FINAL REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC)

Passages ADT (2nd CPC)

1001 S 27th St.
Billings, MT 59101

By:

Dan Kissner
Contract Manager
Montana Department of Corrections

Cassie Breker
Contract Manager
Montana Department of Corrections

Joel Scheett
PREA Investigator
Montana Department of Corrections

Assessment Conducted: **October 16-17, 2024**
Draft Report Submitted: **December 10, 2024**
Final Report Submitted: **January 27, 2025**

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 residents 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) was directed to complete an assessment of the Passages ADT Facility 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 resident rehabilitation, the CPC has been revised twice. A substantial revision was released in 2015 (CPC 2.0) and in 2019, minor revisions were made (CPC2.1). 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 residents. There are three domains in the capacity area including: Program Leadership and Development, Staff Characteristics, and Quality Assurance. The content area includes the Resident 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 residents, observations of direct services, and review of relevant program materials (e.g., resident files, program policies, and procedures, treatment curricula, participant handbook, ect.) 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 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 on 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 take into account all "system" issues that can affect the integrity of the program. Lastly, the process does not address the reason that a problem exists within a program or why certain practices do or do not take place.

Despite these limitations, there are a number of advantages to this process. First, it is applicable to a wide range of programs. Second, all of the indicators included in 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 program that score in the Very High and High Adherence categories look like program that are able to reduce recidivism.

SUMMARY OF THE FACILTY AND SITE VISIT PROCESS

The Passages Alcohol and Drug Treatment program (ADT), located in Billings, Montana, is a 55-bed program that serves adult female residents who have committed felony offenses and are under the supervision of the Montana Department of Corrections (MDOC). The residents are housed in a secure wing of the Passages facility and the building is converted from a former hotel. The participants all have a history of substance use. Also located in the same building is an Assessment, Sanction, Revocation Center (ASRC), Passages' Addiction Recovery Center (PARC), as well as a prerelease center; however, populations between these programs are kept separate at all times. This program was originally a 60-day program but has increased its length to 90-days. Although their primary focus is on substance use treatment, they have found that more people being referred to their program have co-occurring substance use disorders and mental health issues and are working to appropriately meet these specific needs. Referrals to this program come primarily from the MDOC's Probation and Parole Bureau , Passages ASRC, or from the Montana Women's Prison (MWP).

Women who enter this program typically come from the aforementioned ASRC floor conveniently located below this program, from MWP or from supervision. Referrals to the ADT program may be the result of having a court recommendation to attend this specific program or be determined from assessments to be appropriate for treatment. On the ASRC floor, there are a number of the screeners used to measure motivation, drug of choice, intensity of addiction and other responsivity factors, and the results of those assessments stored in the computer system TOMS, which is utilized by the parent organization, Alternatives, Inc. as well as other private non-profits who contract with MDOC. In addition to secondary screeners, a Montana Resident Reentry & Risk Assessment (MORRA) is reviewed prior to acceptance by a designated screening committee.

Upon entering the ADT program, all participants must complete a two-week orientation phase in which staff assess each individual, develop a treatment plan and assign the groups that will be mandatory to complete their program. Groups are assigned based on the outcomes of the participant derived from assessments, screeners, and interviews, the MORRA, as well as the participant's input as to what they would find most useful. Residents attending Moral Reconation Therapy (MRT) generally score on their MORRA in the moderate-medium range. Residents who are considered high-risk may be considered for a different group, but some high-risk residents may be in the MRT group.

The assessment using the CPC took place on October 16th and 17th, 2024. The assessment process consisted of a series of structured interviews with the Program Director of Passages ADT, clinical staff, security staff, case management staff, and several program residents. For the purposes of this assessment, Jen Porter was identified as the Program Director as she oversees the program and services on a daily basis as well as supervises staff. It should also be noted that for purposes of the CPC report, security staff were not considered direct service delivery staff as they provide supervision of the residents by enforcing rules and they neither provide any of the structured programming nor do they maintain a caseload. Additionally, data was gathered via the examination of 20 representative files (open and closed) as well as other relevant program materials (e.g., policy and procedure manuals, staff training information, assessments, curricula, resident handbook, etc.). Finally, seven groups facilitated by both clinical and other direct service delivery staff were observed. These groups include Treatment Plan Group, Moral Recognition Therapy (MRT) group, Core 335, SUD and Victimology. Data from the various sources were then combined to generate a consensus CPC score and specific recommendations, which are described below.

