FINAL REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC)

Great Falls 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 offender 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, the Great Falls Pre-Release Center (GFPRC) was assessed using the Evidence-Based Correctional Program Checklist (CPC). The objective of the CPC assessment is to conduct a detailed review of the program's practices and to compare them to best practices within the criminal justice and correctional treatment literature. Strengths, areas for improvement, and specific recommendations to enhance the effectiveness of the services delivered by the program are offered. The program was assessed as part of a training initiative with the Montana Department of Correction (DOC) in which seven staff were trained on the administration and scoring of the CPC. Given this CPC assessment involved a training process, this CPC report represents an assessment conducted within a training context. This is the first CPC assessment of this program.

CPC BACKGROUND AND PROCESSES

The Evidence-Based Correctional Program Checklist (CPC) is a tool developed by the University of Cincinnati Corrections Institute (UCCI)[1] for assessing correctional intervention programs.[2] 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[3] 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)

[1] 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.

[2] 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.

[3] 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.

and individual items, domains, areas, and overall score. Two additional studies[4] have confirmed that CPC scores are correlated with recidivism and a large body of research exists that supports the indicators on the CPC.[5]

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, resident 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.

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[4] 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.

[5] 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.

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 a concern. Although steps are taken to ensure that the information gathered is accurate and reliable, given the nature of the process, decisions about the information and data gathered are invariably made by the evaluators. Third, the process is time specific. That is, the results are based on the program at the time of the assessment. Though changes or modifications may be under development, only those activities and processes that are present at the time of the review are considered for scoring. Fourth, the process does not take into account all "system" issues that can affect the integrity of the program. Lastly, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place.

Despite these limitations, there are a number of advantages to this process. First, it is applicable to a wide range of programs.[6] 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 Great Fall Pre-Release Center provides a structured pre-release program for adult male and female clients referred by the Montana DOC or Federal Bureau of Prisons. The center helps residents reintegrate into the community while learning necessary life skills to maintain a crime-free lifestyle. The center also provides various treatment services, including various groups that

[6] 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.

cover a variety of topics such as batterer's intervention, relapse prevention, anger management, and Thinking for Good.

Located in Great Falls, Montana, Great Falls Pre-Release Center began providing services as a male pre-release in March 1984. Since then, it has expanded to included three campuses—West campus, East campus and the Women's Center. This report will only focus on the programs at the West and East campuses as they are similar in nature and only serve male clients. The report will refer to the West and East campuses as GFPRC throughout this report. The GFPRC operates as a 190-bed male facility. The East campus has a maximum capacity of 110 residents while the West campus has a maximum capacity of 80 residents. At the time of the assessment, the program was serving 125 adult males.

An assessment of GFPRC using the CPC took place on May 18, 2022. The assessment process consisted of a series of structured interviews with the clinical staff, facility staff, and residents. Clinical staff included the Corrections Treatment Specialist, Licensed Addictions Counselor, Licensed Clinical Professional Counselor, and Community Assistance Specialist. Administrative staff included the Treatment Services Director and the Program Manager. A total of eleven staff and four residents were interviewed.

For the purposes of this assessment, Mike Scott, the Treatment Services Director was identified as the program director as he assumes responsibility for overseeing the treatment services offered across both campuses. Data were gathered via the examination of 8 representative files (open and closed) and other relevant program materials (e.g., policy and procedure manuals, staff training information, assessments, curricula, resident handbook, etc.). Finally, one group session on "Untangling Relationships" facilitated by a staff member was observed. Data from the various sources were 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, Mr. Scott, 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

Mr. Scott has 28 years of correctional experience including being a program manager, residential supervisor and a treatment services director. He is very involved in the process of selecting new staff. For example, Mr. Scott, along with the program director, interview potential staff and make recommendations to the human resources department. In addition, Mr. Scott supervises some service delivery staff at the facility.

The facility has the support of the criminal justice community. Stakeholders include parole boards, probation officers, and police officers. Overall, their support for the GFPRC was rated as positive. For example, probation officers have a lot of interaction with the staff at GFPRC and provide them with support for write-ups for residents. The staff at GFPRC also provide positive ratings when asked about support from the community-at-large. Community stake holders include, local employers, landlords, community college 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 in existence for some time, providing treatment services since 1984. Furthermore, funding for the program has been stable in the recent past, and no large cuts have taken place in the last two years. Finally, the program serves both men and women, however, it provides separate treatment, housing and recreational services for both.

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

Mr. Scott holds a bachelor's degree in Sociology. Mr. Scott, however, has not completed any courses or specializations in working specifically with correctional populations.

- ***Recommendation:*** Should the program need to hire another treatment service director, preference should be given to candidates with at least a baccalaureate degree in a helping profession with classes/specializations in corrections (criminal justice, forensic psychology, etc.).

