EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC)

Great Falls Transition 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 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) is directed to conduct evaluations of programs to reduce recidivism that are founded by the state. Therefore, the Great Falls Transition Center (GFTC) will be evaluated 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 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 of the CPC.

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). Through 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 interventions, 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, observations of direct services, and review of relevant program materials (e.g., offender files, program policies, and procedures, treatment curricula, client handbook, etc.) Once the information is gathered and reviewed, the evaluators score the program. When the program has met a CPC indicator, it is considered a strength of the program. When the program has not met an indicator, it is considered an area in need of improvement. For each indicator in need of improvement, the evaluators construct a recommendation to assist the program's efforts to increase adherence to research and data-driven practices.

After the site visit and scoring process, a report (i.e., this document) is generated which contains all the information described above. In the 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 UCCI's CPC database, which is used 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 empirical literature on what works in reducing recidivism. As such, no program will ever score 100% on the CPC. Second, as with any explorative process, objectivity and reliability can be concerns. Although steps are taken to ensure that the information gathered is accurate and reliable, given the nature of the process, decisions about the information and data gathered are invariably made by the evaluators. Third, the process is time specific. That is, the results are based on the program at the time of the assessment. Though changes or modifications may be under development, only those activities and processes that are present at the time of the review are considered for scoring. Fourth, the process does not consider all "system" issues that can affect the integrity of the program. Lastly, the process does not address the reason that a problem exists within a program or why certain practices do or do not take place.

Despite these limitations, there are several advantages to this process. First, it is applicable to a wide range of programs. 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 assessment conducted to date, program 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 are more likely to reduce recidivism.

SUMMARY OF THE FACILITY AND SITE VISIT PROCESS

The Great Falls Transition Center GFTC, located in Great Falls, Montana, is a comprehensive community-based correctional program since March of 1984. It serves both male and female adult felony offenders referred by MDOC staff. GFTC is a 212-bed capacity facility (not counting the Federal capacity which is not monitored by MDOC) consisting of 176 male beds and 36 female beds designed to assist their residents in transitioning back into the community as well as to provide a cost-effective, program-intensive alternative to incarceration. 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 and groups.

The CPC Assessment took place on April 28-29, 2025. For the purposes of this assessment Shellie Babinecz was identified as the Program Director. The assessment process consisted of a series of structured interviews with their onsite staff (Correctional Treatment Specialists, Correctional Officers, Treatment Specialist, Licensed Clinicians, and Program Director), group observations (MRT Domestic Batterers Intervention and MRT Escaping Your Prison), case plan and file review (10 open and 10 closed files), all the materials provided per the Materials Checklist (policy and procedural manuals, staff training information, staff evaluations, assessments, curricula, client handbook, etc.), and participant interviews. Traces from these 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, Shellie Babinecz serves as the 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

Research shows that Program Directors who are professionally trained with at least a Baccalaureate Degree in a helping profession and specialized course work in corrections or forensic/legal area are more successful. Shellie Babinecz has a bachelor's degree in criminal justice administration with a concentration in corrections and a minor in sociology. Research shows that Program Directors who have at least three years of experience with a justice-involved treatment program are more successful in reducing recidivism. Shellie Babinecz has been employed with the GFTC for 10 years and has been in her current position as the Treatment Services Director for GFTC for one year.

Ms. Babinecz is directly involved in the hiring and approval of staff at GFTC. Ms. Babinecz is on the panel for hiring and is active in selecting staff in the hiring process. Research indicates that Program Directors who conduct some formal training for new direct service delivery staff are more effective than those who do not. Ms. Babinecz trains new staff in several areas once they arrive onsite. Those areas include initial onboarding, how to interact with the residents, case files and case planning, and time management. She also connects new staff with a Community Treatment Specialist mentor where they receive on the job training. Ms. Babinecz provides supervision of staff by reviewing case plans, observing interactions with residents, treatment team meetings, annual reviews, and she will meet individually if it is needed.

