FINAL REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC 2.1)

Sex Offender Program
Montana State Prison

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INTRODUCTION

Research has consistently shown that programs that adhere to the principles of effective intervention, namely the risk, need, and responsivity (RNR) principles, are more likely to impact 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 (see Andrews & Bonta, 2010 and Smith, Gendreau, & Swartz, 2009, for a review). Recently, there has been an increased effort in formalizing quality assurance practices in the field of corrections. As a result, legislatures and policymakers have requested that interventions be consistent with the research literature on evidence-based practices.

Within this context, the Sex Offender Program at the Montana State Prison was assessed using the Evidence-Based Correctional Program Checklist (CPC). The objective of the CPC assessment is to conduct a detailed review of the SOP practices and to compare them to best practices within the correctional treatment literature. Strengths, areas for improvement, and specific recommendations to enhance the effectiveness of the services delivered by the SOP are offered. The SOP was assessed as part of a training initiative with the Montana Department of Corrections (DOC). DOC 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 second 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 Complete Alignment with EBP (65% to 100%), Partial Alignment with EBP (55% to 64%), Developing Alignment with EBP (46% to 54%), or Realignment with EBP Necessary (45% or less). It should be noted that the five domains are not given equal weight, and some items may be considered not applicable in the evaluation process.

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

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

[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.

prior approval. The scores from your program will be added to our CPC database, which we use to update scoring norms.

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

Despite these limitations, there are a number of advantages to this process. First, it is applicable to a wide range of programs.[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 Sex Offender Program (SOP) is operated at Montana State Prison (MSP) by the Montana Department of Corrections. SOP offenders are housed in the main facility of MSP, with groups facilitated on the Low Side and High Side, referencing custody levels based on security risk. SOP at MSP has been in existence since 1988 and provides service to approximately 100 offenders per year. At the time of assessment, there were roughly 66 inmates in the SOP Program. SOP is provided at multiple housing units at MSP; as a result, SOP inmates are housed with general population inmates. SOP is broken up into three phases, SOP I, SOP II, and SOP Aftercare. Offenders are referred to the program upon entrance to MSP when a review of the file indicates current sex offenses. Most offenders are referred due to court orders or through the Board of Pardons and Parole as part of the release plan. There are multiple inmates on the waiting list to

begin programming. Chris Nordstrom is identified as the Program Director for the program. At the time of the CPC site visit, SOP Aftercare was not offered at the institution due to staffing shortages.

SOP I is a closed-ended group which provides educational information to offenders. SOP I is described as an educational phase for offenders who have a documented history of sexually deviant behavior. Most who participate in SOP I are court ordered it is a pre-requisite for entering SOP II. It uses the SABER curriculum for 32 hours of total group time, typically taking 12-16 weeks. The groups are didactic or process groups, strictly discussing educational information. The group was offered by an SOP Tech.

SOP II is an open-ended group that provides programming in two separate settings. The outpatient (OP) SOP II groups are facilitated by a fully licensed therapist with at least a master's degree and who has obtained certification from the Montana Sex Offender Therapist Association (MSOTA). Offenders are housed throughout the institution and only come together during group times each week. The SOP II typically takes 12- 24 months to complete. The curriculum used, Sexually Abusive Behavior: Evaluation and Recovery Program (SABER) is manualized and authored by a MSOTA therapist. At the time of the assessment, the SOP was preparing to adopt a new curriculum, replacing the SABER curriculum. The SOP I SABER manual states using a psychoeducational model and the SOP II manual states using a cognitive behavioral modality. SOP staff routinely supplement the manualized curriculum with additional material. The total program includes 45 specific assignments, with supplemental assignments at the discretion of the facilitator. The SABER curriculum is described as cognitive in nature, with some behavioral-based assignments and groups. At the time of assessment, there was no Aftercare component being offered because of staff shortages.

The CPC evaluation took place at the MSP on May 18, 2022, as part of a training for the Montana DOC. The evaluation consisted of a series of structured interviews with the SOP Program Manager, unit managers, security staff, contracted therapist, case manger, case manager supervisor, and an intake officer. A phone interview post site visit was conducted with the SOP Tech. Additionally, data were gathered via the examination of twenty representative files (open and closed), as well as other relevant program materials (e.g., treatment manuals, assessments, client satisfaction surveys, training logs, ethical guidelines, staff evaluations, and quality assurance plans). Finally, two SOP II treatment groups were observed.

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 youth, as well as the development, implementation, and support (i.e., both organizational and financial) for the treatment services. The evaluators identified Mr. Chris Nordstrom 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 program components should be piloted before full implementation. The values and goals of the program should also be consistent with existing values in the community and/or institution, and it should meet all identified needs. Lastly, the program should be perceived as both cost-effective and sustainable.

Program Leadership and Development Strengths

Mr. Nordstrom poses bachelor's and master's degrees in social work and has taken multiple courses in forensic social work. This meets the CPC's criterion for educational experience. In addition, Mr. Nordstrom meets the CPC criterion for experience working with correctional treatment programs. He has over 20 years of experience working in treatment programs with correctional populations, with much of that time working with sex offenders. in her current position with treatment programs targeting correctional populations.

Mr. Nordstrom is consistently involved in the hiring of new staff. Research demonstrates that correctional programs with program directors who consistently play a role in the hiring decisions of all program staff members have better outcomes than programs that lack these criteria. Currently, Mr. Nordstrom will sit in on interviews and makes hiring recommendations.

Mr. Nordstrom is directly involved in supervision activities. Mr. Nordstrom provides supervision meetings for sex offender therapist and the sex offender tech. Supervision occurs each Monday and lasts 60-90 minutes.

