programming group. Additionally, if substance abuse treatment is recommended, they are also referred to an outside provider. Some of the completion criteria for the BPRC includes maintaining clear conduct, maintaining employment, and having $1400, in a savings account.

Upon arrival residents present with a host of barriers that BPRC staff attempt to mitigate. These include, but are not limited to, medical and mental health needs, high situational anxiety, lack of motivation, difficulties in obtaining and maintaining employment due to medical or mental health issues, lack of clothing or hygiene products.

While residing in the BPRC, residents are allowed to have cell phones and some of them are required to have GPS tracking enabled so staff know where they are at all times. Further, staff at BPRC do random community checks. Residents are required to submit and follow an approved schedule. An approved budget must also be adhered to by the residents.

The assessment, using the CPC, took place on June 22-23, 2021. The assessment process consisted of a series of structured interviews with the clinical staff, facility staff, and residents in the program. Clinical staff include the program director/treatment supervisor, case managers, and a mental health professional. Facility staff include the program administrator and security staff. A total of six staff were interviewed as well as six residents in the program.

For the purposes of this assessment Kimberly Lefebre, Program Director/Clinical Treatment Supervisor, was identified as the program director. It should also be noted that for the purposes of the CPC Report, Case Managers were the staff identified as direct service delivery staff as they facilitate groups and are assigned a certain number of residents to meet with individually. Additionally, data was 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, client handbook, etc.). Finally, three groups facilitated by both clinical and other staff were observed. These included two separate CAT groups, and one AM group. Traces 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 directors (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, both the clinical director and the assistant clinical director serve as program directors 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

Kimberly Lefebre was identified as the Program Director for BPRC. She interned at Cascade County Detention Center (CCDC) and has been with CCCS for over four years. She is responsible for conducting trainings for the direct service delivery staff that she supervises, including the initial 40-hour training/On the Job Training (OJT) that newly hired staff are required to complete. She holds both a weekly staff and separate facilitator meetings and provides one-on-one meetings with her staff on a weekly basis. Along with supervising the direct service delivery staff she also regularly facilitates groups for the residents at the BPRC.

The BPRC has the support of the criminal justice stakeholders in the community and around the state. The stakeholders identified include Judges, local law enforcement (i.e., City Police Department and County Sheriff's Department), Probation and Parole, the Department of Corrections Central Office, and the members of their Board of Directors. Overall, the individuals from these criminal justice stakeholders are supportive of their program and processes have been put into place to discuss concerns as they arise. Likewise, the BPRC recognized the robust level of support they receive from their community stakeholders. The community stakeholders include their Screening Committee, the Chief Executive of the Community, the Civic Center and other employers, educational services that provide the General Education Diploma (GED) and the High School Equivalency Test (HiSET), 4 C's (local non-profit childcare and resource referral agency), and the Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) community.

BPRC has been in existence since 1983, and the funding they receive is both adequate and stable. They have a 25-year contract with the Montana Department of Corrections where they provide services to both the male and female residents, and no large cuts have taken place in the last two years.

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

Ms. Lefebre possesses a Bachelor's Degree in Education as well as two Masters Degrees in Learning Development and Counseling. Programs that are most effective in reducing recidivism have a Program Director who in the course of obtaining their degree(s) have also taken a classroom specific course in corrections or the forensic/legal field. Ms. Lefebre reported she did not complete any classes specific to corrections in the course of her degrees.

- ***Recommendation:*** In the future, should BPRC have an opening for a Program Director, it is recommended that special consideration be given to candidates who, along with education and experience, also possess specific classes in corrections or the forensic/legal field.

The research on program effectiveness asserts that active and engaged program directors are more effective than those who are not. As such, a program director should be involved in the hiring, training, and supervising of all staff who provide services to the residents served by the BPRC.

As discussed above, there are multiple staff delivering individual services and group sessions to the residents in the program. At the time of the assessment, it was identified that the CEO and other program administrators for CCCS are responsible/involved in the hiring and placement of direct service delivery staff for BPRC. To illustrate, they screen, interview, hire, and place newly hired staff, direct service delivery and otherwise, for their different facilities across the state.

- ***Recommendation:*** The Program Director should be involved/have a clear role in the hiring, placement, and training for all direct service delivery staff at the BRPC.

It is important the program is based on the effective correctional treatment literature and all the staff members have a thorough understanding of this research. The Program Director regularly obtains and disseminates literature particular to the criminal justice population. Additionally, this information is kept on their server and hard copies, sometimes books, are also available; however, because the program does not have/use an effective evidence-based intervention model, this section of the CPC Assessment cannot be scored as a strength. Recommendations for this item will be illustrated on the Treatment Characteristics section of the report.

Changes to the BPRC are not routinely piloted before they become a formal facility practice. Research indicates that effective programs observe a formal pilot period prior to implementing modifications as subsequent revisions are often difficult to make once a change has been formally instituted. Piloting is most successful when it is a regular and formalized process. Most large changes should be formally piloted to ensure they are rolled out with consideration to the facility.