The GFTC identified that they have support from multiple criminal justice stakeholders in their community. These stakeholders were identified as the MDOC, local Probation and Parole (P&P), and local law enforcement. Ms. Babinecz as well as various staff stated that they feel they get great support across the board from these stakeholders. In addition, several community stakeholders were identified by staff, and they feel overall supported by these stakeholders. Those included several different businesses that employ their residents, Job Services that come to GFTC weekly, and volunteers.

Research shows that programs that have been in operation for longer than three years and provide single sex programming show better outcomes. The GFTC has been in operation since 1984 and serves both male and female adult felony offenders. All groups and activities residents attend are separated by gender. Additionally, Ms. Babinecz stated that the funding they receive is adequate and stable, and they can implement the program as designed to serve the resident population. Ms. Babinecz provided documentation to show the stability of their funding.

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

The research on program effectiveness asserts that involved Program Directors are more effective. Program directors should 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, Ms. Babinecz was not involved in direct service delivery.

- ***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 a program be based on effective correctional treatment literature and that all staff members have a thorough understanding of the research. This treatment literature must consist of major criminological and psychological journals and key texts, and all staff should have an understanding of the literature and be able to articulate it. Additionally, literature reviews should be conducted on a regular basis to ensure the program is grounded in evidence.

- ***Recommendation:*** The GFTC should conduct regular literature reviews to ensure that an effective program model is implemented consistently throughout all components of the program. The 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, Micheal Braswell, and David Lester. Journals to be regularly reviewed should, at a minimum, include *Criminal Justice and Behavior; Crime and Delinquency;* and *The Journal of Offender Rehabilitation.* It is important that the core program and all 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). The literature should then be covered during regular staff meetings and disseminated to all staff on a regular basis. Staff should be able to show a good understanding of the literature and the program model.

Successful programs that initiate changes or new treatment curriculums in their overall structure have formal, short-term piloting programs where the initiation of the program and its success is evaluated. The pilot program needs to be short in duration, have a clear start and end date, and seek out and involve staff and gather their input. There was a general sense of awareness that treatment groups were being piloted, however, there was no clear understanding of the duration of the pilot program or how the data was being collected.

- ***Recommendation:*** When piloting a program, there should be a clear start and end date that is known and effectively communicated with staff and residents. Information and data on the pilot program should be collected and communicated with staff and residents.

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 is the Program Director, as they were assessed in the previous domain. In total, 16 staff, clinical and case management that are employed by GFTC were identified as providing direct services.

Staff Characteristics Strengths

GFTC program staff meet CPC standards for education and experience. At the time of assessment, the majority of direct service delivery staff have obtained an associate degree or higher in a helping profession, thus exceeding the CPC requirements in these areas. The GFTC should be commended for the education of their programming staff.

When hiring, the GFTC selects staff based on certain skills and criteria beyond solely education or experience. Staff are selected based on skills and values supportive of GFTC's mission and values. Specifically, staff are hired based on a belief that offenders can change, being non-confrontational but firm, strong support for offender treatment and change, and problem-solving.

Staff conducting assessments, individual sessions, or group/interventions are formally trained (and certified if required) on the use of all assessment tools and curricula they are required to use prior to delivery. Shadowing with experienced staff is implemented for new staff and includes observing groups, one-on-one meetings, and general conduct.

Programs that have a formal mechanism in place for staff to provide input into how the program runs demonstrate better outcomes than programs that lack this feature. The totality of the site visit indicated that staff may provide input into the program. Changes must be reviewed and approved by the program director before they are implemented. In addition, staff expressed support for the goals and values GFTC throughout the site visit. Staff support is important so that the program can run as intended.

GFTC has a set of written ethical guidelines that all staff must adhere to. All staff were both aware of the existence of the ethical guidelines and able to identify the location. Effective programs have documented and accessible ethical guidelines.