FINDINGS

Program Leadership and Development

The first subcomponent of the Program Leadership and Development domain examines the qualifications and involvement of the program director (i.e., the individual responsible for overseeing daily operations of the facility), their qualifications and experience, their current involvement with the staff and the residents, as well as the development, implementation, and support (i.e., both organizational and financial) for treatment services. As previously noted above, Jen Porter serves as the Program Director for the purpose of the CPC Assessment/Report.

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

Ms. Jen Porter was identified as the program coordinator of Passages ADT for the purposes of this report. She has been employed by Alternatives, Inc. for 11 years in total and has been the supervisor of ADT for seven years. Prior to her work at Alternatives, Inc., Ms. Porter worked 5.5 years in youth services and Rimrock, a private substance use disorder treatment facility. Ms. Porter has a bachelor's degree in psychology with a minor in addictions, and she is also a Licensed Addictions Counselor (LAC).

Ms. Porter is directly involved in the hiring and approval of staff at ADT. Ms. Porter is on the panel for hiring and active in selecting staff in the hiring process. Service delivery staff are

supervised by Ms. Porter. Training and job shadowing of service delivery is regularly provided by Ms. Porter. There are weekly meetings for all service delivery staff as well as daily Lunch and Learn sessions where Ms. Porter is able to meet with the service delivery staff. In addition to her providing direct supervision to service delivery staff, Jen Porter regularly carries a small caseload of residents, currently numbering nine residents. Ms. Porter is also active in providing direct services to participants by leading two groups and one weekly educational lecture with residents.

Effective programs are based on literature related to effective interventions. The program regularly conducts a literature review consisting of materials focusing on treatment topics as deemed appropriate by the Program Committee. All literature is distributed to staff via email, providing everyone with the ability to review it electronically and is followed up with discussion regarding the literature review at the staff meetings.

ADT regularly conducts pilots of new interventions before they are fully implemented in the program. For example, ADT recently finished piloting Safe Bet Gambling Journaling and is currently piloting CCP Skills Group within the program. The formal pilot period last for several months before officially being implemented with start and end dates.

The facility has the support of the criminal justice community. Stakeholders mentioned include the Department of Corrections, Probation and Parole Officers, Montana Women's Prison, Federal Probation and Alternatives, Inc. Assessment and Sanction Center. Overall, their support for the program was rated as positive. The staff at the program also provide positive ratings when asked about support from the community-at-large. Community stake holders mentioned include Drug Courts, local self-help organizations, past residents, churches, Tribal members, Montana State University-Billings and Elkhorn Treatment Center.

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

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

Ms. Porter has multiple academic credentials as she possesses a bachelor's degree in psychology with a minor in Addictions Counseling and is an LAC. However, Ms. Porter did not complete any courses or specializations working specifically with resident/delinquent populations.

- **Recommendation:** Should ADT ever need to select another clinical director or assistant clinical director, preference should be given to candidates with at least a bachelor's degree in a helping profession that includes at least one course specializing in corrections.

Staff Characteristics

The Staff Characteristics domain of the CPC concerns the qualifications, experience, stability, training, supervision, and involvement of the staff. Certain items in this domain are limited to full-time and part-time internal providers who conduct groups or provide direct services to the

residents in this program. Other items in this domain examine all staff that work in the program. Excluded from this section in totality is the program director, as they were assessed in the previous domain.

Staff Characteristics Strengths

The program currently meets the CPC criterion for staff education. The criterion indicates that 70% of direct service delivery staff have at least an associate's degree in a helping profession. At the time of the assessment, ADT staff exceeded this recommendation. In fact, 100% (12 of 12) of ADT staff met the CPC indicator for education.

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

Programs where all staff meet at least twice a month to discuss all cases demonstrate better outcomes than programs that lack this feature. Currently, ADT professional staff meet weekly for approximately 2.5 hours. These staff meetings include case review for residents, trainings, policy reviews, staff recognition and programming discussions of research articles.

ADT direct service delivery staff are formally assessed annually with a performance evaluation. These evaluations include a competency review of job description areas, knowledge base, effective communication and area's for improvement.