The research on program effectiveness asserts that involved program directors are more effective. Consequently, the CPC requires that program directors be involved in hiring, training, and supervising staff who provide services to those served by GFPRC. As discussed above, Mr. Scott is involved in hiring and supervising a few treatment staff; however, there was no evidence that Mr. Scott provides direct training to new staff. Program directors should also deliver some services to residents themselves, as this helps keep them informed as to population changes and staff challenges. At the time of the assessment, Mr. Scott was not involved in direct service delivery.

- ***Recommendation:*** As new staff are hired to work at GFPRC, the treatment service 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).

- ***Recommendation:*** The treatment service director should be engaged in service delivery. This can take the shape of consistent group facilitation (i.e., co-facilitating a group rather

than filling in when one facilitator is absent), consistent administration of assessments, and/or carrying a small caseload. No matter which format of service delivery is chosen, it should occur consistently.

It is important that the program is based on the effective correctional treatment literature and that all staff members have a thorough understanding of this research. However, a formal literature review in the area of what works in reducing recidivism has not been conducted at GFPRC.

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

- ***Recommendation:*** All staff working in the program should receive related research articles regularly, and a portion of staff meetings should be used to ensure that this information is reviewed and discussed for relevance to the program. Then, the program administrators should ensure that all core services (e.g., group and individual sessions intending to reduce recidivism) are implementing these proven practices (see additional recommendations below).

Changes to the GFPRC are not routinely piloted before they become a formal program practice. Research indicates that effective programs develop a formal pilot period prior to implementing modifications. Piloting is an effective way to introduce new practices, given revisions are often difficult to make once a change has been formally instituted. While staff mentioned programs such as the Honors Program that went through a pilot period, piloting needs to be consistently used for all new interventions, groups etc. 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 into GFPRC, 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 a group of residents to evaluate the new material and how it would best be incorporated into the program. Specifically, a formal pilot period of at least 30 days should be conducted to sort out 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 residents. Other items in this domain examine all staff that work in the program. Excluded from this section is the treatment service director, as he was assessed in the previous domain. In total, 10 staff were identified as providing direct services to residents.

Staff Characteristics Strengths

The CPC requires that 70% of direct service delivery staff have at least an associate degree in a helping profession and 75% with at least two-years of experience working with correctional populations. At the time of the assessment, GFPRC residential staff exceeded both these requirements. 80% (8 of 10) of staff met the CPC indicator for education and 90% (9 of 10) of staff met the CPC indicator for experience.

Staff have input into the program and feel valued by the treatment service director. For example, staff note the Honors program was implemented as a result of their feedback. Finally, the facility has established ethical guidelines that staff are expected to abide by.

Staff Characteristics Areas in Need of Improvement and Recommendations

When hiring new staff, decisions should be made based on skills and criteria beyond solely education or experience. Example of these can include communication abilities, willingness to learn, and background are important. It was unclear if GFPRC has a list of criteria they look for.

- ***Recommendation:*** When hiring new staff, candidates should be selected based on their level of empathy, positive attitude toward behavioral change, boundaries, flexibility, and genuineness. Having screening questions when conducting interviews with potential employees is a good way to ensure new hires have certain skills and values.

Although facility staff do meet regularly to discuss facility issues, service delivery staff do not regularly meet with the intention of conducting case reviews of all residents in the program.

- ***Recommendation:*** The service delivery staff (treatment services director, program manager, corrections treatment specialist, and licensed counselors) should meet at least twice per month to discuss intakes, case reviews, problems, programming, etc.

GFPRC staff receive an annual performance evaluation, however, the evaluations do not include direct service delivery skills. The form includes areas such as communication, time management, and attitudes.

- ***Recommendation:*** Each staff member providing services and interventions to residents should receive an annual evaluation that includes a summary of their direct service delivery skills. The current evaluation forms should be supplemented to incorporate service delivery skills such as knowledge and use of cognitive-behavioral interventions (CBI) and Core Correctional Practices (e.g., effective use of authority, effective reinforcement, effective disapproval, prosocial modeling, building a collaborative working relationship with residents, cognitive restructuring, structured skill building, and problem solving). Further, group facilitators should be regularly and formally evaluated on group facilitation skills and fidelity to curriculum being utilized, and these evaluations could be included in the annual review.

Clinical supervision should be provided at least once a month by a licensed clinical supervisor. Formal clinical supervision by a licensed clinical supervisor is not provided to all direct delivery staff.

- ***Recommendation:*** A qualified and trained clinical supervisor who has a clinical license or certification should provide regular supervision to those providing direct services to residents. At a minimum, the supervision should require at least monthly contacts with all treatment staff (corrections treatment specialist and licensed counselors) to assist them in how they can improve their service delivery. The supervision should focus on how these staff can better incorporate cognitive-behavioral interventions and core correctional practices into their group facilitation and daily interactions. This monthly supervision can happen individually or in a group format.