Staff Characteristics Areas in Need of Improvement and Recommendations

Successful programs are those where direct service delivery staff have worked in programs with criminal/juvenile justice populations for at least two years. Through the staff surveys, it was observed that a little more than half of direct service delivery staff have worked in treatment programs with justice involved participants for at least two years. The CPC requires that the vast majority of direct service delivery staff have at least two years' experience working with criminal/juvenile justice populations.

- ***Recommendation:*** When hiring new service delivery staff, preference should be given to candidates who have more than two years' experience with the criminal justice population.

At GFTC, the case managers and correctional treatment specialists meet weekly, all treatment staff meet monthly, and all GFTC staff meet monthly. During these meetings policy updates are discussed, procedures are reviewed, and they have opportunities to discuss difficult cases. There is no systematic review of all cases on a regular basis. Programs that demonstrate better outcomes have staff meetings that occur at least twice per month where specific client cases are reviewed on regular intervals in detail.

- ***Recommendation:*** One of the current meetings with all direct service delivery staff should be reformatted to ensure a formal case review for every client at a set interval. Opportunities to openly discuss progress and issues on an ongoing basis will assist both the staff and the program participants.

Programs should assess professional staff at least annually on service delivery skills. GFTC conducts an annual employee evaluation on each member of staff; however, they are not assessed on service delivery skills.

- ***Recommendation:*** GFTC should continue to conduct an annual staff assessment. The assessment should include evaluations of staff's skills as it relates to service delivery. Examples of service delivery skills may include assessment skills and interpretation of results, redirection techniques, group facilitation skills, effective interventions, or knowledge of the treatment intervention model. These skills could also be assessed separately for program delivery staff if it is not included in the general employee evaluation. Assessment of skills should be documented and conducted annually for all service delivery staff.

Professional staff do not receive clinical supervision by a licensed clinical supervisor.

- ***Recommendation:*** All direct service delivery staff should receive supervision by a licensed clinical supervisor. Supervision can include observing groups, periodically attending weekly case manager/correctional treatment specialist meetings, signing off on completed treatment plans, and 1:1's with staff as needed.

Ongoing staff training does not meet the minimum amount required as indicated by research for effective programs. This research suggests that programs should provide a minimum of 40 hours of annual training for all direct service delivery staff related to delivering effective services. Providing treatment for the criminal justice population is an ever-evolving field. Research and best practices continue to be updated and modified as more research is conducted and providing ongoing staff training ensures staff remain knowledgeable about best practices.

- ***Recommendation:*** Each service delivery staff member should receive a minimum of 40 hours of formal training annually. These hours should be directly related to delivering criminogenic services to participants involved in the justice system. Training may include principles of effective intervention, assessments, specific program components (e.g., anger management, dual diagnosis, substance abuse), group facilitation, core correctional practices, cognitive-behavioral interventions, social learning, etc. Training in areas not directly related to service delivery (i.e., CPR, restraint, bloodborne pathogens, etc.), while required for different aspects of the job, should not be counted towards this criterion.

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 majority of residents at the GFTC were appropriate for services offered. Staff indicated that roughly 5% of the participants were inappropriate due to medical or mental health issues. The facility should continue to monitor these concerns and ensure that it does not exceed the 20% threshold. GFTC does have written exclusionary criteria for the program. They do not accept Sexual Offenders unless they meet a very specific set of criteria, which has resulted in no sexual offenders currently placed at the facility. This criterion is followed consistently.

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 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 GFRC have a MORRA completed prior to or during their placement. Risk and need assessment tools should be validated with scoring ranges for risk/need levels. The MORRA is a validated risk/need assessment instrument.

GFTC provides an environment where most of their residents are classified as moderate to high risk. Specifically, more than 70% of residents at GFTC are either categorized as being moderate or high risk of recidivating.