Programs where clinical supervision is provided to professional staff at least once a month by a licensed clinical supervisor shows a reduction in recidivism. Formal clinical supervision by a licensed clinical supervisor is provided to all direct service delivery staff at ADT. As indicated by the professional staff at ADT, a supervisor regularly observes groups and individual sessions with those direct service providers on a monthly basis. Supervisory staff also review and provide feedback on file management and progress notes.

At the time of the site visit, ADT has a training process in place that requires all staff to receive training on the treatment model and interventions before delivering the service. Additionally, each new staff member has one week of training conducted by HR, followed by a six-month training checklist. During this time, staff are assigned a mentor to assist with on-the-job shadowing. The CPC criterion for on-going training recommends that programs receive 40 hours a year of on-going training related to evidence-based practices. At the time of the site visit, ADT training records were provided for review. Based on the training records, ADT staff are receiving in excess of 40 hours a year of related training.

Programs that have a formal mechanism in place for which staff are able to provide input into how the program runs, demonstrate better outcomes than programs that lack this feature. The totality of the site visit indicated that staff feel comfortable offering input into the program. Staff have informal opportunities to provide feedback such as sending an email to their immediate supervisor or offering suggestions during weekly staff meetings. An example of a program change based on employee suggestions was the implantation of curriculum that staff was trained

in, such as UCCI Core SUD. Staff expressed support for the resident's rehabilitation throughout the site visit.

Staff Characteristics: Areas in Need of Improvement and Recommendations

The CPC recommends that 75% or more of direct service delivery staff have worked with criminal/juvenile justice populations for at least 2 years. At the time of the assessment, ADT staff did not meet this target with 67% (8 out of 12) of direct service delivery staff that had at least 2 years of experience working with criminal/juvenile justice populations.

- ***Recommendation:*** When recruiting new direct service delivery staff it is recommended to hire staff with two or more years of previous experience working with criminal/juvenile justice populations.

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 Resident Assessment domain examines three areas regarding assessments: 1) selection of residents, 2) the assessment or risk, need, and personal characteristics, and 3) the manner in which these characteristics are assessed.

Offender Assessment Strengths

The most effective programs are those whose participants are deemed appropriate and can be adequately served by the program. The ADT program has a referral and screening process in place to determine which residents are appropriate for their program. Additionally, residents receive a substance use disorder evaluation to further determine their appropriateness for the program.

Programs that are most effective in reducing recidivism measure risk factors with a validated, standardized, and objective risk assessment instrument that produces a level of risk. Additionally, these tools are crucial as they determine which criminogenic need areas residents have related to recidivism (e.g., antisocial attitudes, substance abuse, peer associations, employment, etc.). The 90-day program uses the Montana Resident Reentry Risk Assessment (MORRA) to identify risk levels and criminogenic needs for the residents in the program. The MORRA is renamed from the Ohio Risk Assessment System (ORAS) and is a validated risk assessment instrument.

Equally important to using validated, standardized, and objective risk assessment instruments to identify risks and needs are secondary assessments to identify additional domain specific needs, key resident types, and responsivity factors. Because the general risk and needs assessment tools do not adequately identify specific areas (e.g., substance abuse, sexual residents, or domestic violence) additional needs assessments should be utilized. The ADT program uses the American Society of Addictive Medicine (ASAM) to determine the level of care needed, as well as the

Alcohol, Michigan Alcohol Screening Test (MAST), Drug Abuse Screening Test (DAST), and Adverse Childhood Experiences (ACEs), to determine additional risk and responsivity factors.

Programs that are effective in reducing recidivism have 70 percent or higher of moderate to high-risk residents in their program. Through file review and electronic records gathered from the Resident Management Information System (OMIS) it was determined that the percentage of moderate to high-risk residents in the program met this recommendation.

Programs that are most effective in reducing recidivism have developed and follow specific criteria, found in policy and procedures, for the firm exclusion of certain types of residents from program participation. ADT has written exclusionary criteria and procedure that they follow.

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 essential elements of effective interventions include matching the resident's risk, needs, and personal characteristics with appropriate programs, intensity, and staff. Finally, the use of relapse prevention strategies designed to assist the resident in anticipating and coping with problem situations is considered.