Programs that have program directors who are formally conducting some aspect of the program demonstrate better programmatic outcomes than programs that lack this feature. Active involvement in program administration helps program directors and the program better understand changing populations and client issues, to name but two benefits. Mr. Nordstrom currently facilitates five Phase II groups throughout the week and carries a caseload consisting of the inmates in his groups.

Research demonstrates that established treatment programs—programs that have been consistently in operation for a minimum of three years—demonstrate better outcomes than programs that have yet to establish themselves. The MSP SOP meets this criterion as it has been in operations since the early 1990s.

The SOP is valued by the criminal justice community. There is stakeholder support from the warden, MSP administrations, DOC, correctional officers, case managers, and unit managers.

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

Research demonstrates that program directors who are directly involved in some formal aspect of the training of new staff have better outcomes than programs that lack this criterion. Currently, the program director is not involved in the training of staff. All new staff receive New Employee Orientation at the institution, but there is no specific training for the SOP. Training is supervised by the program coordinators.

- ***Recommendation:*** The program director should have active involvement in conducting some formal training for all new direct service delivery staff. This can include, but is not limited to, direct training, direct involvement in the shadowing process for new staff (i.e., a weekly check-in with direct feedback), and observing/providing feedback in day-to-day activities. Again, the program director should consistently be involved in the training process for all positions of the program that interact directly with clients.

It is important the program is based on the effective correctional treatment literature and that all staff members have a thorough understanding of this research. At the time of assessment, the program being offered by SOP was not selected based on evidence in the correctional treatment literature; rather, the program was previously designed by a staff member with experience working in sex offender programs. A formal literature review about what works with justice-involved individuals in reducing recidivism has not been conducted and shared with the staff.

- ***Recommendation:*** The MSP (or DOC) as an agency and/or the program 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 SOP. 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).

- ***Recommendation:*** All staff working in the program should regularly receive related research articles, and a portion of each staff meeting should be used to ensure that this information is reviewed and discussed for relevance to the SOP. Then, the SOP should ensure that all core services (e.g., group and case management sessions intending to reduce recidivism) are implementing practices that are in line with proven/effective methods (see additional recommendations below).

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

- ***Recommendation:*** As new components are incorporated into the SOP, a formal pilot period for each new component should be undertaken. (This will be especially important as MSP will soon be rolling out a new SOP curricula.) For example, should the program

supplement a current curriculum or add a new curriculum, this should first be piloted. 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 client and staff feedback, and a 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.

Finally, funding for the program is not adequate or stable. MSP has been experiencing staff shortages and this has directly and indirectly impacted the SOP. The SOP program has recently been subject to a loss of FTE, with money being shifted away from SOP to fund hiring in different positions at MSP. In addition, the program cannot currently run Phase 3, and when units on the high or low side of MSP are low on staff, groups are not being facilitated.

- ***Recommendation:*** DOC, MSP, and the SOP are attempting to address staff shortages; however, the shortages continue to be an issue that impacts program delivery. All necessary administrators should continue to make sure there is adequate funding available so that all components of the SOP can be delivered as intended.

- ***Recommendation:*** In addition to adequate funding, program funding should be stable. Programs that have consistently stable budgets outperform programs with unstable budgets.

Staff Characteristics

This section of the CPC concerns the qualifications, experience, stability, training, supervision, and involvement of the program staff. Staff members considered in this section include all full-time and part-time internal or external staff that conducts groups or provides direct services/treatment to clients in the program. Excluded from this group are other staff members who interact with the program, but who do not deliver direct services within the program, as well as the program director who was evaluated in the previous section.

Staff Characteristics Strengths

The program currently meets the CPC criterion for staff education level. Currently, 100 percent of service delivery staff meet the education criterion of the CPC, which is a minimum of a two-year degree in a helping profession. Degrees include a Ph.D. in clinical psychology, a bachelors in criminal justice, along with progress towards the completion of a master's in social work.

When hiring, the SOP selects staff based on certain skills and criteria beyond solely education or experience. Staff are selected based on skills and values supportive of the SOP's program. Specifically, staff are hired based on having an unconditional positive regard, humanity, communication skills, treating others with respect, leadership ability, and knowledge of programming.

Programs where all staff meet at least twice a month to discuss all cases demonstrate better outcomes than programs that lack this feature. Currently, SOP staff meet every Monday to review

cases. All cases are reviewed over the course of one month. During the meetings, staff discuss cases, focusing on the staffing of difficult cases and the progress in completing the SOP. In addition, Mr. Nordstrom provides clinical supervision during these meetings.

Programs that have a formal mechanism in place for which staff are able to provide input into how the program runs, demonstrate better outcomes than programs that lack this feature. The totality of the site visit indicated that staff can provide input into the program. Staff have informal opportunities to provide feedback such as sending an email to the program director or using the program director's open-door policy. Staff also express suggestions during the weekly staff meeting. An example of a program change based on employee suggestions was the development of a Phase IV for the curriculum. Staff expressed that more skills should be provided to clients about to graduate, which led to the creation of Phase IV. In addition, staff are supportive of the SOP at MSP. Staff—internal and external to SOP—expressed support for the SOP throughout the site visit. Staff support is important so that the program can run as intended.

The SOP has documented ethical guidelines. There are ethical guidelines in place as part of licensure for SOP staff, and as staff of MSP. The latter guidelines provide guidance on how staff can ethically interact with inmates.

Staff Characteristics Areas in Need of Improvement and Recommendations

MSP SOP staff currently lack the necessary CPC criterion for work experience. Programs that have at least three-quarters of staff who have worked with a justice-involved population in a treatment setting for a minimum of two years demonstrate better outcomes than programs that fail to meet this threshold of staff experience. At the time of assessment, 50 percent of SOP staff had met this criterion.