Offender Assessment Areas in Need of Improvement and Recommendations

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

- ***Recommendation:*** In addition to the MORRA, the program should utilize validated, standardized needs assessments to determine placement in and duration of treatment services for substance abuse and domestic violence offenders, and to address criminal thinking. Examples of these include ASI (Addiction Severity Index) or Texas Christian University (TCU) – Drug Screen 5 for substance abuse, TCU-Criminal Thinking Scales for criminal thinking, and PCL-R/V-RAG for domestic violence.

Successful programs assess and provide services based on responsivity factors (e.g., motivation, readiness to change, intelligence, reading level, etc.). Responsivity factors should be assessed using one or more validated, standardized, and objective instruments. The results of the assessment(s) should be used to make clinical or staffing decisions based on the necessary responsivity factors.

- ***Recommendation:*** Responsivity factors can affect amenability to treatment such as level of motivation, level of cognitive functioning, and level of anxiety and/or depression 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), *URICA (University of Rhode Island Change Scale)* measure motivation for change, *Beck's Anxiety Inventory* (measures anxiety), *Beck's Depression Inventory* (measure depression). These instruments should be used to place offenders in certain treatment groups, on appropriate staff caseloads, or used to address responsivity factors as needed. Additionally, staff should be made aware of the responsivity factors assessed and how they can use the assessments to mitigate responsivity issues.

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

Case planning is a critical step in addressing criminogenic needs. Programs that have shown to reduce recidivism involve participants in the development of their own plan which encourages participant buy-in to the process. Case plans should be unique to each participant's needs but may contain similar objectives based on criminogenic needs. Observations made during the onsite visit indicated that the residents at the GFTC arrive at the facility/program, are assessed and given a treatment plan based on those results and from input with the resident. Residents review their treatment plan with their assigned case manager during weekly one-to-ones.

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

GFTC residents are supervised using accountability checks, security personnel visuals, phone calls, and Google GPS tracking system.

GFTC has detailed program manuals that outline key information within the program. This includes the program philosophy, case planning, and phase advancement. The program also has manuals for all their treatment programming, which includes lesson plans, goals of the session, homework assignments, and recommended teaching methods.

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 GFTC meets this requirement with most residents spending a large portion of their time engaging in employment.

Residents at GFTC are assigned to groups or services that match best with their needs and other responsivity factors as determined by the MORRA. GFTC offers the same group at different times to meet the employment needs of the residents as well as a focus on court orders/judgments and what the Board of Pardons and Parole has recommended.

GFTC values the resident's input. They gather this information through suggestion boxes and end of group evaluations.

GFTC has developed a range of rewards including positive incident reports, phase system, monthly newsletter that recognize the residents, Honors Program, and educational/vocational recognition board.

The residential program has developed some appropriate punishments, including extra duty, loss of passes, loss of phone privileges, moved to the dorm if in Honor's Program, write-ups, community services and program extension of 30 or more days.

Based on file review and interviews with staff members, the current successful completion percentage was between the allotted amount that CPC recommends.

Treatment Characteristics Areas in Need of Improvement and Recommendations

Based off the file review and interviews with staff and residents, it was identified that GFTC focuses less than the CPC recommended percentage on its effort on criminogenic factors. 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. 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 GFTC are using cognitive components, further incorporating behavioral components to treatment would be beneficial.

- ***Recommendation:*** To focus more on the effort of criminogenic factors, creating and/or incorporating a program where the focus is mainly on criminogenic needs and not non-criminogenic needs. Possible program targets that can be included are substance abuse/relapse prevention; antisocial/prosocial thinking, attitudes, values, and beliefs; high risk situations that lead to illegal behavior; antisocial peers/lack of prosocial peers; positive attitudes/performance in education/employment.

- ***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.

To ensure that effective interventions are being used at GFTC, 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 GFTC 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 GFTC 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.

At GFTC, 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, GFTC 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.

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. By definition, we know that people who are at higher risk for recidivism 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 GFTC, 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.

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 GFTC does not continually use assessments to match residents to programming and/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.

Based off staff interviews, GFTC requires all case management staff to be trained in MRT. Group facilitators are assigned to groups based off who is trained to facilitate the group and scheduling.