Treatment Characteristics Strengths

To reduce the likelihood that participants will recidivate, characteristics associated with recidivism (criminogenic needs) must be targeted. The ADT program offers services that target criminogenic needs, including criminal attitudes/antisocial thinking, substance abuse, peer associations, impulsivity, unstructured leisure time, poor emotional regulation, and education/employment. Overall, the ADT program is targeting over 50 percent of their treatment efforts on criminogenic need areas.

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 participants in the ADT program arrive at the facility/program, are assessed and given a treatment plan/case plan based on those results and from input with the participant. Participants go over the treatment plan/case plan with staff and then sign it. Additionally, those treatment plans/case plans are updated at minimum every other week.

The use of Cognitive Behavioral Therapy has been shown to be effective in other programs. ADT uses some evidence-based intervention models in its program, but also has some programming for educational purposes only.
Research suggests that programs providing services should be between three and nine months in length, and not exceed 12 months (not including aftercare). The average length of stay for

participants in the ADT program is 90-days. The participants in the program are separated from the other participants at Passages and are solely located on the third floor of Passages. Additionally, the primary treatment model utilized in the program is Cognitive Behavioral Therapy (CBT) and some evidence-based interventions are utilized for the groups they facilitate.

Participants in the ADT program are adequately supervised and monitored by staff at all times. The participants do not interact with other programs of Passages as each program has its own dedicated floor to the building.

ADT does have a program manual for their 90-day substance use program that outlines all major aspects and expectations of the facility. Additionally, the ADT program does have program manuals for all the core risk reducing curricula they offer. When observing groups, it was found that the manuals were consistently followed to ensure fidelity.

Research indicates that the most successful programs are those where 40 percent of the participant's time per week is spent in structured tasks. Structured tasks can include school, work, treatment groups, and other staff supervised tasks (e.g., community meetings, homework time, and case management sessions), and the range of structured tasks should be between 35 to 50 hours per week. Participants in the ADT program have a highly structured weekly schedule, including structured activities during the weekends, and fall above the recommended threshold.

Participants' needs and responsivity factors, such as personality characteristics or learning styles, should be used to systematically match participants to the most suitable type of services. Additionally, these assessments should be taken into consideration when assigning participants to different staff. The ADT program matched participants to specific groups based on their needs and responsivity factors. The ADT program also matched staff to participants based on these need and responsivity factors.

Successful programs are those that assign staff to programs/groups based on the staff's skills, experience, education, and/or training (e.g., Licensed Addiction Counselors are conducting substance abuse groups). The ADT program utilizes those staff who are licensed to facilitate certain groups requiring such, and all staff who facilitate groups are trained to do so. Additionally, all groups and structured tasks the participants are involved in are monitored by professional staff from beginning to end, and none of the formal groups observed were facilitated by participants in the program.

Programs that are successful in reducing recidivism are those whose participants have input into some programmatic structures and features of the program. Examples may include house meetings, elected representatives, suggestion boxes, or feedback forms. Indicators observed showed that participants in the ADT program have multiple official options in place for participants to provide input into the program.

The ADT program provided a sufficient range of reinforcers as rewards within the program. It was noted the participants in the program receive multiple reinforcers, including verbal praise/acknowledgment, stickers in groups for completing homework, increased incentives when moving up phases, and Positive Incident Reports that can be cashed in for prizes. Additionally,

the research on reinforcers shows that rewards need to be meaningful and specific to each participant and need to outweigh negative consequences (punishers). ADT was found to be doing a variety of reinforcers and doing them above the 4-1 ratio of reinforcers to punishers.

All staff administer rewards, and these rewards were given immediately or as soon as possible. These rewards were given consistently and applied after the appropriate behavior. Staff have multiple options for rewards, so each reward given may be individualized to the participant. Reinforcers often were coupled with the participant about the short- and long-term benefits of the positive behavior.

ADT has an appropriate range of punishers available to promote behavioral change in the future by showing participants that behaviors have consequences. These punishers included verbal disapproval, incident reports classification system, being down phased, and loss of privileges.

ADT participants regularly observe and anticipate risky thinking and problem situations through the modeling and demonstrations by staff. ADT regularly reviews its treatment curriculum, reviews staff demonstrating their skills and concepts, observes groups and reviews their case plans.