- ***Recommendation:*** When hiring new staff, preference should be given to candidates who have at least a 2-year experience working in a treatment setting with correctional clients.

While the SOP staff members are formally assessed annually with performance evaluations, the majority of the items fail to measure skills related to direct service delivery or practices aimed at producing long-term behavioral change. In order to promote behavioral change, programs need to assess staff annually on their abilities and skills related to evidence-based practice service delivery.

- ***Recommendation:*** Each staff member providing services and interventions to clients at the SOP should receive an annual evaluation that includes a summary of direct service delivery skills. The current evaluation forms should be supplemented to incorporate service delivery skills such as knowledge of the treatment intervention model and effective interventions, core correctional practices (see below in the Treatment Characteristics domain section for additional information on core correctional practices), assessment skills and interpretation of assessment results, modeling of new behaviors, behavioral reinforcements and sanctions, group facilitation skills, and the ability to build positive working relationships with clients.

At the time of the site visit, the SOP did not have a training process or policy in place that required

all staff to receive training on the treatment model and interventions before being delivered. In addition, the CPC criterion for ongoing training requires that programs receive 40 hours a year of ongoing training related to evidence-based practices. Staff are currently required to receive 20 hours of training per year (for their licensure). The CPC requires a minimum of 40 hours of formal training *directly relevant to program and service delivery*.

- ***Recommendation:*** All staff should receive training on the program model and program practices and training on curricula used. The program should adhere to the specific program manuals being implemented as to whether or not they require certification to use, as shadowing other facilitators, in general, is not a sufficient means of training staff on adherence to evidence-based manuals. The SOP program should make sure all staff delivering any curriculum or assessments receive formal training and certification if necessary. The program should develop a training checklist, making sure this checklist includes evidence-based service delivery criteria (e.g., effective reinforcement, effective disapproval, proper modeling and role play, etc.).

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

Offender Assessment

The extent to which offenders are appropriate for the services provided and the use of proven assessment methods is critical to effective treatment programs. Effective programs assess the risk, need, and responsivity of offenders, and then provide services and treatment accordingly. The Offender Assessment domain examines three areas regarding assessment: selection of offenders, the assessment of risk, need, and personal characteristics of the offender, and the manner in which these characteristics are assessed.

Offender Assessment Strengths

Clients admitted to the program are deemed appropriate for the services offered at the SOP by staff. Observations and interviews revealed that relatively few clients are judged by staff to be not suitable for the treatment services provided.

Risk, need, and responsivity assessment tools are crucial components of effective intervention for all individuals involved in the criminal justice system. Risk assessment tools are a vital aspect of EBP because these assessment scores assist in determining which clients are suitable for services, determining duration of services, and determining the intensity of treatment services. Need assessment scores are also crucial as they determine which criminogenic need areas clients have. The MSP SOP utilizes the Montana Offender Reentry and Risk Assessment (MORRA) which provides the program with a risk score with levels and an assessment of multiple criminogenic need areas. Evidence-based programming with sex offenders also requires the addition of a sex

offender specific risk assessment to assist in predicting the probability of sexual recidivism. MSP SOP utilizes the Static-2002R, which is a valid sex offender risk assessment tool. In addition, the MORRA has been validated on similar populations in multiple jurisdictions.

Some specialized populations require additional assessment beyond a general risk/need tool. One such population is those with a sex offense, as they require additional assessment of items related to sexual recidivism. The program meets this criterion, as SOP uses the STABLE and ACUTE sex offender needs assessment tools. These tools provide an overview of specific criminogenic needs related to sexual reoffending.

Offender Assessment Areas in Need of Improvement and Recommendations

The SOP lacks exclusionary criteria for clients who may be inappropriate for services. Programs that are able to identify and exclude offenders that are inappropriate for services have better programmatic outcomes than programs that lack exclusionary criteria.

- ***Recommendation:*** The program should develop clear criteria, adopt a formal policy, and adhere to the criteria.

As noted above, risk and need assessments are critical to the execution of evidence-based programming. Risk assessment is important for a number of reasons, with one of the primaries being that only higher-risk individuals (those that score as high or moderate) are targeted for interventions. Research demonstrates that mixing low risk clients with high risk clients leads to increased levels of recidivism for low risk clients. Additionally, the program should ensure that at least 70 percent of clients in the program are high to medium risk. Based on the reviewed files, the majority (roughly 16 of 20 files) were low risk on the Static-2002R. This results in a mixing of higher risk clients and lower risk clients.

- ***Recommendation:*** Individuals who score as low risk should be treated differently than non-low risk and the criminal justice population. The SOP should use assessment results to ensure a minimum of 70 percent of clients are medium to high risk. MSP SOP will inevitable serve low risk sex offender inmates; however, efforts should be made to keep these two populations separate from one another (also, see the recommendations in the Treatment Characteristics Section). There should be "low risk" groups that only serve those scoring as low on the Static-2002R. Moderate and high risk inmates can be served together, separate from low risk inmates.

Responsivity assessments assist in determining clients' 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 program uses some responsivity tools—Beck's Depression and the University of Rhode Island Change Assessment (URICA); however, the administration of these tools was not consistent, as file review and interviews indicated that only some inmates get these assessments. All SOP inmates should receive responsivity assessments.