GFPRC has training protocol in place which includes a review of policies, ethics, PREA training, and an overview of programs provided at the facility. The CPC, however, recommends that new staff, who are expected to deliver any type of service, receive thorough training in the theory and practice of interventions employed by the program. Staff conducting assessments, individual sessions, or groups should be formally trained (and certified if required) on use of all assessment tools and curricula they are required to use prior to conducting assessments, sessions, or groups.

- ***Recommendation:*** All staff delivering treatment interventions should receive sufficient initial training on key topics such as principles of effective offender rehabilitation and group facilitation. This training should include formal training on the curricula utilized by the program and on the eight core correctional practices (CCP) essential to working with justice-involved individuals.

It is equally important that the GFPRC staff receive ongoing training related to service delivery. The CPC requires at least 40 hours of annual training for all direct service delivery staff with the majority of training hours focused on delivering effective services. While all staff are required to receive annual trainings, the number of hours of training staff currently receive is inadequate, and

the large majority of these trainings (e.g., Basic First Aid, Emergency Plan, Accountability and Security Procedures) are not focused on service delivery skills.

- ***Recommendation:*** All service delivery staff should receive at least 40 hours of ongoing training each year. The majority of these hours should be directly related to delivering treatment services. This should include a review of the principles of effective intervention, behavioral strategies such as modeling and role play, the application of reinforcers and punishments, risk assessment, group facilitation skills, case planning, and updates to the field of rehabilitation of justice-involved individuals.

Offering treatment services within a secure facility can be challenging. Thus, it is imperative that the administration communicates with all staff that the priority goal of the facility is rehabilitation. There should be evidence that *all* facility staff support rehabilitative goals and values. There are some concerns that security staff are not supportive of rehabilitation and change within justice involved individuals.

- ***Recommendation:*** Facility administration should focus on the culture of the program Rehabilitation with the goal of long-term behavioral change should be the primary focus of the institution. Some of the recommendations related to hiring and training of staff (e.g., CCP training) will assist with this as will the recommendations for revising the current behavioral management system (provided below).

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 GFPRC 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 assessment scores assist in determining which residents are suitable for services as well as determining duration and intensity of treatment services, based on risk level. Need assessment tools are also crucial as they determine the criminogenic needs of the individual. Treatment should

be individualized to target the most severe criminogenic needs of each resident. All residents at GFPRC have a risk and needs assessment done before placement in the center.

The specific tool used is the Montana Risk of Recidivism Assessment (MORRA) which is a validated tool. Further, more than 70% of resident at GFPRC are either categorized as being moderate or high risk of recidivating.

Offender Assessment Areas in Need of Improvement and Recommendations

While the program has some exclusionary criteria for certain types of offenders, such as sex offenders (level 2 and level 3) and very violent offenders, these criteria are not written and are vague.

- ***Recommendation:*** The GFPRC 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.

GFPRC serves specialized populations, including substance abuse, and domestic violence offenders. Beyond the MORRA, however, no tools are used to assess these domain specific needs. 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 MORRA, 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 and PCL-R/V-RAG for domestic violence.

Responsivity assessments assist in determining residents' possible barriers to treatment (i.e., mental health concerns, trauma histories, low motivation for treatment, learning or 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 GFPRC staff currently do not conduct responsivity assessments at intake. The program should be assessing responsivity areas with a validated, standardized and objective instrument(s). The responsivity assessments chosen should be relevant to the services offered by the program. For example, a structured cognitive behavioral program should consider conducting an intelligence or cognitive functioning assessment to identify residents who may struggle with the program approach.

- ***Recommendation:*** Responsivity factors can affect amenability to treatment such as level of motivation, level of cognitive functioning, level of anxiety, or verbal ability should be assessed upon intake. Several instruments are available that can classify residents into subgroups based on personality characteristics and provide strategies for case supervision. Examples include the *Jesness Inventory* (measures antisocial personality traits), Texas

Christian University's Institute of Behavioral Research's (TCU IBR) *Desire for Help, Treatment Readiness, or External Pressures* scales (measures motivational levels), *Beck's Anxiety Inventory* (measures anxiety), and *Beck's Depression Inventory* (measures depression). The program may wish to consult the TCU IBR's website for possible free responsivity assessments that were developed on offending/delinquent populations. The website can be accessed here: http://ibr.tcu.edu.

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 person'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 a resident will recidivate, characteristics associated with recidivism (criminogenic needs) must be targeted. The GFPRC offers services that target criminogenic needs in areas such as: antisocial thinking, coping strategies and relationships. Overall, the residential program is targeting at least 50 percent of their treatment efforts on criminogenic need areas.

According to the CPC criteria, the average length of treatment for effective programs should be between 3 and 9 months, and should not exceed 12 months, for the vast majority of program residents. At the GFPRC, the average length of treatment is below that range with most residents staying for approximately 6 months.

The CPC requires that while at the center, residents spend at least 40 percent of their time per week in structured tasks (i.e., 35 hours). Residents involved in structured activities have less down time. The GFPRC meets this requirement with most residents spending a large portion of their time engaging in employment.