- ***Recommendation*:** As new components are incorporated at the BPRC, a formal pilot period for each new component should be undertaken. For example, should the program supplement a current curriculum or add a new curriculum, this should first be piloted with one group of residents to evaluate the new material and how it would be best incorporated into the facility. Specifically, a formal pilot period of at least 30 days should be conducted to sort out the content and logistics and identify any necessary modifications to be made. The pilot period should conclude with a thorough review of the changes, including resident and staff feedback, and review of relevant data. Following this review, the decision should then be made about whether to fully implement the new component with the appropriate revisions.

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 participants. Other items in this domain examine all staff that work in the program. Excluded from this section in totality are the program directors, as they were assessed in the previous domain. In total, nine staff, clinical and case management, were identified as providing direct services.

Staff Characteristics Strengths

The CPC requires that 70% of direct service delivery staff have at least an associate's degree in a helping profession. At the time of the assessment, the BPRC staff met this requirement. In fact, 77.7% of the BPRC staff met the requirement for education. Further, 100% of the staff also met the criteria of having experience working with individuals in the criminal justice system.

Facility staff meet regularly in different formats. There is a facilitator meeting that includes the case managers, employment specialist, and mental health staff. All other staff have a monthly meeting which includes all staff from the facilitator meeting as well as the administrator and security staff. There is an agenda followed for both meetings and it remains fairly consistent. During the pandemic, it was modified slightly to include updates to the process by which staff were expected to meet health and safety needs of the residents. Other topics include any management or MDOC changes, treatment specifics, policies, caseloads, and struggles staff are encountering with a plan of action to alleviate issues. These meetings usually take between one to two hours.

In addition to the regularly meetings noted above, staff also receive individual clinical support from Ms. Lefrebre. It is noted that she is still in a candidate status; however, under the guidelines of the Montana Department of Labor and Industry (DLI) standards for Licensed Clinical Professional Counselor (LCPC) candidates, she meets qualifications to provide clinical oversight to service delivery staff whom she supervises at the BPRC. Ms. Lefrebre is commended on her progress on this certification and is strongly encouraged to take the final step to attain full LCPC certification.

When staff are initially hired to work at the BPRC, they are required to attend 40 hours of training at the central headquarters, 40+ hours of position specific training, and an additional 20-40 hours of facility specific training. If duties assigned to an employee include facilitating groups, there is a firm expectation that they be thoroughly trained in the curriculum by the publisher or appropriate entity. Until a staff is trained, they will not be expected to facilitate any groups.

Finally, the BPRC has established ethical guidelines that staff are expected to abide by both in policy and procedure and a standard of conduct that is companywide. Further expectations are outlined in the ACA standards, and for the clinical staff, through their licensure process and certification.

Staff Characteristics Areas in Need of Improvement and Recommendations

Staff who are hired to work at the BPRC are not always required to go through a competitive hiring process. Due to the fact that the facility has been in operation for a significant length of time, coupled with the length of tenure of some employees, at times staff are hired due to their familial connections, word of mouth, or connections made in other contexts. Research has shown that programs who hire candidates based on specific skills and values through a competitive process have a more positive impact on behavior change when working with the criminal justice population.

- ***Recommendation:*** When hiring new staff for any position at the BPRC, they should be selected for their level of empathy, positive attitude toward behavioral change, boundaries, flexibility, and genuineness. Education and experience should also be taken into consideration when competitively hiring for open vacancies within the CCCS/BPRC programs. The BPRC should also continue to perform background checks, and should there be questionable violations, ensure MDOC is in agreement with the hiring decision.

The BPRC staff receive an annual performance evaluation relative to their position. There is a second "Group Facilitator Observation Form" that does contain most areas needed and provides feedback to staff on their direct service delivery skills and abilities. However, there is a disconnect between the form being completed and the utilization of the information to improve service delivery all encompassed into one formal annual evaluation process.

- ***Recommendation:*** Programs that effectively evaluate and use the feedback gained from annual evaluations to improve service delivery to participants are found to be most effective. The BPRC should develop a tool that encompasses not only the generic areas of employee performance, but also incorporate the characteristics that make service delivery most effective for a formalized annual evaluation process. Areas evaluated should include assessment skills and interpretation of results. Further, they should also effectively communicate the strengths, deficits and recommendations made from both evaluations to the staff to further enhance their direct service delivery.

Equally important to the BPRC is the ongoing training of program delivery staff. Research shows that effective programs require at least 40 hours of annual formal training for all professional staff relative to delivering effective services. As a corporate requirement, all the BPRC staff are required to receive at least 40 hours of training each year; however, most of these hours are not dedicated to service delivery skills, but rather, Prison Rape Elimination Act (PREA), First Aid, restraints, etc.

- ***Recommendation:*** All professional staff who deliver services should receive at least 40 hours of ongoing training each year. These hours should be directly related to delivering criminogenic services to adults involved in the justice system 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 assessments, group facilitation skills, case planning, and updates to the field of offender rehabilitation. Because staff receive feedback from the Group Facilitator Evaluation Form, this would be an excellent opportunity to provide training in areas that are determined to need improvement.