- ***Recommendation:*** The program needs to measure two or more responsivity factors (e.g., motivation, readiness to change, intelligence, maturity, reading level, mental health, depression, etc.). The assessment of these results can be used to make decisions on how staff, clients, and the program work together. Examples of low cost/no cost responsivity tools include the Texas Christian University (TCU) Client Self-Rating Scale, TCU Client Evaluation of Self at Intake/Treatment, Beck's Depression (if administered on all clients), University of Rhode Island Change Assessment (URICA), and the Global Appraisal of Individual Needs-Short Screener (GAIN-SS). The URICA, GAIN-SS, or TCU tools would be especially recommended to the SOP, as these tools assess motivation and the program uses motivational interviewing. The program can review available, free responsivity tools at: https://ibr.tcu.edu/

Treatment Characteristics

This domain of the CPC examines whether or not the program targets criminogenic behavior, the types of treatment used to target these behaviors, specific treatment procedures, the use of positive reinforcement and punishment, the methods used to train offenders in new prosocial skills, and the provision and quality of aftercare services. Other important elements of effective intervention include matching the offender's risk, needs, and personal characteristics with appropriate treatment programs, treatment intensity, and staff. Finally, the use of relapse prevention strategies designed to assist the offender in anticipating and coping with problem situations is considered.

Treatment Characteristics Strengths

At a minimum, 50 percent of the program should target characteristics associated with future re-offending, known as criminogenic needs. The SOP targets a number of criminogenic needs such as: sex offending, appropriate relationship skills, substance abuse, social skills, criminal thinking and family dynamics. The program also targets non-criminogenic needs such as trauma and mental health. Programs should focus at least 50% of its effort on those characteristics associated with recidivism (criminogenic needs). The SOP program meets this criterion.

Research on successful offender programs should provide services between three and nine months in length, and should not exceed 12 months (not including aftercare). However, research is less specific with sex offender treatment programs, due to the extended nature of programming with this population. Research has established that sex offender programs should last longer than four months; however, there is no maximum time specific in the research literature. MSP SOP lasts on average 12-24 months, depending on whether or not the inmate is required to complete Phase II.

MSP assigns staff to treatment programs based on their skills/training and experience in the subject matter being presented. The program director and contracted counselor have experience and educational training to work with this population and administer the Phase II component of the program. The newer Technician teaches Phase I which is delivered under a psychoeducational dynamic. Thus, the SOP makes assigns staff to programming based on their skills, education, and experiences.

A good behavioral management system consists of rewarding prosocial behaviors that will sustain behavior in the long term, as well as sanctioning unwanted behaviors. At the time of assessment,

the SOP had an appropriate range of punishers available to curtail undesired behaviors. These punishers included group removal, a short time out from the group, verbal disapproval, and a loss of points for not completing homework.

The successful program completion rate should range of a program should be between 65 percent and 85 percent, indicating that clients do not indiscriminately complete the program or that too few clients progress through the program. Based on file review and interviews, the current successful completion percentage was roughly 85 percent, meeting the CPC criterion. It is recommended that the program track these data and review the data at least semi-annually.

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

The totality of the site visit confirmed formal discharge plans developed upon program completion. These plans include goals, objectives, and notes regarding specific individualized need areas. The process of developing the plan begins at intake and is revisited and updated during the program.

Treatment Characteristics Areas in Need of Improvement and Recommendations

It is important that the majority of the program targets criminogenic needs. To further reduce the likelihood that clients will recidivate, the ratio of criminogenic needs targeted to non-criminogenic needs should be 4:1 (80 percent criminogenic). As indicated previously, SOP does target some of the key criminogenic need areas; however, the program spends additional time on targets that are not considered criminogenic.

- ***Recommendation:*** The SOP should work to focus more time spent on criminogenic areas and less group time should be spent on non-criminogenic areas. While some of these are important responsivity issues that need to be addressed for the targeting of needs (e.g., mental health), this is not always the case for each individual client. In other words, the SOP should not blanketly address specific needs issues for all clients in the program; following the recommendations of a responsivity assessment (as discussed above) should assist with this.

Programs that individualize case plans based on formal assessment results and include targets for change, goals, objectives, time frames for completion, and performance indicators demonstrate better outcomes than programs that lack this feature. The SOP does develop case plans for all clients, but they are not consistently driven by assessment results and can oftentimes focus on what the client desires to work on (which may not be reflected in objective assessments) or be based solely on clinical judgment. Case plans should be constructed based on the results of objective, empirical risk/need assessment tools (i.e., MORRA). Furthermore, case plans should be consistently updated and reviewed with clients. This process can occur more frequently with higher-risk clients as they have more need areas to target.

- ***Recommendation:*** Case plans should be developed based on formalized assessment results. Therefore, the SOP should ensure that the results from the Static-2002R, Stable,

and Acute (and MORRA and other need and responsivity tools) are driving the development of the case plan. Furthermore, the goals and objectives for targets should be unique, as not all clients are the same. Finally, the SOP should ensure that all goals and objectives have (1) time frames to completion that are tracked, and (2) there should be listed performance indicators (how the client and case manager know the goal/objective was completed). These plans should continue to be reviewed *and* updated on an ongoing basis.

Research indicates that the most successful modality related to producing long-term behavioral change and reducing recidivism is the cognitive-behavioral model. The totality of the site visit indicated there are limited attempts to follow a cognitive-behavioral (CBT) model, but this does not occur consistently. For example, Phase I operates under a psychoeducational modality. Phase II does incorporate cognitive components into treatment, but lacks beahvioral components (see discussion below). The observed groups did reference how thinking drives behavior (i.e., the foundation of cognitive therapies), but there was no skill teaching, skill streaming, or skill practicing (the hallmark of correctional behavioral therapies)..

- ***Recommendation:*** The program should adopt an evidence-based modality when targeting criminogenic needs. CBT programs are a well-established EBP modality. These programs focus on identifying antisocial thinking, linking the thoughts to behaviors, restricting antisocial thoughts, and teaching new prosocial behaviors through modeling, role play, and advanced practices. (More information on these techniques is described below.) If curricula are developed in-house, they should be structured and consistently apply cognitive-behavioral strategies and interventions. Further, individual sessions with case managers should operate from a CBT standpoint by exploring high risk situations, a client's thinking and behavior in those situations, and helping clients manage those high-risk situations in healthy ways. Having the case managers formally trained in CBT and core correctional practices will help ensure consistent service delivery across the SOP program.