- ***Recommendation:*** It is recommended that staff are assigned to programs/groups based on their skills, experience, education, or training (e.g., staff with a chemical dependency license are conducting substance abuse groups).

Programs for criminal justice populations should identify and apply appropriate reinforcers in order to change behavior effectively. The GFTC has established 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 GFTC. Finally, program staff do not receive any formal training in the administration of rewards.

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

    - Reinforcers should be increased and 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 only be focused on short-term behaviors (e.g., cleaning), 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/formal contacts and in groups. All staff, including security staff, should be using reinforcement techniques.

    - For consequences to achieve maximum effectiveness, consequences given 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 completes for each resident). Successful completion from GFTC is currently based upon finishing up all Phases described in the resident handbook and/or meeting 200-days. 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.

- **Recommendation:** GFTC 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.

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 the resident's 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 GFTC 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 formal 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 to include scheduled follow-up appointments with dates and times. 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 GFTC 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

No strengths were noted for the Quality Assurance section of this report.

Quality Assurance Areas in Need of Improvement and Recommendations

Research shows that programs will be more effective if they have an internal management audit system. This should include file review, regular observations of staff delivering groups/services, and mechanisms to provide participant feedback on their progress in the program. While onsite the assessment team did see indicators of minimal file review and participant feedback during case management meetings, there was not an indication of group monitoring or feedback given to group facilitators.

- ***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. Observation should occur once per quarter or once per group cycle for each staff in each intervention (group and individuals).

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 GFTC does utilize outside treatment providers to meet the needs of their residents. Through file review and staff interviews it was evident that information and/or progress on how each resident is doing in treatment is not consistently shared with the staff at the GFTC.

- ***Recommendation:*** The Program Director, or designee, should formally observe outside treatment providers to ensure that the services being provided are of high quality. Observation of outside treatment providers/group sessions should occur on a regular basis and the GFTC should require that each treatment provider submit regular progress reports for each resident. Additionally, the GFTC should ensure that all assessments, progress notes, or any additional information regarding how the residents did during group(s) is shared and consistently found in resident files with an appropriate Release of Information (ROI).

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 GFTC does use a suggestion box and group participant survey at curriculum completion, such as MRT Escaping Your Prison. 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 GFTC 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 residents are meeting target behaviors are more effective. Indicators may include pre- and post-testing on target behaviors, reassessments using standardized instruments, monitoring progress through detailed treatment plans, and making changes/updating those plans on a regular basis. In conducting a file review of closed files, there was no tangible evidence found to support that a standard reassessment process takes place.

- ***Recommendation:*** The GFTC should develop and implement 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 in their case/treatment plans. This policy and/or procedure should include sections identifying case management, criminogenic needs, current and reassessment timeframes, and life-altering events.

Research shows that programs that gather offender re-arrest, reconviction, or re-incarceration data at six months or more after participant termination from the program are more effective. The GFTC does not track these data points. Additionally, the GFTC has not undergone a formal evaluation comparing its treatment outcomes with a risk-control comparison group. Finally, the GFTC does not work with an internal or external evaluator that can provide regular assistance with research/evaluation. While MDOC compiles some of this information and OMIS allows for some reports to be run, the GFTC has not identified a process to ensure that available data are examined to help the facility/program make data-driven decisions. Due to not having a formal evaluation, there were no findings to review for reduction of recidivism related to a comparison group.

- ***Recommendation:*** Recidivism, in the form of rearrest, reconviction, or reincarceration, should be tracked at six months or more after termination from the GFTC. The program can do this on their own 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 understands 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. The GFTC should explore if they have 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 may include Montana State University (Bozeman, Billings or Northern), University of Montana (Missoula), or Montana Tech (Butte). Departments that could assist with such a project include fields like criminal justice, sociology, and psychology.