While all staff working at the BPRC meet on a regular basis to provide input and share ideas, the capacity to make programmatic changes does not occur at this staffing level and rather operates from a traditional top-down command structure. As a result, staff do not feel they have input in modifying program components.

- ***Recommendation:*** Staff should have input in modifying program components that are approved by supervisors or a review board. The suggestion from above related to piloting will help ensure that staff voices are heard. The facility may also wish to put anonymous

suggestion boxes around the facility for staff to provide feedback and make suggestions. These suggestions and the responses from the facility administration should be made public and/or discussed at the various staff meetings so there is an understanding that the suggestion was heard, considered and a determination made to implement changes or not.

There should be evidence that *all* facility staff support rehabilitative goals and values. The training security staff receive is not standardized and is dependent on which staff is providing OJT. Due to the lack of standardized training, there is a significant lack of consistency among staff who perform this duty. Further, it is noted that there is a disconnect between program philosophies based on the position held by the staff and have an 'us versus them' mentality between staff.

- ***Recommendation:*** Facility administration should focus on the culture of the facility. Security and program delivery/treatment staff need to be equally prioritized, and staff should be made aware of how they complement one another. Some of the recommendations related to hiring and training of staff (e.g., CCP training) will assist with staff appreciating how each of their roles are important components to providing an effective program. Equally important is holding staff accountable for unprofessional behavior toward residents and other staff. This requires supervisors to listen to concerns from other staff, to be on the floor regularly, and for them to provide accountability, feedback, and coaching when needed.

OFFENDER ASSESSMENT

The extent to which residents 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 residents, and then provide services and interventions accordingly. The Offender Assessment domain examines three areas regarding assessment: 1) selection of residents; 2) the assessment of risk, need, and personal characteristics; and 3) the manner in which these characteristics are assessed.

Offender Assessment Strengths

The use of effective risk, need, and responsivity assessment tools is an essential component of effective intervention for all participants involved in the criminal justice system. Needs assessment scores are also crucial as they determine which criminogenic need areas residents have in their lives. The BPRC uses Women's Risk and Needs Assessment (WRNA) and Montana Offender Reentry and Risk Assessment (MORRA) to measure both risk and need domains. Both of these tools are validated. Typically, these assessments are required as part of the screening packet but if it is not available, or if a residents' assessment becomes outdated (12 months lapsed since the last assessment); a reassessment will be completed by the BPRC staff. Risk assessment tools are a crucial piece of evidence-based correctional programming as these assessment scores assist in determining which offenders are suitable for services as well as the duration and intensity of treatment services, based on risk level.

According to the risk principle, treatment resources are most effective when they are reserved for moderate and high-risk residents and intensive services can actually make low-risk residents worse. Because the BPRC requires the WRNA and MORRA as part of the criteria for acceptance, the program is credited for only having approximately 27.5% of their population as low risk.

Offender Assessment Areas in Need of Improvement and Recommendations

The most effective programs are those whose participants are deemed appropriate and can be adequately served by the program. Staff consistently reported there were a high number of offenders accepted into the program who are not appropriate for the program. Because the BPRC has accepted a number of residents who are unable to work and apply for Social Security Income (SSI) or Social Security Disability Income (SSDI), it was reported that these residents are unable to fulfill the requirements of the program. This includes obtaining and maintaining employment in order to save the minimum amount of money needed to successfully complete the program. Because of this requirement, some residents have been held in the BPRC for 300-400-days when it is only designed to be 180-210-day program due to debt accrued, sometimes upwards of $1800. It should be noted that staff make every effort to support these residents in filling out needed applications appropriately, maintaining appointments, and providing/obtaining appropriate documentation to support the resident's case for SSI/SSDI. The Department supports the placement of these special-needs offenders into a prerelease program as a way to effectively support the residents in developing individualized and appropriate release plans.

- ***Recommendation:*** There should be separate and different expectations for offenders who are unable to obtain and maintain employment as part of the successful completion of the BPRC program (e.g. an individualized program). Considerations should be taken into account during the screening process to identify this population earlier for the Case Management staff. Due to the amount of time dedicated to these residents, BPRC could consider assigning a specific staff member/case manager designated to work with this population (e.g. having a specialized caseload).

Successful programs have developed and follow clinical, community, and legal criteria (e.g., severe mental illness, low risk, violent offenses, etc.) for the exclusion of certain types of offenders. At the time of the assessment the eligibility criteria provided was subjective and not consistently followed. Current eligibility criteria states, "persons with long or serious history of violence/assaultive behavior, persons who have a history of walking away from programs and/or escaping, bail jumping, ect., persons who have disabilities beyond the scope of resources available by the corporation. This includes severe retardation, acute psychosis, and having an active drug/alcohol addiction. Persons who have failed to adjust to parole and/or probation or who have adjusted poorly in the institution." Eligibility criteria are not the same as exclusionary criteria. Exclusionary criteria should clearly outline which type of offenders are not appropriate for the program.