For institutional treatment programs, research has demonstrated that programs produced larger effects when treatment populations are separated from the general population. This practice allows for staff to reinforce behaviors learned in treatment, for staff and inmates to hold others accountable for their use (or lack thereof) of material learned in the group, and to provide an environment that emphasizes the skills and lessons learned in treatment. Currently, SOP clients are located throughout MSP and report from different units for treatment.

- ***Recommendation:*** It is recognized that not all institutions have space available to separate treatment populations from non-treatment populations. It should be noted that this was previously practiced at SOP, but staffing shortages have necessitated changes. MSP is encouraged to work towards having a separate SOP unit if and when it is possible.

Research indicates that programs that have mechanisms for clients to provide input/feedback on programmatic structures and features have better outcomes than programs that do not provide mechanisms for client feedback. MSP does not provide a feedback survey after intake or after exit. The policies reviewed did not indicate any formal mechanism for client feedback (beyond that of a grievance procedure); furthermore, interviews with staff and clients demonstrated that not all staff or clients are aware of a formal mechanism to provide feedback to the program.

- ***Recommendation:*** Clients should have the ability to provide (formal) feedback to the program in a formal and consistent manner. Open door policies or grievance procedures are not sufficient to meet CPC criteria. The program should provide mechanisms at different time points to provide formal feedback. These could include unit meetings, elected representatives, suggestion boxes, or feedback forms.

The SOP should have a detailed program manual that specifies all major aspects of the program. This manual should include the program description, philosophy, admission criteria, assessment, scheduling, case planning, phase advancement, behavior management, completion criteria, discharge planning, and aftercare. This manual should also include how groups are structured, the goals of each session, and recommended teaching methods

- ***Recommendation:*** The program should include a detailed description of all client activities as they move through the program. Furthermore, any groups offered by the program should have a detailed curriculum that provides the information noted above.

- ***Recommendation:*** The SOP staff should consistently follow the manuals provided for the interventions, using the material provided by the manual. This is important because manuals guide the intervention process, provide examples, give homework, etc. Moreover, evidence of intervention impact is based on fidelity to the program. Not following the manual or significantly altering the curriculum affects fidelity which can impact the effectiveness of the program.

Clients should spend at least 40 percent (35 to 50 hours a week) of their time per week in structured tasks, which can include work, treatment groups, and other staff-supervised tasks. Currently, inmates in the SOP are only required to complete between 90-120 minutes of structured tasks (i.e., group) per week.

- ***Recommendation:*** The SOP in coordination with MSP can work to increase structured activities including education classes, work, treatment groups, and other staff-supervised tasks. For example, offenders who don't have programming can be placed into a staff-supervised skills group. Additionally, more non-programming activities (e.g., work duties) can be included and supervised to increase the amount of structured time an offender has.

Programs that vary the dosage (i.e., the number of hours of services targeting a criminogenic need) and duration of services according to the client's risk level demonstrate improved outcomes over those that fail to do this. Said differently, clients that are high risk should receive more interventions and services than clients that are medium risk. Some clients are only required to complete Phase I, while others are required to complete both Phase I and II. This decision, however, is based on court orders and not risk level.

- ***Recommendation:*** Only interventions that (1) target a criminogenic need and (2) use an evidence-based modality should be counted towards dosage. Observations, interviews and material review demonstrate that the SOP onsite interventions currently would not count towards dosage as they are not conducted using an evidence-based modality (i.e., CBT; see discussion above). The SOP should ensure that programs counted towards tracking dosage meet the above requirements.

- ***Recommendation:*** While research currently suggests that moderate-risk clients should receive between 100-150 hours of dosage and high-risk clients should receive 200+ hours of dosage, clients should be: (1) referred to groups based on their assessed needs (i.e., not all program clients get the same programming or just volunteering for programming) and (2) allowed to complete the group so that they receive the full benefit of the specific intervention.

- ***Recommendation:*** SOP should consider developing two treatment tracks—one for low risk and one for moderate/high risk. For the treatment tracks, the low risk inmates can report less often and receive less intensive group and individual services. Moderate and high risk inmates can report more often and receive more intensive group and individual services. Importantly, high risk should still receive more services—additional phases, more assignments, or referral to a skills group.

Effective programs are structured so that lower-risk clients have limited exposure to their higher-risk counterparts. At SOP, low-risk individuals are not separated from their higher-risk counterparts.

- ***Recommendation:*** As noted above, the SOP should work to separate programming between low risk clients and higher-risk clients. If admitted, the SOP should separate low risk clients from moderate and high-risk clients to prevent iatrogenic effects.

There is no method in place to match clients to the treatment programs deemed necessary through this process. Referrals to treatment are made based on court orders and referrals to particular groups are made based on housing units. Furthermore, responsivity assessments are lacking (see discussion above). Similarly, staff are currently assigned cases based on their group (which is based on housing) and not on responsivity factors (e.g., clients who have mental health needs should be matched with staff who have the skills and education necessary to best serve this individual).

- ***Recommendation:*** Results from standardized criminogenic need and responsivity assessments should be used to assign clients to different treatment groups and staff. To illustrate, clients who do not have an assessed family criminogenic need should not be placed in family/communication groups; clients who are highly anxious should not be placed in highly confrontational groups or with staff who tend to be more confrontational. Likewise, clients who lack motivation may need their motivation issues to be addressed first before being assigned to a service that targets their beliefs and teaches skills. Clients should be matched to each of the services they receive and staff they are assigned to by using the results from the need and responsivity assessments.