If correctional programming hopes to increase participant engagement in prosocial behavior, participants must be taught skills in how to do so. Role plays should be done and should be consistent throughout the course of a group/program. At the time of the site visit role models and role plays were consistently observed in specific groups.

Research indicates that treatment/intervention groups should not exceed eight to ten participants per facilitator unless specifically noted in curricula. Additionally, if there is a co-facilitator, they should be involved in the group (actively engaged in the treatment being provided). Groups observed during the onsite visit were facilitated by one staff member and had a range of 9-11 participants. The groups that had over 10 participants were allowed by the manual to have up to 12 participants.

As observed through file review, the ADT program consistently had a formal discharge plan for all participants who complete the program. These discharge plans included continuum of care recommendations (ASAM and recommendations for each dimension and an aftercare plan), goals, objectives, and because the majority of participants release to a pre-release center (PRC), recommendations are specific for this type of placement.

Treatment Characteristics: Areas in Need of Improvement and Recommendations

Research indicates that the ratio of criminogenic needs addressed to non-criminogenic needs for successful programs should be a least 4 to 1. While ADT does target at least 50 percent of their treatment efforts on criminogenic needs areas they do not meet the 4 to 1 ratio.

- ***Recommendation:*** The ADT program should increase the number of criminogenic targets for participants in the program (e.g., problem-solving skills, emotional regulation, antisocial thinking). This can be accomplished by identifying the most consistent

criminogenic needs from the MORRAs completed on participants in this program and implementing an evidence-based curriculum that aims to address that need.

As noted in the Resident Assessment section the ADT program does use the MORRA as their validated risk assessment tool and the program does utilize the tool to separate participants into treatment groups based on their risk score/level. Observations showed that in general low-risk participants were separated from high-risk participants. However, due to not having enough low-risk participants for their own group, they were often mixed with low/moderate or moderate participants.

- ***Recommendation:*** With an effective program, low-risk participants are not to be placed in groups with moderate to high-risk participants. Participants who are assessed as being low-risk should be offered individual sessions or placed in programming that is strictly made up of low-risk participants.

Programs should vary the intensity, length, and overall programming for the participants based on risk levels. Participants in the ADT Program do attend different tracks for high-risk residents versus the moderate, moderate/low, and low risk participants. The high-risk participants currently receive a minimum of 189 dosage hours. Moderate, moderate/low, and low risk participants receive a minimum of 171 dosage hours. There is another 56.5 optional dosage hours available to all participants.

- ***Recommendation:*** Overall, research indicates that residents who are at moderate risk of reoffending 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 with multiple high-need areas may need 300 hours of evidence-based services. Only individual sessions, case management sessions, and groups targeting criminogenic need areas (e.g., antisocial attitudes, values, and beliefs, antisocial peers, anger, self-control, substance abuse) using an evidence-based approach (i.e., cognitive, behavioral, cognitive-behavioral, or social learning) can count toward the dosage hours. Developing separate programming tracks based on risk and responsivity factors, and including case plans in the process, would ensure that an resident is not provided too little or too much programming based on need. It is recognized ADT has two different tracks; however it is recommended these dosage hours be adjusted to meet the dosage hour recommendations listed above. This could include extra groups for higher risk participants, extra case management sessions including role modeling and role plays, or more/longer duration of programming.

A good behavioral management system consists of rewarding prosocial behaviors that will sustain prosocial behavior in the long term, as well as sanctioning unwanted behaviors. Although ADT had a wide range of punishers/sanctions, it was found that these were not consistently applied by all staff.

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

after punishment is administered; and 6) there should be variation in the consequences used (when possible).

Additionally, after a punisher is administered, staff should be trained in how to monitor participants to ensure they do not display any negative effects from the punisher. Staff and participant responses on the use and applications of punishers were consistent, and staff were not trained to observe the negative effects of the punishment.

- ***Recommendation:*** The ADT program has a wide range of punishers/sanctions (behavioral management system) that can be utilized by staff. However,, 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 could include core correctional practices such as 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 appropriately. Procedure 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 ADT 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, lack of disciplinary infractions, or completion of court requirements. Observations indicated that the ADT program completion criteria is based more on time in the program rather than measuring active participation in groups, participant change, skill acquisition, or progress in treatment.