Some staff at GFPRC are being matched to the specific services they deliver. For example, licensing determines who can deliver relapse prevention services and mental health services.

The residential program has developed some appropriate punishments, including GPS for accountability, write ups, and loss of cell phone privileges.

All treatment groups are conducted by direct service delivery staff (e.g., corrections treatment specialists) from beginning to end and are of appropriate size (8-10 resident per facilitator).

Treatment Characteristics Areas in Need of Improvement and Recommendations

To further reduce the likelihood that resident will recidivate, the ratio of criminogenic needs targeted to non-criminogenic needs should at least be 4:1 (80 percent criminogenic). While the program targets a number of criminogenic needs, it also targets a number of non-criminogenic needs. These include life skills, victim impact and mental health. As such, while the interventions focused on the criminogenic needs provided at the GFPRC surpasses the 50 percent ratio of criminogenic to non-criminogenic needs, it does not meet the 80 percent ratio. The emphasis of programming should greatly favor criminogenic needs as these are most likely to reduce recidivism. Moreover, the most effective programs are based on behavioral, cognitive behavioral, and social learning theories and models. While some of the programs at GFPRC are using cognitive components, further incorporating behavioral components to treatment would be beneficial.

- ***Recommendation:*** To increase the emphasis on criminogenic targets, staff should enhance the topics in the group and individual sessions to focus on the already identified core criminogenic needs and reduce the time spent on non-criminogenic needs. All groups could be re-focused to target the top tier of criminogenic need areas (i.e., attitudes, values, and beliefs; peer associations; and personality characteristics like impulsivity and coping skills). Targeting these need areas can be accomplished through the implementation of Cognitive Behavioral Interventions that give residents ample opportunity to practice prosocial skills. As residents progress through treatment, they should be provided advanced practice opportunities throughout their length of stay. These advanced practice opportunities should focus on high-risk situations that residents may face in the community when they are released. At the same time, the program should de-emphasize time spent on non-criminogenic needs. This can be achieved by reviewing all topics and removing sessions that are not related to the "central eight" risk factors.

Case plans should be based on formal assessment results. At the time of the CPC, formalized assessments were being conducted but were not used to create case plans. Case plans should include identification of targets for change, goals and objectives, time frames for completion, and performance indicators. Case plans should be developed in conjunction with the residents.

- ***Recommendation:*** Information from assessments should be used to develop effective case plans. The case plans for residents should target two or three of the highest criminogenic needs identified by the assessments. Residents should be involved in the development of their case plan, and the case plan should be routinely updated.

To ensure that effective interventions are being used at GFPRC, an overarching evidenced-based intervention modality should be adopted, and all group and individual sessions should be consistent with the program model. Modalities such as cognitive-behavioral or structured social learning have been shown to be effective at reducing recidivism among justice involved individuals. While GFPRC makes use of cognitive elements in treatment by incorporating MRT, no treatment includes any cognitive restructuring or structured skill learning. Thus, none of the groups could be considered behavioral in nature. The program should make enhancements to include regular cognitive restructuring and structured skill-building throughout a resident's length of stay.

- ***Recommendation:*** The GFPRC should implement a comprehensive program model based on social learning and cognitive behavioral theories and approaches. This model should also be reflected in the program manual, group interventions, and in all other interactions with residents. The program should review all treatment elements for social learning and CBT elements. All elements that do not contain a focus on changing thinking or providing new ways to think and behave in high-risk situations need to be eliminated or supplemented. The evidence-based curricula that are sporadically in use should be formally taught to staff that are expected to run them, and staff should be provided feedback and coached to enhance their service delivery.

- ***Recommendation:*** The focus of treatment should be on teaching residents to identify and replace antisocial thinking and choices with prosocial ones (i.e., cognitive restructuring). Cognitive restructuring can be taught through behavior chains, thinking reports, and cost-benefit analysis. The program should also focus on teaching the residents skills critical to their leading a crime-free lifestyle (e.g., refusal skills, relapse prevention skills, problem-solving skills, decision making skills, etc.), reinforcing residents for appropriate behaviors and choices, and holding residents accountable for antisocial behaviors and choices through the use of appropriate consequences.

Residents who go into the community for work are not adequately monitored by the center. For example, currently the center uses Google timeline to track residents. However, this does not provide real time tracking of residents. Further, work visits or phone checks are not conducted consistently for all residents going into the community.

- ***Recommendation***: For residents who go into the community, the facility staff should monitor their whereabouts closely. Some ways of doing this can include conducting random work visits, random drug screens, call-ins from residents, or call employers to check on residents.

A program manual that details some of the major aspects of the program does exist. For example, there is a resident handbook that explains various phases of the program, sanctions, and the rules and structure of the program. However, the program does not currently have a detailed program manual that specifies all major aspects of the program for both staff and residents.

- ***Recommendation***: The program manual(s) should include key pieces such as the program description, philosophy, admission criteria, assessment, scheduling, case planning, phase advancement, behavior management, completion criteria, discharge planning, aftercare, etc.