A good behavioral management system consists of rewarding prosocial behaviors that will sustain behavior in the long term, as well as sanctioning unwanted behaviors. To properly reinforce, a program should have (1) have a menu of reinforcers and (2) consistently apply reinforcers. The SOP lacks a menu of reinforcers available to encourage prosocial behaviors. Reinforcers need to be applied consistently, and there is great variation across staff. For example, staff are not formally trained in the application of rewards. Furthermore, reinforcement is most effective when the

reinforcer occurs immediately following the desired behavior and when that behavior is clearly linked with the reinforcer. Finally, the research is also clear that rewards need to outweigh negative consequences (i.e., punishments) by a ratio of 4:1. Based on the totality of information received and observed during the site visit, the SOP is falling short of the 4:1 to ratio required by the CPC.

In addition to appropriate rewards, a good behavior management system has a wide range of negative consequences or punishments available to promote behavioral change. At the time of the assessment, the SOP had an appropriate range of punishers, as discussed above. Staff are not trained on how to properly administer effective negative consequences. For example, there is no formal policy on graduated sanctions or how staff should apply sanctions. Policy and training should alert staff to issues beyond emotional reactions such as aggression toward punishment, future use of punishment, and response substitution.

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

- ***Recommendation:*** The program is encouraged to work with MSP and DOC to develop an appropriate menu of reinforcers for inmates in institutions that do not compromise security concerns. Examples of reinforcers used at other institutions include: verbal praise (currently used by the program), extra food/snacks, indirect praise, free time, group recognition, lunch with a staff member, television/radio privileges, extra visit/phone call, extra rec. time, items from the commissary, playing host for visitors, badges, ribbons, certificates, a job in a special setting, game room privileges, or extra showers.

- ***Recommendation:*** Reinforcers should be provided in exchange for a client demonstrating progress toward individualized treatment goals (i.e., role-playing a skill satisfactorily, exceptional homework report, or demonstrating prosocial skill ability in the real world) and key target behaviors (e.g., walking away from a fight, maintaining employment for 30 days, etc.). Reinforcers should be monitored to ensure they are being consistently applied, administered as close in time to the desired behavior as possible, and that staff link the reward to the desired behavior. All staff, regardless of their role, should administer rewards as appropriate.

- ***Recommendation:*** The SOP should strive to achieve a 4:1 ratio of reinforcers to punishments to encourage desirable behavior.

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

- ***Recommendation:*** All staff should be trained in the behavior management system and be monitored to ensure they are using the system consistently and accurately. This training

should include the core correctional practices of effective reinforcement, effective disapproval, and effective use of authority. Staff should understand that punishment may result in certain undesirable outcomes beyond emotional reactions and be trained to monitor and respond to these responses. Policy and training should alert staff to issues beyond emotional reactions such as aggression toward punishment, future use of punishment, and response substitution.

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

- ***Recommendation:*** The SOP should develop clear, objective criteria for program completion status. This can include progress in acquiring prosocial behaviors, attitudes, and beliefs—as measured through validated, empirical assessments. It may also include a demonstration of the acquisition of prosocial skills (i.e., objective demonstrations of skills taught in programs).

If correctional programming hopes to increase client engagement in prosocial behavior, clients have to be taught skills in how to do so. At the time of the site visit, very little of the group and individual services incorporated cognitive restructuring, and no structured skill-building (i.e., skill modeling, client practice, and graduated practice) was observed or noted. Thus, modeling and role play are not consistently occurring. These should be a consistent practice at the SOP across *all* groups and case management sessions that target criminogenic needs.

- ***Recommendation:*** Clients 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 *rules tools, thinking reports, cost–benefit analysis, and behavior chains*. All staff should incorporate cognitive-restructuring techniques in their discussions/meetings/sessions/groups even if the curricula do not already call for them.
- ***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 client buy-in as to the importance of the skill; 3) staff teaching the steps of the skill; 4) staff modeling the skill for the client; 5) client rehearsal of the skill (role-playing); 6) staff providing constructive feedback to clients on their use of the skill; and 7) generalizing the skill to other situations (e.g., homework or advanced role plays). Following this, clients should practice the skill in increasingly difficult situations, which forms their graduated skills practice. The identification of high-risk situations and subsequent skill training to avoid or manage such situations should be a routine part of programming. All staff members should use these steps consistently and provide constructive feedback to the clients.

Finally, the SOP does not offer a formal aftercare period. While there is a Phase III that is intended to function as an aftercare program, it is currently not being offered because of staff shortages.

- ***Recommendation:*** The SOP should explore options for systematically providing aftercare services to the clients served, as research indicates that this is an important component of effective programs where the goal is to maintain long-term behavior change. Quality aftercare should include: 1) involvement of families and significant others; 2) incorporation of skill-building and graduated practice of skills clients learned while in the program; 3) variation of the duration and intensity of aftercare by the 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 Areas in Need of Improvement and Recommendations

The program lacks quality assurance measures aimed to ensure program fidelity. Specifically, programs should have a file auditing system, group observations with feedback policy and practice, and a formal feedback process for inmates in groups.

- ***Recommendation:*** The SOP should develop policy for consistent, systematic process wherein (1) there is a consistent process for timely file reviews, (2) there is quarterly observation of staff service delivery for each staff delivering SOP, and (3) offenders are provided feedback on their progress in the curriculum. With regards to the observation of staff service delivery, this needs to be consistently done by the program director and there should be documented feedback provided to the staff based on the observations of the program director. In regards to offender feedback, this can take the form of biweekly, monthly, or quarterly (or other time frames) meetings where the offender receives feedback on their progress in meeting treatment and case planning goals, their progress in group, and what they need to do to successfully complete the program. This process needs to be systematic for all offenders.

