FINAL REPORT

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST (CPC 2.0)

Commitment to Change
High Desert 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 Nevada Department of Corrections is partnering with the University of Cincinnati Corrections Institute (UCCI) to assess correctional programs across the state of Nevada using the Evidence-Based Correctional Program Checklist (CPC). One of the programs selected to be assessed by NDOC is the Commitment to Change (CTC) program at High Desert State Prison. The objective of the CPC assessment is to conduct a detailed review of the program's practices and to compare them to best practices within the correctional treatment literature. Program strengths, areas for improvement, and specific recommendations to enhance the effectiveness of the services delivered by the program are offered.

CPC BACKGROUND AND PROCESSES

The Evidence-Based Correctional Program Checklist (CPC) is a tool developed by the University of Cincinnati Corrections Institute (UCCI)[i] for assessing correctional intervention programs.[ii] The CPC is designed to evaluate the extent to which correctional intervention programs adhere to evidence-based practices (EBP) including the principles of effective intervention. Several studies conducted by UCCI on both adult and juvenile programs were used to develop and validate the indicators on the CPC. These studies produced strong correlations between outcome (i.e., recidivism) and individual items, domains, areas, and overall score. [iii] Throughout our work, we have conducted approximately 1,000 program assessments and have developed a large database on correctional intervention programs.[iv] In 2015, the CPC underwent minor revisions to better align with updates in the field of offender rehabilitation. The revised version is referred to as the CPC 2.0, but for ease, we will refer to it as the CPC throughout this report.

The CPC 2.0 is divided into two basic areas: content and capacity. The capacity area is designed to measure whether a correctional program has the capability to deliver evidence-based interventions and services for offenders. There are three domains in the capacity area including: Program Leadership and Development, Staff Characteristics, and Quality Assurance. The content area includes the Offender Assessment and Treatment Characteristics domains, and focuses on the extent to which the program meets certain principles of effective intervention, namely RNR. Across these five domains, there are 73 indicators on the CPC, worth up to 79 total points. Each domain, each area, and the overall score are tallied and rated as either Very High Adherence to EBP (65% to 100%), High Adherence to EBP (55% to 64%), Moderate Adherence to EBP (46% to 54%), or Low Adherence to EBP (45% or less). It should be noted that all 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 is generated which contains all of the information described above. In the report, the program's scores are compared to the average score across all programs that have been previously assessed. The report is first issued in draft form and written feedback from the program is sought. Once feedback from the program is received, a final report is submitted. Unless otherwise discussed, the report is the property of the program/agency requesting the CPC and UCCI will not disseminate the report without prior program approval.

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 assessment is 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.[v] 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,

8% of the programs assessed have been classified as having Very High Adherence to EBP, 22% as having High Adherence to EBP, 21% as having Moderate Adherence to EBP, and 49% 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 COMMITMENT TO CHANGE PROGRAM AT HIGH DESERT STATE PRISON AND SITE VISIT PROCESS

The CTC is operated at the High Desert State Prison (HDSP) in Indian Springs, Nevada. The CTC program began in 2008. The CTC program provides programming services to men who volunteer for the program at HDSP. The intent of the program is to introduce and explore the concept of thinking errors, help clients become aware of their thinking, encourage and motivate personal change, and provide a program which can help clients work toward change. The CTC program utilizes the Commitment to Change three part series, which includes manuals and movies. The first series provides 11 sessions and focuses on errors in thinking; the second series provides nine sessions and focuses on how thoughts lead to behaviors and explores tactics for moving beyond these thoughts; and the final series focuses on overcoming the thinking errors and is delivered across nine sessions. Participants attend class and go through the session with a group facilitator. There are two co-program directors for the purpose of this report: Dr. Francis Oakman and Dr. Laurie Hoover, both are charged with overseeing programming and services for the CTC program for different HDSP yards. In addition to the two program managers, the CTC program utilizes six staff from Psychologist II and Mental Health Counselor II positions to deliver programming. There are also caseworkers who provide case management to CTC clients, as well as men in other programs at the institution.

The CPC assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to the CTC program on October 18, 2017. Data were gathered via the examination of twenty representative files (open and closed) as well as other relevant program materials (e.g., manuals, assessments, curricula, resident handbook, etc.). Finally, a CTC group was observed. Data from the various sources were then combined to generate a consensus CPC score and specific recommendations, which are described below. This is the first CPC assessment of this program.

FINDINGS

Program Leadership and Development

The first sub-component 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 program), his/her qualifications and experience, his/her current involvement with the staff and the program participants, as well as the development, implementation, and support (i.e. both organizational and financial) for the program. As previously mentioned, Dr. Oakman and Dr. Hoover were identified as the co-program directors for the purpose of this report.

The second sub-component of this domain concerns the initial design of the program. 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

The co-program directors are qualified and experienced. Dr. Hoover has a Ph.D. in psychology with course specialization in forensic psychology. Moreover, she has over 20 years of experience working with correctional treatment populations, including 17 years at HDSP. Dr. Oakman has a Psy.D. in clinical psychology and did undergraduate course work in corrections. Dr. Oakman has nearly 12 years of experience with correctional treatment programs, including almost eight years at HDSP. Both Dr. Hoover and Dr. Oakman are directly involved in selecting staff for the CTC program. Each receives a candidate list from HR, selects applicants for interviews, and participates in those interviews.