- ***Recommendation:*** All curricula/groups/lessons should be examined for their inclusion of cognitive restructuring and structured skill building. The program should consider using curricula that have more CBT techniques already built in. Examples are T4C and Cognitive Behavioral Interventions for Substance Abuse (CBI-SA). These curricula consist of manuals with structured lesson plans and require formal training from qualified trainers. More information regarding the *Thinking for a Change* curriculum and training can be gathered from the National Institute of Corrections website at http://nicic.gov/?q=t4c.

Additional information about CBI-SA curriculum and training requirements can be sought from the University of Cincinnati Corrections Institute's (UCCI) website at https://www.uc.edu/corrections/services/trainings/changing_offender_behavior/cbi-satrainingoverview.html). Should the program wish to continue using its current curricula, the program should supplement lessons with cognitive restructuring and skill building techniques.

At GFPRC, residents are not separated based on risk level. Research has shown that mixing low-risk people with moderate- or high-risk people can increase their risk of recidivism. Low-risk residents may be negatively influenced by the behavior of high-risk residents, thereby increasing their risk of recidivism. Thus, effective correctional programs inform service delivery using the risk, need, and responsivity levels of the resident. For example, effective programs are structured so that lower risk residents have limited exposure to their higher risk counterparts.

- ***Recommendation:*** Using MORRA scores, GFPRC should give preference to moderate- and high-risk clients. When low-risk clients are accepted into the facility, they should be provided separate housing units and separate treatment groups. They should not be mixed with moderate or high-risk residents. Individual sessions should be provided for low-risk residents, if the number of low-risk residents is too small to warrant separate groups.

Similarly, programs should use risk, need, and responsivity levels to vary the dosage (i.e., the number of hours of services) and duration of services a resident receives. We know that people who are at higher risk for recidivism by definition have more criminogenic needs, and they should be required to attend additional services, informed by the needs identified on the risk and need assessment tools. Currently the program does not consider dosage of treatment for residents. Types of services that can count toward dosage include interventions targeting a criminogenic need area using an evidence-based approach. At the GFPRC, most of the groups are workbook based. Based on the treatment groups observed, very little of the current hours of services would currently count toward dosage.

- ***Recommendation:*** Overall, the research indicates that people 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 residents need over 200 hours of services to reduce their risk of recidivating. Very high-risk or high-risk residents 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. As stated above, the facility can proactively plan for different treatment dosages based on risk level to ensure that service intensity varies upon risk and need levels. To illustrate, **Track A** could be reserved for those who are low risk. The residents in Track A would have less requirements for treatment services, and staff should ensure that they receive as little services as possible while still addressing key need behaviors (e.g., if the person is high need for substance abuse treatment). The overall hours and the time spent in the program should be shorter for these individuals (i.e., 3 to 4 months) as well. **Track B** could then be reserved for moderate-risk residents. The program would then design this track to provide group and individual sessions for

approximately 6 months and aim to deliver between 100 to 150 hours. Finally, **Track C** could be reserved for high-risk residents. These individuals would receive the highest intensity and length of services—over 200 hours and over the course of 9 months.

Responsivity factors like personality characteristics or learning styles should be used to systematically match residents to services. Assessed responsivity factors can also be used to assign staff, given that programs have better outcomes when staff are matched to residents based on assessed need and/or responsivity factors. Currently, the GFPRC does not use any assessments to match residents to programming or staff.

- ***Recommendation:*** Results from standardized criminogenic need and responsivity assessments should be used to assign residents to different treatment groups and staff. To illustrate, residents who are highly anxious should not be placed in highly confrontational groups (e.g., encounter groups) or with staff who tend to be more confrontational. Likewise, residents who lack motivation may need motivation issues addressed before an assignment to a service designed to address beliefs and teach skills.

Research indicates that programs that have mechanisms for residents to provide input/feedback on programmatic structures and features have better outcomes than programs who do not provide mechanisms for resident feedback. Currently, GFPRC does not seek resident input on programs and services provided. While the program conducted exit interviews with residents in the past, it no longer does so.

- ***Recommendation:*** Residents should have the ability to provide feedback to the program in a formal and consistent manner. Feedback can be sought through suggestions boxes, exit interviews, feedback forms or even through regular meetings with residents.

With regard to reinforcers and punishers, the program can increase its adherence to evidence-based principles by improving the use and process of administration of positive and negative consequences. Programs for criminal justice populations should identify and apply appropriate reinforcers in order to change behavior effectively. The program has established some appropriate reinforcers (i.e., honors program and positive incident reports), however, the administration of reinforcers needs improvement. For example, there is evidence that delivery staff provide their own incentives to residents and thus, rewards are not consistently applied throughout the program. Further, the ratio of rewards to sanctions (i.e., punishers) needs to increase. The research is clear that rewards need to outweigh sanctions by a ratio of 4:1. There was evidence that sanctions far outweigh rewards at GFPRC. Finally, program staff do not receive any formal training in the administration of rewards.