- ***Recommendation:*** Clear standards should be set as to when participants can complete their active treatment and eventually complete the program. Benchmarks should be implemented to allow someone to successfully navigate through the program. These can include attendance and participation standards, scores on pre-and post-testing, meeting a certain percentage of objectives from their case and treatment plans, or a checklist of behavioral/attitudinal criteria.

A program with too low of a completion rate may not address the needed criminogenic risk factors in a proactive way. Too high of a completion rate may indicate a need for stricter standards or a more universal application of standards of completion. Based on file review and interviews with staff members, the current successful completion rate for the ADT program is between 96 percent.

- ***Recommendation:*** Once the ADT program outlines completion criteria/status for the participants, it should monitor the successful completion rate, which should range between 65 percent and 85 percent. This range can be obtained using benchmarks to navigate through the program and consistent standards for participation and completion of the program.

Groups should also include increasingly difficult situations that require the use of more skills or skills in an advanced way. Graduated practice allows participants to develop comfort with the new skill in a safe setting while practicing the application in real-world scenarios.

- ***Recommendation:*** Structured skill building should be routinely incorporated across the service elements. Staff should be trained to follow the basic approach to teaching skills, which includes: 1) defining skills to be learned; 2) obtaining buy-in as to the importance of the skill; 3) staff teaching the steps of the skill; 4) staff modeling the skill; 5) participant rehearsal of the skill (role playing); 6) staff providing constructive feedback on their use of the skill; and 7) generalizing the skill to other situations (e.g., homework or advanced role plays). Following this, participants should practice using multiple skills in increasingly difficult situations, which forms their graduated skills practice. The identification of high-risk situations and subsequent skill training to avoid or manage such situations should be a routine part of programming. All staff members should use these steps consistently and provide constructive feedback to residents.

Research shows that significant others and family members who are trained to provide support to help support participants can help support long term positive behavior. The ADT program currently does not have a family training as part of their program.

- ***Recommendation:*** The ADT program should add a family support training to train family members and significant others how they can support the participant through the treatment program and to support the participant to maintain the positive changes they have made. This training should be ongoing through the program and not solely informational about the program.

Research demonstrates that aftercare is an important component of effective programs in order to help participants maintain long-term behavior change. The ADT program does not currently have aftercare components for all participants who complete the program. Due to aftercare not being provided to the discharged participants, the quality of aftercare cannot be determined. ***Recommendation:*** All participants should be required to attend a formal aftercare period in which continued treatment and/or supervision is provided. High-quality aftercare includes planning that begins during the treatment phase, reassessment of the participant's risk and needs, requirements of attendance, evidence-based treatment groups or individual sessions, and duration and intensity based on risk level.

Quality Assurance

This CPC domain examines the quality assurance and evaluation processes that are used to monitor how well the program is functioning. Specifically, this section examines how the staff ensures the program is meeting its goals.

Quality Assurance Strengths

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. ADT has exit surveys they provide to their residents to elicit feedback on the program, the residents are able to provide feedback during their one-on-one sessions with their LAC and case manager, and resident interviews indicated they felt their feedback was given consideration.

Programs that are most effective have a periodic, objective, and standardized re-assessment process in place to determine if residents are meeting target behaviors. As mentioned earlier, ADT uses several different assessments to determine the needs of their residents. ADT conducts pre and post assessments and has detailed treatment plans that track their progress throughout the program.

Quality Assurance: Areas in Need of Improvement and Recommendations

Effective programs have a management audit system in place that includes the quality assurance processes of file review, regular observation of staff delivering services/groups with feedback provided, and a mechanism to provide participant feedback on their progress in the program. While the regular observation of staff delivering services/group with feedback and the participant feedback component was met, observations indicated that ADT was not reviewing all case files for missing components prior to closing the file.

- ***Recommendation:*** ADT should develop an internal quality assurance process that includes file review to ensure case files are reviewed for missing components prior to closing the file. One option to ensure that nothing is missing from the closed or open client files could include a checklist staff can utilize to ensure all items in the client files are accounted for.