The SOP currently lacks a process to solicit feedback on service delivery from clients and uses that information to improve programming.

- ***Recommendation:*** The SOP should develop policy and practice to consistently solicit feedback from inmates on services provided by the program. This can take the form o quarterly surveys, exit/completion surveys, or post-release surveys. This information should be gathered, and written documentation should be shared consistently to determine if program changes are necessitated.

The program does not have a periodic objective and standardized reassessment process to determine if clients are meeting target behaviors.

- ***Recommendation:*** The SOP should formalize a periodic reassessment process in which objective, standardized reassessment takes place. This can include pre-and post-testing using the Stable and Acute or other standardized risk or need assessment tools that may be adopted. Having a subjective assessment (e.g., professional judgement) is not sufficient to meet this requirement. Monitoring progress through a detailed treatment plan in which changes in the plan occur on a regular basis is sufficient to meet this criterion.

The SOP does not collect recidivism data related for those who have attended the program. Related, the SOP has not retained a trained evaluator to assist with research and evaluation. Finally, the program has not received a formal evaluation that included a risk-controlled comparison group.

- ***Recommendation:*** The SOP should work the DOC or a local university to collect and review recidivism data for all clients who participate in the program. These data should then be examined over time to identify trends. Data should be collected a minimum of 6 months after a client has been discharged; more common time frames in the research literature are 1 year and 2 years post-release.

- ***Recommendation:*** The SOP should identify an evaluator who is available to assist with data. If this is an internal position, the evaluation must be the main focus of their position, and they should have appropriate credentials. Alternatively, the facility could partner with a local college or university for research purposes to limit the cost. While conversations could center on having a faculty member responsible for this task, part of the conversation should relate to the possibility of using undergraduate or graduate interns to assist with data collection activities (at no cost to the facility) so that financial remuneration is limited to payment for analysis and reporting.

OVERALL PROGRAM RATING AND CONCLUSION

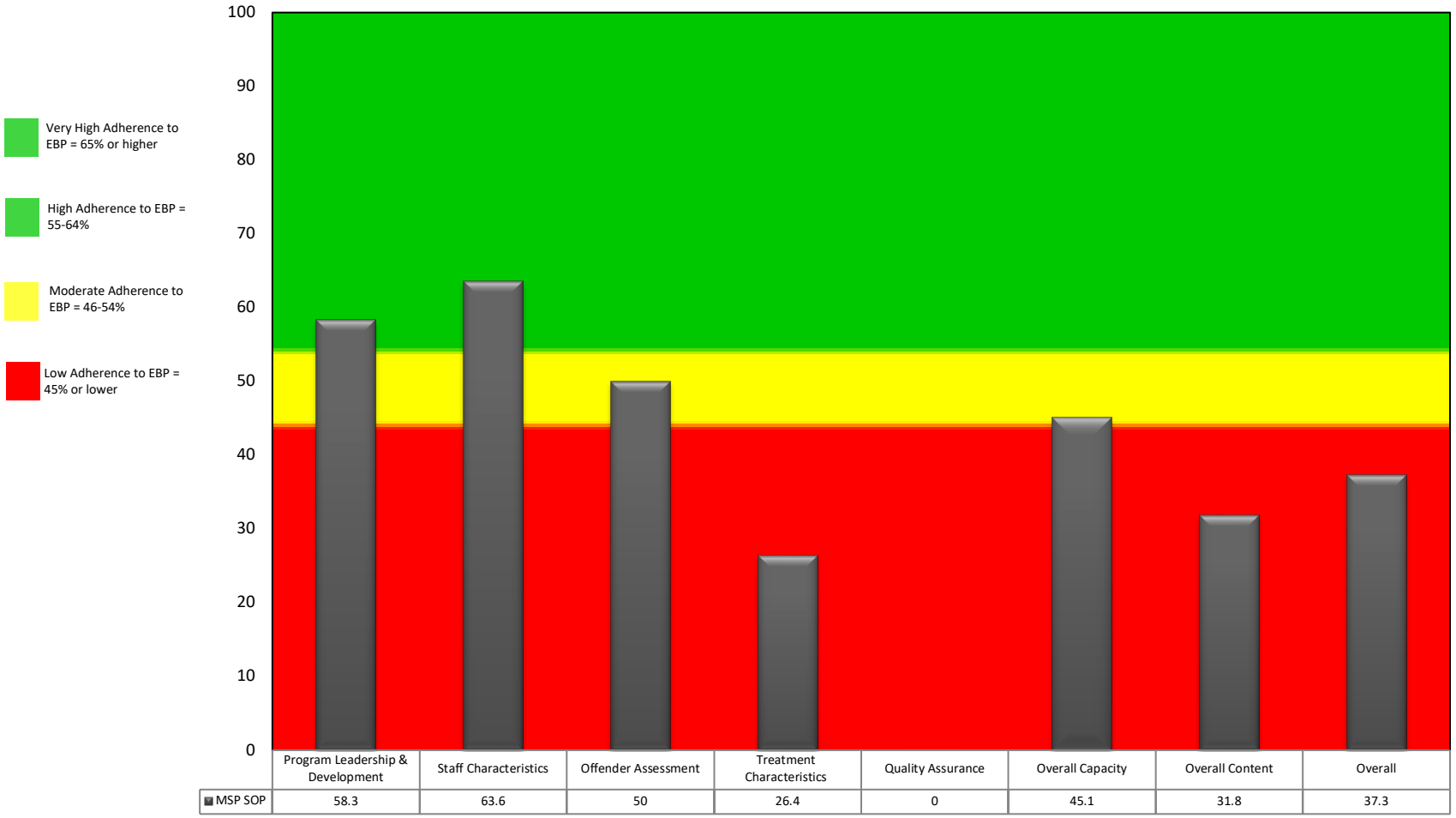
As mentioned previously, the CPC standards represent an ideal program. No program will ever score 100% on the CPC. Based on the assessments conducted to date, programs typically score in the Low and Moderate Adherence to EBP categories. Overall, 14% of the programs assessed have been classified as having 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.