In addition to appropriate rewards, a good behavior management system has a wide range of consequences available to promote behavioral change when appropriately applied. The GFPRC has established some punishers as mentioned above, but the program relies heavily on punishers. In addition, staff are also not trained on how to properly administer effective negative consequences. For example, there is no formal policy concerning negative effects that may occur after the use of punishment. Policy and training should alert staff to issues beyond emotional reactions such as aggression towards punishment, future use of punishment, and response

substitution. CPC recommendations in this area are designed to help programs fully utilize a cognitive-behavioral model.

- ***Recommendations:*** The current behavior management system should be modified in the following manners:

    - Reinforcers should be increased and be monitored to ensure they are being consistently applied, administered as close to the time of the desired behavior as possible, and staff link the reward to the desired behavior. For key target behaviors, staff should have the resident articulate the short-term and long-term benefits of continuing that behavior. The use of reinforcements should not be focused on short term behaviors (e.g., cleaning, following TC protocol), but should focus on long term prosocial behaviors (e.g., avoid trouble with others, problem solving, etc.)

    - The program should strive for a 4:1 ratio of reinforcers to punishers. The program can increase its ratio by using reinforcement in informal contacts and in groups. All staff, including security staff, should be using reinforcement techniques.

    - For consequences to achieve maximum effectiveness, they should be administered in the following manner: 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 applicable).

    - Staff should understand punishment may result in undesirable outcomes that are beyond emotional reactions and should be trained to monitor and effectively respond to these responses. In addition to emotional reactions, staff should be trained to watch for avoidance/aggression towards punishers; mimicking of the same type of punishment received (e.g., if staff yells at a resident, the resident may yell at others in the program); responding by substituting inappropriate behavior with a new inappropriate behavior; and/or lack of generalization in the punishment (e.g., the consequence is not tied to reducing behavior long term).

    - There should be a written policy to guide the administration of rewards and punishers. 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.

The facility has not yet established completion criteria for the treatment program (i.e., when the treatment successfully terminates for each offender). While termination from GFPRC is currently based upon finishing up all Phases described in the resident handbook, progress in acquiring prosocial behaviors, attitudes, and beliefs is not evaluated as part of this process and residents are not differentially discharged from the facility. Treatment programs should expect approximately

65-85% of residents to successfully complete the program. At GFPRC, the successful completion rate for residents is not tracked by staff.

- ***Recommendation:*** The program should develop clear criteria to determine when a resident is ready to be discharged from the program. Currently, there is no consistent measurement of the acquisition of prosocial attitudes and behaviors. Behavioral assessments can be used for pre-post testing as a measure of change in attitudes and behaviors while in the program.

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

If correctional programming hopes to increase resident engagement in prosocial behavior, residents have to be taught skills in how to do so. As noted above, there was little evidence of cognitive restructuring or structured skill building (i.e., skill modeling, participant practice, and graduated practice) in groups.

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

- ***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 for the participant; 5) rehearsal of the skill (role-playing) by the participant; 6) staff providing constructive feedback to the participant on their use of the skill; and 7) generalizing the skill to other situations (e.g., homework or advanced role plays). Following this, participants 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 each participant.

At the time of the assessment, no services for family were provided. The CPC recommends that significant others (e.g., family and/or friends) receive training to provide structured support to residents as they transition home. Services should be provided that formally train family members to support the resident in making prosocial decisions using the skills and concepts taught by the program.

- ***Recommendation:*** The GFPRC 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.

The program staff do not currently develop a discharge plan for each resident that outlines their current needs and treatment goals.

- ***Recommendation:*** The program should develop a formal discharge plan for each resident at termination. The discharge summary should be sent to the parole officer and any referral agencies to ensure that the person is receiving seamless care once they transition out of the program.

Finally, research demonstrates that aftercare is an important component of effective programs when the goal is to help residents maintain long-term behavior change. Residents in the GFPRC do not routinely receive aftercare following the completion of the program. Aftercare services are largely dependent on availability in the community they return to.

- ***Recommendation:*** The program should explore options for aftercare or booster services once residents leave the program. To ensure that high quality aftercare is delivered, the program should consider the following: (1) involvement of families or significant others in aftercare so that the support system has an opportunity to report and discuss residents' behavior (including continued or even expanded use of the curriculum); (2) reassessment of risk/needs levels with a validated risk assessment instrument; (3) incorporation of cognitive restructuring/skill building and graduated practice of skills the resident learned while in the program; and (4) variation of the duration and intensity of aftercare by level of risk.

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

None

Quality Assurance Areas in Need of Improvement and Recommendations

The program is lacking key quality assurance mechanisms. Administrators do not conduct periodic file reviews and the program does not have a comprehensive management audit system in place. For example, there is no consistent observation of services (both group and individual) with feedback provided to the staff. Moreover, there is no formal mechanism to provide residents feedback on their progress in addressing their criminogenic needs. Residents seem unaware of what they need to accomplish in order to complete the program, aside from staying out of trouble and completing the minimum number of months.