- ***Recommendation:*** Once a program evaluation can be conducted a positive finding between a comparison group and the treatment group should show a statistically significant difference or a substantial reduction in recidivism rates should be found to meet CPC standards/recommendations. If a comparison study is conducted that does not show a significant difference or reduction in recidivism rates, the GFTC should make programmatic changes to improve the outcomes.

- ***Recommendation:*** Similarly, the GFRPC should identify an evaluator who is available to assist with data analysis. If this is an internal position, evaluation must be the focus of their position, and they should have appropriate credentials. Alternatively, the GFTC 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 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 can reduce recidivism.

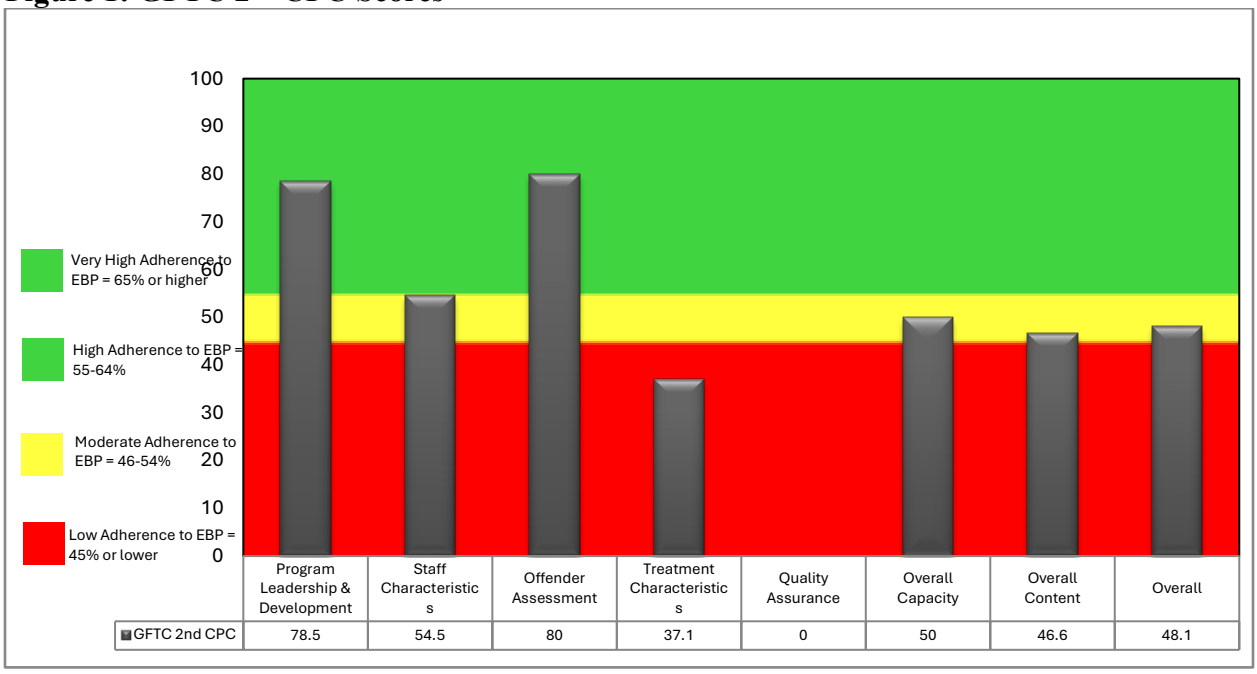
The GFTC received an overall score of 48.1% on the CPC. This falls into the Moderate Adherence to EBP category, which is a significant improvement from their previous CPC. In the Capacity Domain, GFTC scored 50% which falls into the Moderate Adherence category. In the Content Domain, GFTC scored 46.6% which is Moderate Adherence to EBP. These scores were a great improvement from their previous CPC Assessment conducted in 2022 where the Capacity Domain scored 35.2%, Content Domain scored 33.3%, and their Overall score was 34.1%. While there is still room for improvement and changes that could be made, GFTC staff should commend themselves for the work they have done.