- ***Recommendation:*** The BPRC should have a set exclusionary criterion (e.g., some relevant clinical, demographic, legal criteria). Once a criterion is established, it should be written in policy and followed by the screening committee.

Programs that are most effective in reducing recidivism have a validated, standardized, and objective domain specific needs assessment to assess key offender types. The BPRC serves these specialized populations, including residents with substance abuse disorders, violent offenses, and domestic violence convictions. Additional assessment tools are needed to ensure appropriate services/referrals are obtained, (i.e.: substance use disorder treatment or Batterers Intervention). In order to ensure the appropriate services are delivered to these specialized populations, BPRC staff need to have the specific information that these domain specific assessments provide.

- ***Recommendation:*** The BPRC should administer validated domain-specific needs assessments to ensure referrals are made to the appropriate services. Examples of validated domain-specific needs assessments are the Psychotherapy Check list Revised (PCL-R); or the Violence Risk Appraisal Guide (V-RAG), or the Ontario Domestic Assault Risk Assessment for domestic violence; the TCU-DS or American Society of Addiction Medicine for substance use, the GAINS-SS for behavioral health disorders. BPRC should obtain any domain-specific needs assessments from all outside treatment providers for placement into the resident's file and use by professional staff in the development of each resident's case plan.

In order to fully adhere to the Risk Needs and Responsivity (RNR) model of best practice, the third component, Responsivity, must be assessed to determine a resident's individual characteristics. Then, taking this information into consideration, appropriate services or accommodations can be provided. There are a number of factors that depend on this area being adequately assessed for the most effective programming to take place. The MORRA does not provided the needed responsivity feedback; however, the WRNA does provide the required information.

- ***Recommendation:*** The BPRC should choose a minimum of two validated assessments that measure responsivity. For example, a Patient Health Questionaire-9 (PHQ-9), and Minnesota Multiphasic Personality Inventory (MMPI), or a Beck's Depression Inventory can be used to assess mental health in adult residents. If BPRC decides to measure motivation as a responsivity factor, the Client Evaluation of Self and Treatment (CEST) or the University of Rhode Island Change Assessment (URICA) are validated for this population. If BPRC wanted to assess educational levels, the Test of Adult Basic Education would be appropriate. The results of these assessments should be used to determine appropriate services or accommodations that need to be made to a participants' comprehensive participation at the BPRC.

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

Case planning is a critical step in addressing criminogenic needs. The BPRC develops personalized case plans for each resident using the MORRA/WRNA as a guide. The resident is also involved in the development of the case plan, thus buy-in to the process is achieved. Achievements are documented and the case plan is updated on a routine basis, adding to, and removing goals as needed. The residents are given objectives to reach, and the staff work with residents to develop steps to achieve objectives using the risk/need assessments as a guide. The risk level of the resident is also used to ensure residents attend groups only with similar risk levels. The CPC requires low risk offenders are placed into groups with only other low risk offenders. Likewise, high risk offenders are only attending programming with other high-risk offenders.

The BPRC's program is approximately 180 days, which is within the recommended lengths of programming to be conducive to change. Along with treatment length, residents are routinely monitored inside and outside of the facility. This is achieved through spot-checks, a cell phone app, and staff walk-throughs.

Effective programs require that while in the program 40% of a resident's time per week is spent in structured activities. The BPRC requires full-time employment, along with programming, case plan work, and chore duties around the facility. This ensures residents are involved in a structured activity for over 50% of their week.

Successful programs maintain appropriate group sizes. The BPRC consistently maintains appropriate group sizes in all observations. The groups are conducted by professional staff who are trained in the curricula or maintain the correct professional license.

Finally, the BPRC has a detailed program manual. The manual is easily accessible to staff members for review and interviews showed staff were able to articulate policies and curriculum based on the manuals. Treatment providers were able to demonstrate knowledge of manuals provided for specific programming.

Treatment Characteristics Areas in Need of Improvement and Recommendations

Effective programs use evidence-based intervention models. Curricula and intervention examples include social skills training and structured cognitive-behavioral groups. Additionally, at least 50% of a program's efforts should target criminogenic factors. Finally, the actual programming offered should also target criminogenic needs versus non-criminogenic needs at a ratio of 4:1. Some examples of these factors include high risk situations that lead to illegal behavior, poor interpersonal relationships within family, substance abuse/relapse prevention, use of leisure time, and antisocial personality factors. The BPRC has components available to address criminogenic factors versus non-criminogenic factors at a ratio of 6:5; however, the program's efforts to address criminogenic factors is not at least 50% of the program. The BPRC programming appears to emphasize earning money, working, and acquiring housing.

- ***Recommendation:*** Observations and interviews showed residents working more than 75% of their time spent in the program, with limited focus on acquiring, applying, and

using preventative skills for recidivism. Although employment and housing are important factors, the emphasis should be balanced to also address other criminogenic factors. The BPRC should increase the number of criminogenic targets for offenders (e.g. problem-solving skills, emotional regulation, antisocial thinking) rather than allowing offenders to work more than full-time. Increasing the number of criminogenic targets and the overall time spent addressing those targets will result in a more balanced/effective program for residents.