- ***Recommendation:*** The treatment services director or the program manager should conduct regular audits to assess the quality of treatment planning and assessment of residents' progress. This process should allow for feedback and coaching of treatment staff and help ensure that high quality services are being delivered.

- ***Recommendation:*** The treatment services director or the program manager should allot time to directly observe staff delivering services. This process should allow for feedback and coaching. Observation and feedback help to ensure that high quality services are delivered, and that fidelity to the models being used is maintained. These observations can inform ongoing training needs, and also enhance the annual feedback provided to staff on their specific treatment skills (see the Staff Characteristics section). Observation should occur once per quarter or once per group cycle for each staff in each intervention (group and individuals).

- ***Recommendation:*** Residents should routinely receive formal and structured feedback on their individual progress toward meeting their individualized treatment plan goals and objectives. This gives them opportunity to correct and improve and increases the likelihood they successfully complete the program.

Currently, the GFPRC is not tracking the recidivism of the residents who are released from the facility, nor does it have a plan to do so. While the state produces a recidivism report each year, facility rates by institution are not included. Offender re-arrest, reconviction, or re-incarceration should be examined at least 6 months or more after leaving the facility.

- ***Recommendation:*** The GFPRC should work with the Montana DOC central office to collect and review recidivism data for all residents who are released from the facility. These data should then be examined over time to identify trends.

- ***Recommendation:*** The program should be formally evaluated. The outcome evaluation should provide a comparison between the recidivism rate of the program and a risk-controlled comparison group. The evaluation report should include an introduction, methods, results, and discussion section. The program should explore if Montana DOC has the ability to complete such a study through an internal evaluation. 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 doctoral dissertation (in order to provide another no-cost/low-cost option for evaluation). Local colleges and universities such as University of Providence and Montana State University-Northern might be reasonable options. The departments that could assist with such a project include fields like criminal justice, sociology, and psychology.

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

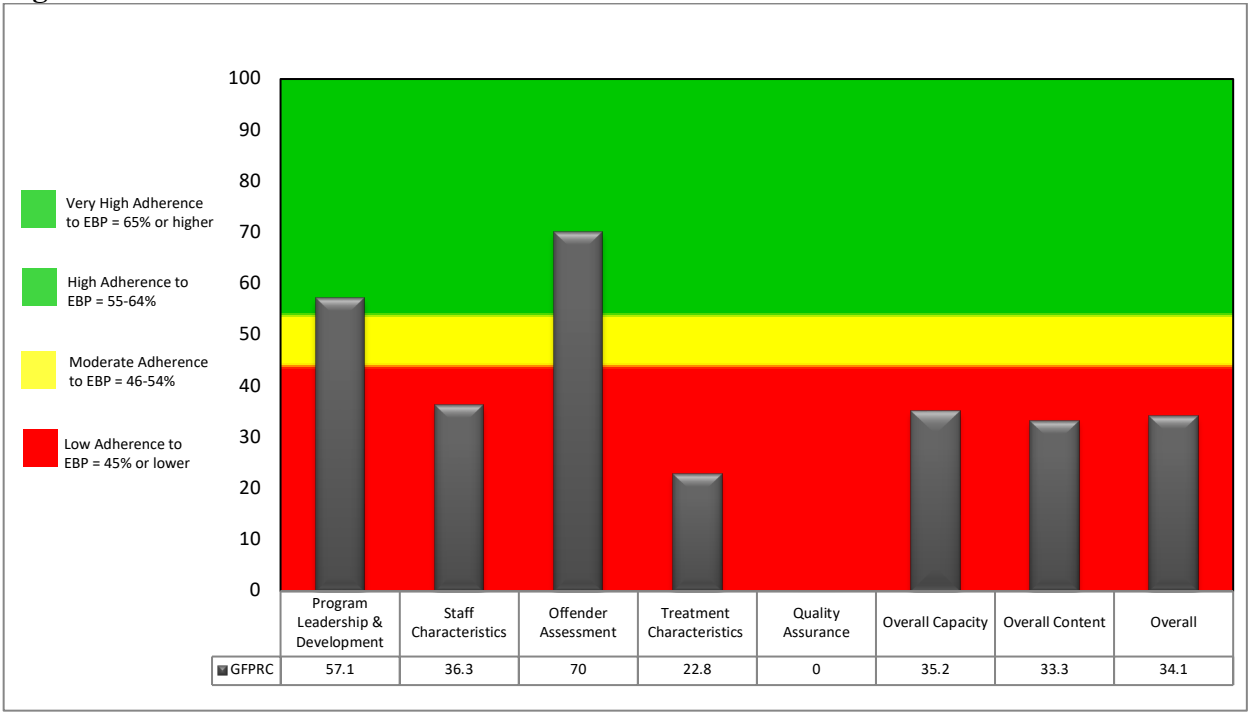
conducted by UCCI indicates that programs that score in the Very High and High Adherence categories look like programs that are able to reduce recidivism.