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 systematically address them. Should GFTC want assistance with action planning or technical assistance, MDOC can provide or recommend others to help in these endeavors. Evaluators note that GFTC staff are open and willing to take steps towards increasing the use of EBP within the facility. This was clearly identified during the kickoff call, ongoing communications, and onsite visit.

Shown below are two graphs (Figure1 and 2) indicating the percentage(s) received in each domain of the CPC. Figure 1 shows the percentages the GFTC received for each domain based

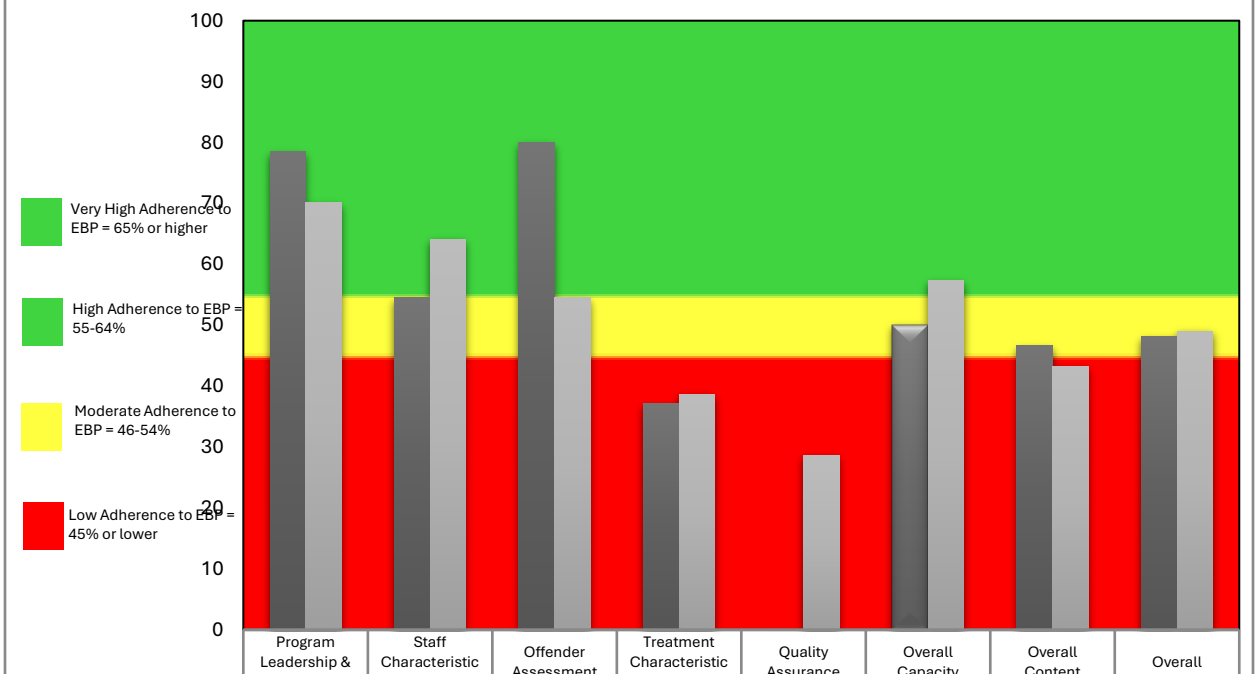
on how each item was scored. Figure 2 shows the GFTC's percentages compared to the CPC's average scores.

Figure 1: GFTC 2nd CPC Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
GFTC 2nd CPC	78.5	54.5	80	37.1	0	50	46.6	48.1

Figure 2: GFTC 2nd CPC Compared to the CPC Average Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
GFTC 2nd CPC	78.5	54.5	80	37.1	0	50	46.6	48.1
CPC Average Scores	70.1	64.1	54.5	38.7	28.7	57.3	43.3	49

i. In the past, UCCI has been referred to as the University of Cincinnati (UC), UC School or 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. Reference 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, Division 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 support 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.