A strength of the BPRC is its development and maintenance of a program manual. To ensure program fidelity, manuals and curriculum in programming must also be followed. Staff members were knowledgeable of the program manual and curriculum in programs; however, group observations demonstrated variances in program delivery from staff member to staff member. Not all groups demonstrated using lesson plans as directed.

- ***Recommendation:*** The evidence-based curricula that are already in use should be implemented with fidelity to ensure all groups are following the treatment manuals. Further, group facilitators should be provided feedback and coached to enhance their service delivery. Group monitoring should include program fidelity components along with facilitator skill and understanding of the material.

Programs should vary intensity, length, and overall programming for residents based on risk levels. Higher risk residents should receive the highest intensity and duration of services. The BPRC programming separates residents into groups based on risk; however, the variance of hours is not significant enough to impact the criminogenic risk and needs for the high-risk levels. CAT is provided to all residents with minimal modifications based on risk and the prior program from which the resident transfers from, and any additional programming is based on court judgements.

- ***Recommendation:*** Overall, the research indicates that offenders who are at moderate risk to reoffend need approximately 100 to 150 hours of evidence-based services to reduce their risk of recidivating, and high-risk offenders need over 200 hours of services to reduce their risk of recidivating. Very high-risk or high-risk with multiple high-need areas 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. Developing separate programming tracks based on risk and responsivity factors, and including case plans in the process, would ensure that an offender is not provided too little or too much programming based on need. This could include extra groups for higher risk residents, extra case management sessions including role modeling and role plays, or more/longer duration of programming.

The BPRC puts effort towards facilitator matching to groups; however, risk and needs assessments were not utilized to evaluate the match effectively and objectively. The BPRC neither assesses responsivity factors for residents, nor obtains this information from outside providers, making it hard to determine the best matches for group placement. Along with this, staff members indicated varying levels of desire and comfort to facilitate groups. A lack of skill

or motivation in the facilitator may result in poor buy-in, poor engagement, and a lack of motivation for participants in a group. Furthermore, resident needs and responsivity factors like personality characteristics or learning styles should be used to systematically match residents to the most suitable type of service and staff. Along with this, staff members should be assigned groups based on skill set, motivation, training, and experience. A professionally licensed staff assigned to facilitate specialized groups is an example.

- ***Recommendation:*** Results from standardized criminogenic need and responsivity assessments should be used to assign participants to both the appropriate treatment groups and facilitator. To illustrate, participants who are highly anxious should not be placed in highly confrontational groups or with staff who tend to be more confrontational. Likewise, participants who lack motivation may need their motivation issues to be addressed first before being assigned to a service that targets their beliefs and teaches skills. Additionally, ongoing staff training, skill assessment, and coaching by program leaders may identify staff who struggle with facilitation skills, motivation to facilitate groups, and rapport building.

Participant buy-in to the program is an important component for success. Participants having input into some programming and features is one way to allow buy-in. Some participants reported making suggestions to program leaders; however, there was no evidence of any follow-up or plans to implement input after the initial suggestion. Some indicators were that residents did not feel their input or suggestions were taken into consideration due to lack of communication between staff and residents. Additionally, an open-door policy and/or informal procedure are not enough to meet the criterion.

- ***Recommendation:*** The BPRC should develop a formalized process for obtaining resident's feedback into the program consistently throughout the duration of their program. Resident input in the form of resident meetings, surveys, or feedback forms should include the further step of plans and actions taken to address the feedback. Bulletin boards indicating upcoming changes, resident representatives, or newsletters could also solicit feedback and continue to apprise the population of the decision made regarding changes based on their feedback.

The most effective programs use reinforcement strategies and techniques to encourage the use of new skills and prosocial behaviors both within the program and long-term for each resident. Tokens, tangible rewards, and social rewards should be available for all residents. These may include earning privileges, verbal praise, or removal of punishers. Consistent application of both punishers and reinforcers must be demonstrated from all staff in the program, along with good communication to ensure consistency within the program.

The BPRC did not provide a sufficient range of reinforcers as rewards within the program. Observations and interviews also demonstrated inconsistency in rewards based on which staff member provided the reinforcement of behavior. As an example, one person may receive verbal praise while another receives written praise and more recognition from staff members. Further, the reinforcer is not applied as soon as possible to the behavior or effectively communicated as a reinforcer.

- ***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 as appropriate.

- ***Recommendation:*** The application of reinforcers should include: 1) comes immediately after the behavior or as close to the behavior as possible; 2) is consistently and then intermittently applied after the appropriate behavior; 3) is individualized to the resident when possible; 4) involves a discussion with the resident of the short and long-term benefits of maintaining that particular behavior.

In addition to appropriate rewards, a good behavior management system has a wide range of negative consequences or punishers available to promote behavioral change. Ineffective punishments can detract from the program and diminish programming provided. Good punishment application is designed to extinguish antisocial behaviors and promote prosocial behavior changes in future situations. The BPRC can identify antisocial behaviors but was not able to consistently provide feedback on prosocial behaviors that may be alternatives.