Research indicates that programs that track recidivism by gathering rearrest, reconviction, or reincarceration data six months after a participant has completed/terminated from the program are more successful. Further, programs should undergo a formal evaluation comparing treatment outcomes with a risk-control comparison group, and work with an internal or external evaluator who can provide regular assistance with research/evaluations. ADT does not track the recidivism rates of the participants who complete their program. Additionally, the program has not undergone a formal evaluation comparing its treatment outcomes with a risk-control comparison group or worked with an internal or external evaluator for regular assistance on research/evaluation. While MDOC compiles some information related to recidivism, and some reports can be run through Jaspersoft, the program has not identified a process to ensure that available data is examined to help the program make data-driven decisions.

- ***Recommendation:*** Recidivism, in the form of rearrest, reconviction, or reincarceration, should be tracked for six months or more after release from the program. The program can do this on their own or work with a third party to collect and review recidivism data for all participants who are released from the program. There should be evidence the program receives and understands the data. Additionally, this data should then be examined over time to identify trends.
- ***Recommendation:*** In relation to the formal evaluation, a comparison study between the program's recidivism rate and a risk-controlled comparison group should be conducted and include an introduction, methods, results, and discussion section. Passages leadership should determine 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 include Montana Tech, The University of Montana (Missoula), and Montana State University (Bozeman). Departments that could assist with such a project include fields like criminal justice, sociology, and psychology.