MSP SOP received an overall score of 37.3% on the CPC. This falls into the Low Adherence to EBP category. It should be noted that within the area of capacity, the Program Leadership and Development domain score is 58.3% which falls into the High Adherence to EBP category, and the Staff Characteristics domain score is 63.6% (High Adherence to EBP). This means that the SOP program is well-positioned to address the areas in need of improvement in this report.

In reviewing this report, please keep in mind that the facility was not designed with the CPC in mind, and the SOP staff should commend themselves for the work they have done to date to make treatment available in the community. Recommendations have been made in each of the five CPC domains, and these recommendations should assist the SOP in making the necessary changes to increase adherence to what works in reducing recidivism. Certainly, care should be taken not to attempt to address all recommendations at once. Agencies that find the assessment process most

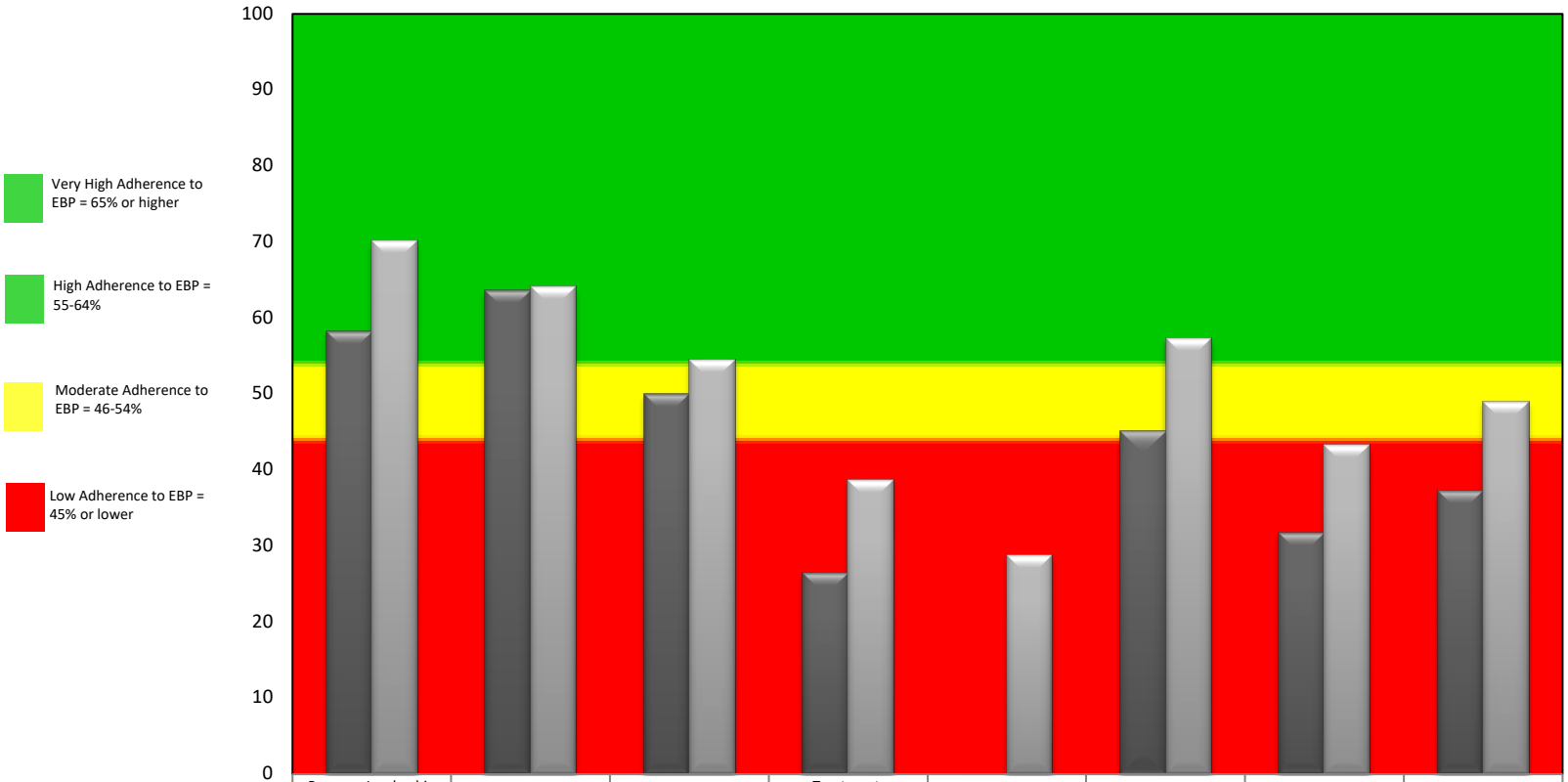
useful are those that prioritize need areas and develop action plans to systemically address them. More information about this is included in the cover letter.

Figure 1: Montana State Prison Sex Offender Program CPC Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
MSP SOP	58.3	63.6	50	26.4	0	45.1	31.8	37.3

Figure 2: Montana State Prison Sex Offender Program CPC Scores Compared to the National Averages



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
MSP SOP	58.3	63.6	50	26.4	0	45.1	31.8	37.3
CPC Average Scores	70.1	64.1	54.5	38.7	28.7	57.3	43.3	49

*National Average based on 660 program evaluations completed between 2005 and 2019

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