Treatment activities should not be used as punishers. For example, residents who receive write-ups reported being sent to mental health services as a punishment for behaviors. These residents may equate mental health services as a negative due to the connection to a punisher.

A program should also implement practices concerning recognizing, addressing, and mitigating negative effects related to punishers. Effective communication about the specific antisocial behavior being addressed, communicating the goal of the punisher in learning a new skill, and follow-up after the punisher should all be standard practice. Using the above example, staff may have recognized residents equating mental health treatment with a punishment and addressed concerns with residents.

Ineffective punishments were also being used. These include inappropriate verbal reprimands and shaming techniques. There was also a lack of consistency and clarity in prescribing punishment for specific behaviors. For example, residents reported it was easier to get away with negative and unhealthy behaviors when certain staff were not on shift. Staff are also not trained on how to properly administer effective negative consequences. Staff were able to articulate policy; however, could not give real-world examples of reinforcers and punishers in consistent use. Similarly, staff were able to identify a goal of having 4 reinforcers to 1 punisher. However, observations and interviews demonstrated either a punisher heavy program, or at best an equal ratio between the two.

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

- ***Recommendation:*** The inappropriate sanctions previously referenced (inappropriate verbal reprimands and shaming techniques) should be discontinued immediately. When inappropriate sanctions are used by staff, staff should be held accountable.

- ***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.

- ***Recommendation:*** The BPRC should strive to achieve a 4:1 ratio of reinforcers to punishments to encourage desirable behavior. This should include monitoring to demonstrate knowledge of the policy and application of the policy.

The facility has not yet established criteria that clearly outlines the successful completion of the program (i.e., when the treatment successfully terminates for each resident). The BPRC currently has a time-based completion, along with mostly monetary goals to complete prior to leaving the program. We now know due to current research that effective programs are ones that have completion targets for residents related to the demonstration of new pro-social skills. Case plans are reviewed; however, prosocial milestones and behavior changes are not weighted the same as amount of money in savings, employment, and housing. Observation and interviews also indicated subjective releases made by program administrators. This includes having some residents successfully completing the program while not having met all the time, money, or employment standards.

A program's successful completion should fall between 65% and 85%. A program with too low a completion rate may not address the needed criminogenic risk factors in a proactive way. Too high a completion rate may indicate a need for stricter standards or more universal application of standards of completion. The BPRC provided documentation and files that indicated a 100% completion rate.

- ***Recommendation:*** Clear standards should be set as to when individuals can complete their active treatment phase and can move from active treatment to aftercare. Benchmarks should be implemented to allow someone to successfully navigate through the program. These can include attendance and participation standards, scores on pre- and post-testing, meeting a certain percentage of objectives from their case plan, or formal reassessment of offender risk and needs.

- ***Recommendation*:** Once the BPRC delineates completion status, it should monitor its successful completion rate, which should range between 65% and 85%. This range can be obtained using benchmarks to navigate through the program and consistent standards for participation and completion of 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, consistent modeling of prosocial behaviors was not observed. Role modeling and role plays should be done separately and include only staff in the role model. These two components appeared interchangeable in the BPRC programming. Some role plays were observed, but this was not done on a consistent basis through all groups, nor was there evidence it was included on a regular basis in all groups. Groups should also include increasingly difficult situations that require the use of more skills or skills in an advanced way. Graduated practice allows residents to develop comfort with the skill in a safe setting, while practicing application of the skill in real world scenarios.

- ***Recommendation:*** Role models and role plays should be completed in most groups. Role models should be planned out and completed only by staff members. Role plays are opportunities to practice the newly learned skills. Staff should interrupt role plays that are not using skills appropriately. The ability to redirect the skill learning is an important component. Further, if there are steps to a newly learned skill, those steps should be evident in the practice by the resident.

- ***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 buy-in as to the importance of the skill; 3) staff teaching the steps of the skill; 4) staff modeling the skill; 5) resident rehearsal of the skill (role-playing); 6) staff providing constructive feedback 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 residents.

BPRC currently provides a "Progress Summary Report" (PSR) to the participants receiving probation/parole officer. In this report recommendations are made that would support the ongoing needs of the participant. Because the BPRC does not currently provide aftercare services, the quality of these services cannot be determined. Aftercare and discharge planning are designed to assist the resident in maintaining the prosocial changes made in the program and include program monitoring for the quality of aftercare provided if it is an outside referral. The BPRC does not include aftercare services or planning as part of release. Formal referrals and information on target behaviors was not included in release planning.

Successful programs include a formal aftercare period in which both programming and supervision are provided to a participant after they have successfully completed the program and discharged. Aftercare planning should begin during the treatment phase. The services provided

should be determined based on the participants prosocial changes, information gained from reassessments. The duration and intensity should be based on the participants' risk level.