The Great Falls Pre-Release Center received an overall score of 34.1% on the CPC. This score falls into the Low Adherence to EBP category. Each of the domains and both areas (i.e., capacity and content) of the CPC also score in the Low Adherence to EBP category.

In reviewing this report, please keep in mind that the facility was not designed with the CPC in mind, and program staff should commend themselves for operating the program with limited resources. Recommendations have been made in each of the five CPC domains, and these recommendations should assist the program staff with making the necessary changes to increase adherence to what works in reducing recidivism.

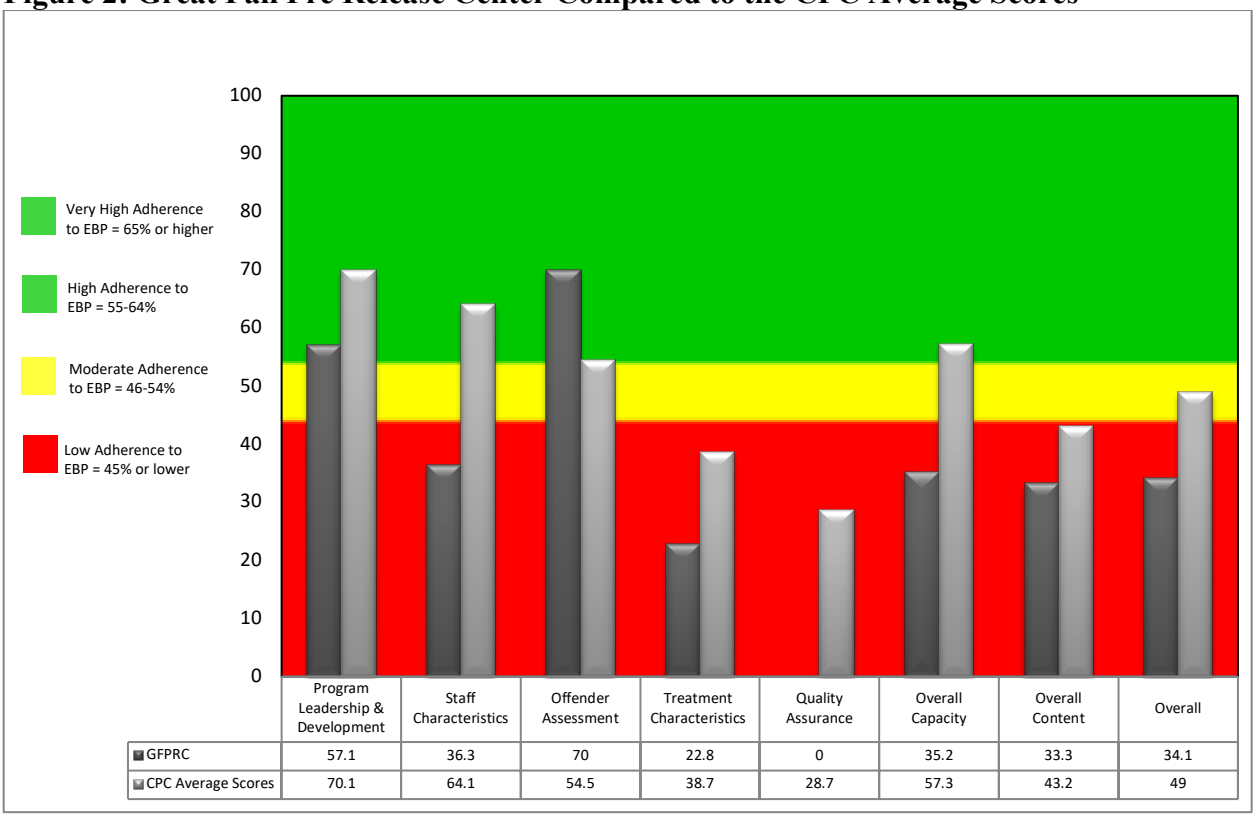
Certainly, care should be taken not to attempt to address all recommendations at once. Facilities that find the assessment process most useful are those that prioritize need areas and develop action plans to systemically address them. Should the program staff and/or MDOC central office need assistance with action planning or technical assistance, UCCI can provide or recommend others to help in these endeavors. Evaluators note that during the site visit it was clear that GFPRC staff are open and willing to take steps toward increasing the use of EBP within the facility. This motivation will no doubt help the program implement the changes necessary to bring it further into alignment with effective correctional programming.

Figure 1: Great Falls Pre Release Center CPC Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
GFPRC	57.1	36.3	70	22.8	0	35.2	33.3	34.1

Figure 2: Great Fall Pre Release Center Compared to the CPC Average Scores*



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
GFPRC	57.1	36.3	70	22.8	0	35.2	33.3	34.1
CPC Average Scores	70.1	64.1	54.5	38.7	28.7	57.3	43.2	49

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