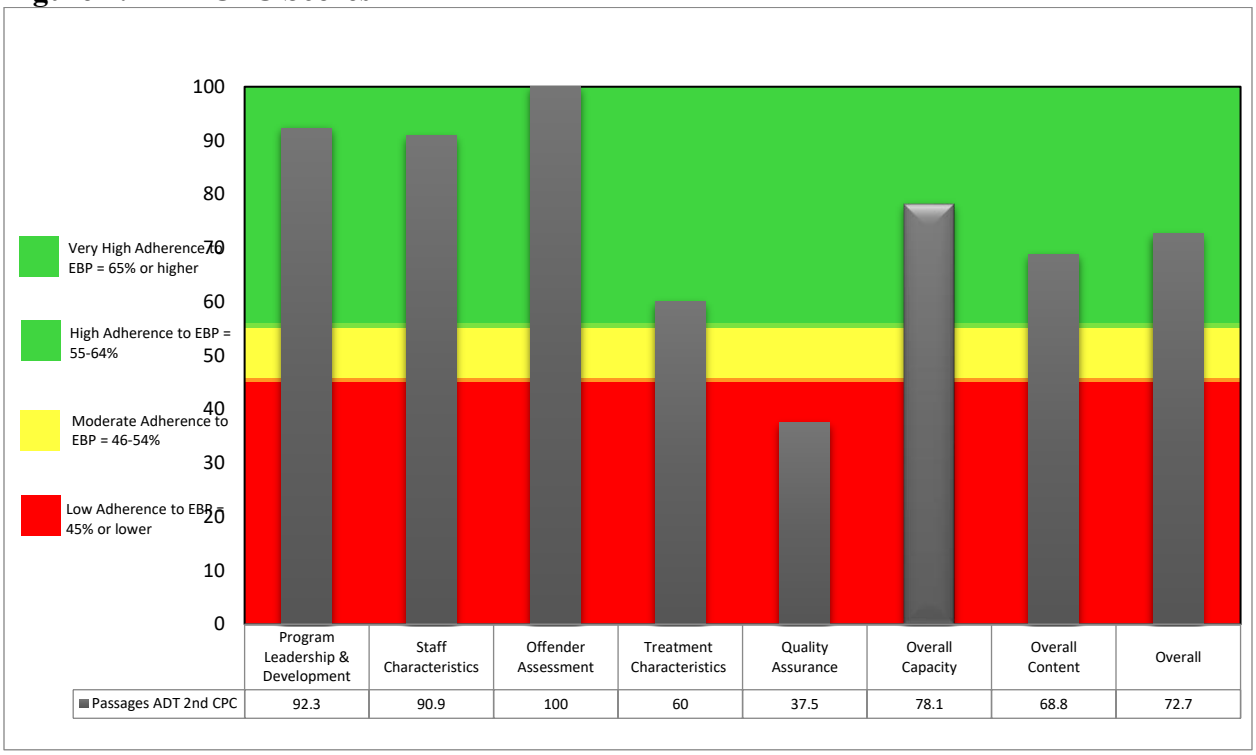
Overall Program Rating and Conclusion

As mentioned previously, the CPC standards represent an ideal program. No program will ever score 100 percent on the CPC. Based on the assessments conducted to date, programs typically score in the Low and Moderate Adherence to EBP categories. Overall 7 percent of the programs assessed have been classified as having Very High Adherence to EBP, 17 percent as having High Adherence to EBP, 31 percent as having Moderate Adherence to EBP, and 45 percent 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. In the Capacity Domain, they scored 78.1 percent, which falls into Very High Adherence to EBP. In the Content Domain, they scored 68.8 percent, which falls into Very High Adherence to EBP. This is the second CPC Assessment for the ADT program, and they received an overall score of 72.7 percent on the CPC which falls into the Very High Adherence to EBP category. Their overall score shows an improvement from their first CPC and indicates their commitment to quality programming.

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

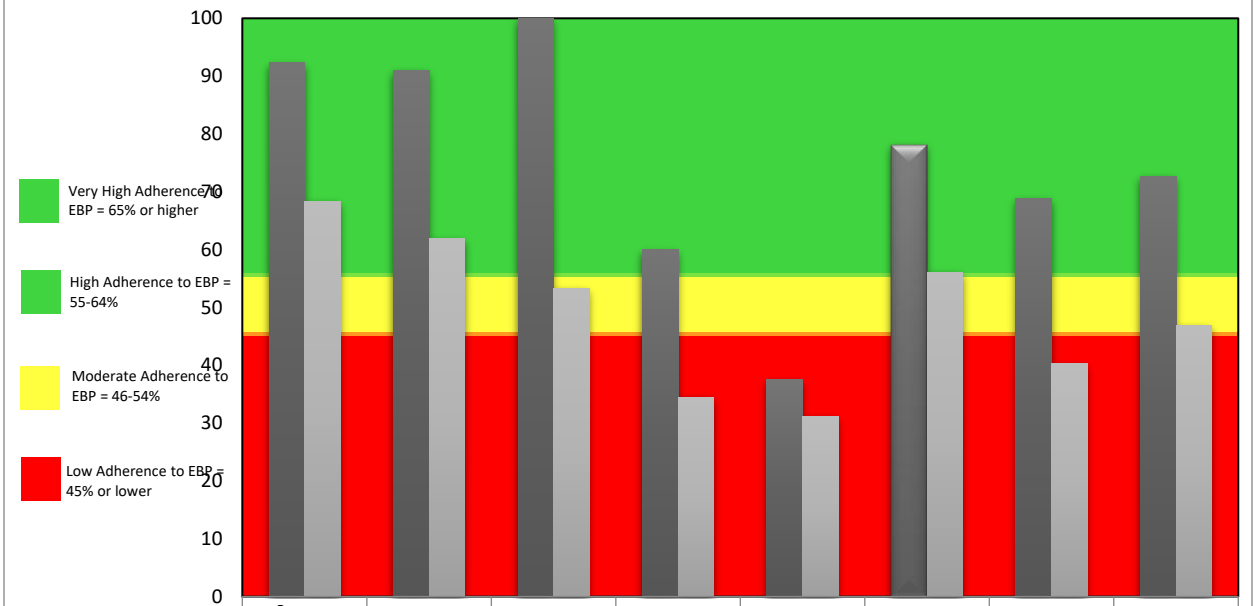
Shown below are two graphs (Figures 1 and 2) indicating the percentage(s) received in each domain of the CPC. Figure 1 shows the percentages ADT received for each domain based on how each item was scored. Figure 2 shows the percentages compared to the CPC's average scores.

Figure 1: ADT CPC Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
Passages ADT 2nd CPC	92.3	90.9	100	60	37.5	78.1	68.8	72.7

Figure 2: ADT compared to the CPC Average Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
Passages ADT 2nd CPC	92.3	90.9	100	60	37.5	78.1	68.8	72.7
CPC Average Scores	68.4	61.9	53.2	34.5	31.2	56.1	40.3	46.9

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 Residents: 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 resident/delinquent populations such as sex residents, substance abusers, drunk drivers, and domestic violence residents.