- ***Recommendation:*** The BPRC should work with each resident to develop individualized discharge plan. The plan should include formal referrals to other services and resident's progress in meeting target behaviors and goals. Staff should use this information to note areas that need continued work. These items could be included in all Request for Investigation and Conditional Release paperwork. It is highly recommended these discharge plans be shared with the residents.

- ***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.

- ***Recommendation:*** The aftercare should include the following components: planning for aftercare during treatment phase, reassessment of offender risk and needs, requirement of attendance, providing evidence-based groups or individual sessions, and duration and intensity based on resident risk level. Last, supervision should be required throughout aftercare services. The BPRC is responsible to ensure the quality of these services.

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 BPRC 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 BPRC consistently provide feedback to the residents on their caseloads.

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 BPRC does rely on outside providers (i.e., contractors) to deliver some 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 BPRC.

- ***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 regular progress reports for each offender in their services that is reviewed by BPRC staff, periodic site visits to the outside provider, 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 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. The BPRC does use a form for their residents to complete and turn in two weeks prior to leaving the program. This timeframe also allows for staff to interview the resident(s) if needed. As noted above in the need for participant input, although this process does provide for some resident feedback it is not conducted on a regular basis, and there are no noted programmatic changes as a result of the process.

- ***Recommendation:*** The BPRC should have a more formalized process, possibly by forming a quality assurance committee, to conduct resident satisfaction surveys, including satisfaction survey completed throughout all phases of the program. The results of these surveys should be reviewed by facility leadership during leadership meetings. Appropriate changes/recommendations should be both implemented and communicated with all staff and residents.

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. The BPRC does use TCU Scales and CEST; however, those assessment were not consistently found in the closed files reviewed.

- ***Recommendation:*** The BPRC 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.

The BPRC does not track recidivism of its residents after completion of the program. Additionally, the BPRC 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 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 BPRC. 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. CCCS Inc. should explore if the BPRC 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 Tech, The University of Montana (Missoula), and Montana State University (Bozeman). Departments that could assist with such a project include fields like criminal justice, sociology, and psychology.

- ***Recommendation:*** Similarly, CCCS 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 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.

The BPRC received an overall score of 39.7% on the CPC. This falls into the Low Adherence to EBP category. In the Capacity domain, BPRC scored a 50%, Moderate Adherence. In the Content domain, BPRC scored a 31.8%, Low Adherence.

In reviewing this report, please keep in mind that the facility was not designed with the CPC in mind, and the BPRC staff, specifically Program Director Ms. Lefebre, should commend themselves for the work they have done to date to make treatment a facility focus.

Recommendations have been made in each of the five CPC domains, and these recommendations should assist the BPRC in making the necessary changes to increase adherence to what works in reducing recidivism.

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 the BPRC and/or CCCS Inc. want assistance with action planning or technical assistance, UCCI can provide or recommend others to help in these endeavors. Evaluators note that the BPRC staff are open and willing to take steps toward increasing the use of EBP within the facility. This motivation will no doubt help to implement the changes necessary to bring it further into alignment with effective correctional programming.

Shown below are two graphs (Figures 1 and 2) indicating the percentage(s) received in each domain of the CPC. Figure 1 shows the percentages the BPRC received for each domain based on how each item was scored. Figure 2 shows the BPRC's percentages compared to the CPC's average scores.

Figure 1: BPRC CPC Scores

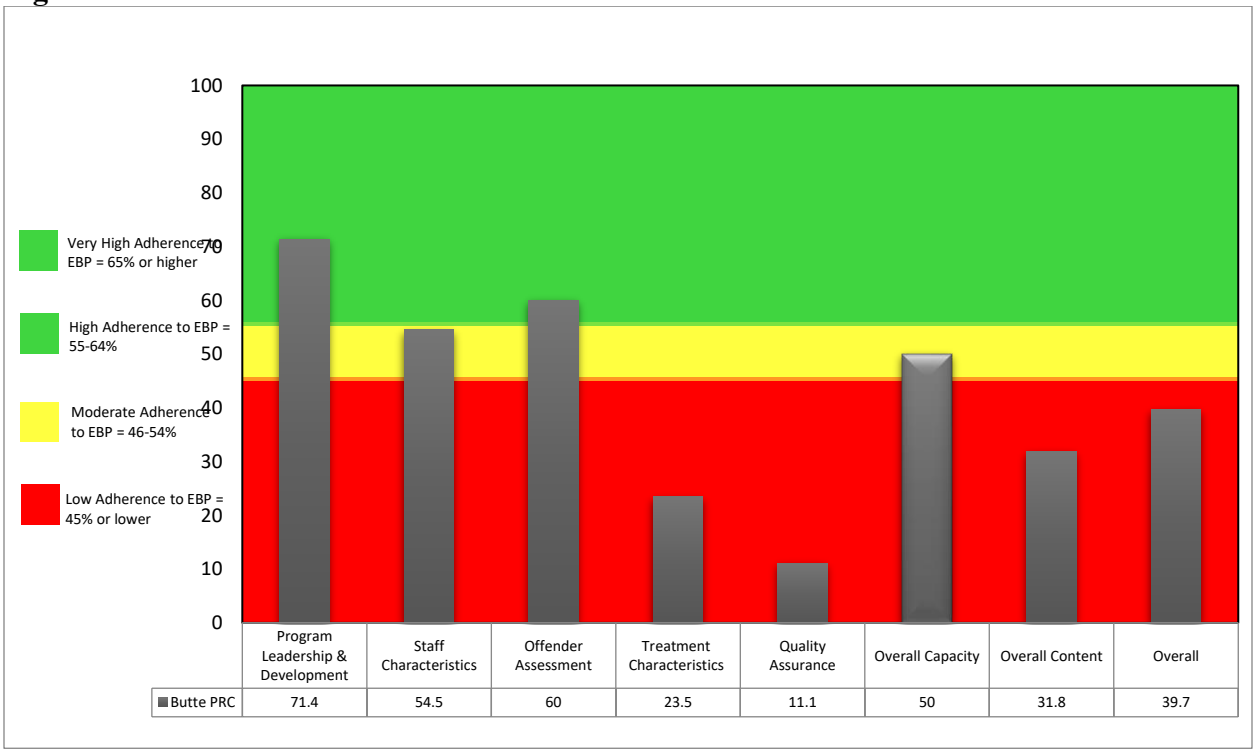
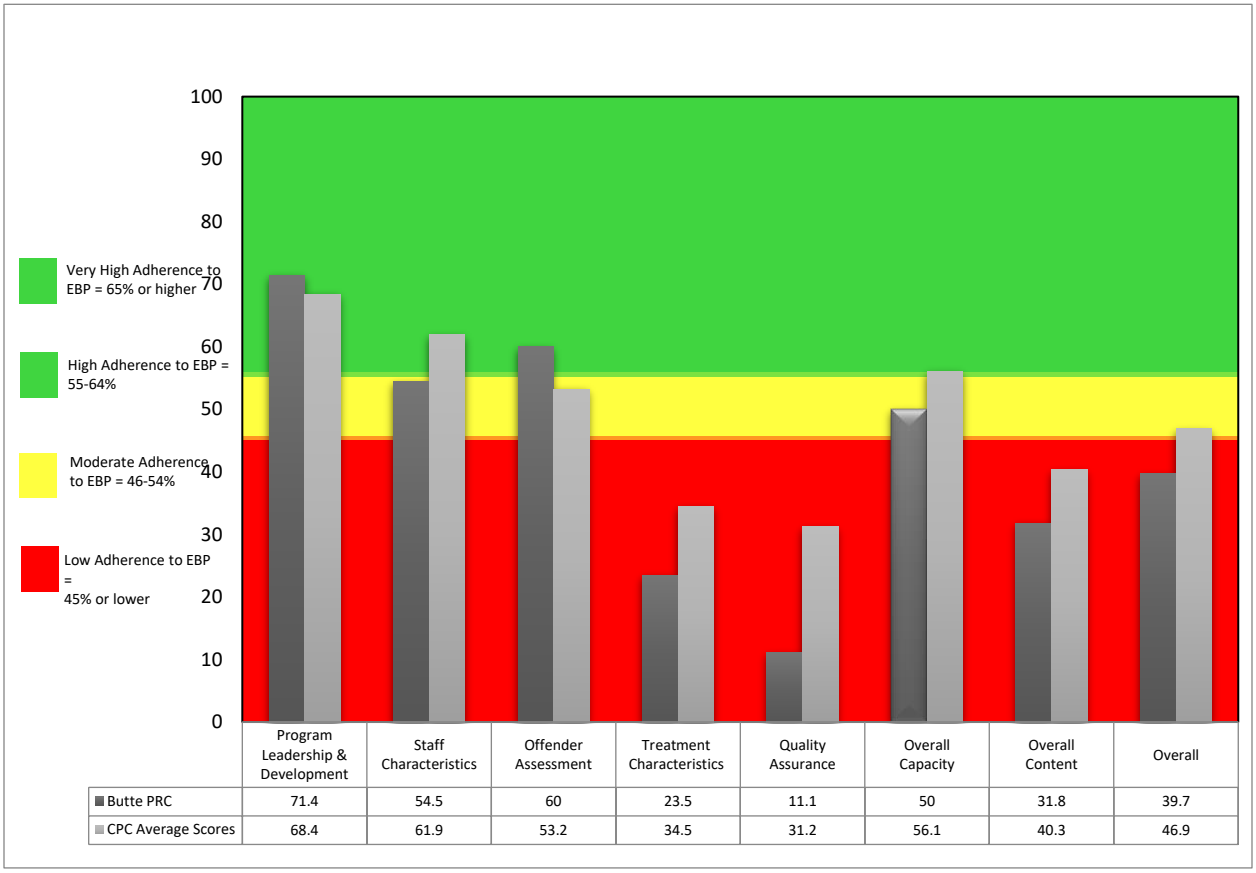


Figure 2: BPRC Compared to the CPC Average Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
Butte PRC	71.4	54.5	60	23.5	11.1	50	31.8	39.7
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.