Both program directors are involved in the training of new staff. Dr. Oakman has created a "dos and dont's" list that she distributes to new hires and reviews. She also reviews all of the CTC dvds and group material before new staff administer the program, and provides training on appropriate boundaries between staff and clients. Dr. Hoover reviews administrative regulations (AR) and operating procedures (OP) information, has new staff review all treatment related materials, assigns new hires to shadow experienced staff, and provides training on NDOC software. In addition to training staff, both program directors are involved in direct supervision of service delivery staff—Dr. Oakman has monthly meetings with her staff and Dr. Hoover has meetings every 6-8 weeks with her staff.

Program funding is adequate to implement the program as designed and there have been no major decreases in funding that have significantly impacted the program within the past two years. The CTC program has been offered at the facility for roughly 10 years, which meets the CPC criterion of being an established program.

Program Leadership and Development Areas in Need of Improvement and Recommendations

Program directors that are actively involved in the delivery of program services are more aware of the current and changing needs of the staff and participants in the program. Thus, programs that have program directors actively involved in the delivery of services demonstrate better programmatic outcomes. Both Dr. Hoover and Dr. Oakman have many other job related duites besides overseeing the CTC program. While they are involved in the delivery of direct services in other aspects of their job (i.e., Dr. Hoover carries a caseload of inmates admitted to suicide watch; Dr. Oakman conducts a social skills group for the extended care unit and administers Static-99R assessments for sex offender parolees), neither program director provides direct service delivery in the CTC program or with CTC participants.

- ***Recommendation:*** The program directors should have active involvement in CTC direct service delivery. This can take the shape of consistent group facilitation, consistent

administration of assessments, and/or carrying a small caseload. Both program directors would need to have consistent involvement in the delivery of CTC services to meet this criterion.

It is important the program be based on the effective correctional treatment literature and that all staff members have a thorough understanding of this research. While the administrative team responsible at the time for programming conducted an internet search for relevant programming, a formal literature search was not conducted prior to establishing the CTC program, nor is one conducted on an ongoing basis. As such, staff are not formally and regularly informed about evidence-based practices with this population.

- ***Recommendation:*** The CTC and/or the program director should conduct a literature search to ensure that an effective program model is implemented consistently throughout all components of the program. The literature should also be consulted on an ongoing basis. 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 by the program. It is important that the core program and all of its components be based on a coherent theoretical model with empirical evidence demonstrating its effectiveness in reducing recidivism among criminal justice populations (e.g., cognitive behavioral and social learning theories).

- ***Recommendation:*** This information on what works should be disseminated to all staff delivering direct services in the program on a regular basis. This can be achieved by sharing this information at the staff meetings, hosting a discussion on the information, and determining how the program is or should incorporate the information into its daily practices.

Formal piloting of potential changes to the program are not consistently conducted. The CTC program should consistently have a formal pilot period where program logistics and content are sorted out before a change or a new process begins.

- ***Recommendation:*** On-going modifications to the program should be formally piloted. Piloting of new interventions (e.g., curriculum changes, case planning, behavior management, etc.) should last at least one month and should involve formal start and end dates. Information and data should be collected and staff should be included in making adjustments. Piloting should be a consistent programmatic practice. The CTC program should consider piloting the DBT program that is currently being developed. (See comments in Offender Assessment for more recommendations on incorporating DBT programming.)

Programs that feel they have support from key criminal justice stakeholders like institutional administration and DOC central office administrators demonstrate better programmatic outcomes than programs that lack this support. The totality of the site visit suggested the program does not appear to have the necessary support of its criminal justice stakeholders. Concerns were expressed that HDSP administration and NDOC central office do not understand the demands of health and programming staff. Mental health staff are placed in a position where they are responsible for dealing with mental health/illness of inmates and then also tasked with providing programming to address criminogenic needs. These two demands place staff in dual roles and are often given little support in how to address these two distinctly different job demands. Additionally, some institutional policies are placing stress and leading to nonevidence-based decisions. For example, there is a policy that programs are canceled if there are less than 5 inmates in a group. Further, inmates may have to leave group for a number of reasons, most commonly because of a change in housing. Because of this policy and the uncertainty around movement, staff often have to rush through programs to ensure they are completed.

- ***Recommendation:*** The CTC program staff should work closely with HDSP and NDOC, to identify areas where administrative policies are impacting the successfulness of the programming and work together to resolve these issues. By finding solutions that work for all parties, support for the CTC program will be demonstrated.

Staff Characteristics

The Staff Characteristics domain of the CPC concerns the qualifications, experience, stability, training, supervision, and involvement of the program staff. Staff considered in this section includes all full-time and part-time internal and external providers who conduct groups or provide direct services to the clients. Excluded from this group is support staff and the program director, who was evaluated in the previous section. In total, six staff were identified as providing direct services. These positions included Psychologist II and Mental Health Counselor II staff.

Staff Characteristics Strengths

CTC program staff meet CPC standards for education and experience. At the time of assessment, 100% had obtained an associate's degree or higher in a helping profession. In fact, all had master's degrees or higher in a helping profession. The CPC requires that at least 70% of staff have this level of education. For experience, the CPC requires that at least 75% of staff have worked in programs with criminal/juvenile justice populations for at least two years. Again, 100% of CTC staff currently met this mark. The CTC program should be commended for the education and experience of their programming staff.

Staff have a voice in the program and their input is valued. Staff have the ability to suggest modifications to the program at staff meetings, and to either program director (via their open door policy). As an example of input, a staff member recently suggested that a dialectical behavior therapy component be explored. A program manager has approved this and development is currently underway.

The CTC has ethical guidelines in place for all staff. These guidelines are found in NDOC administrative regulations.

Staff Characteristics Areas in Need of Improvement and Recommendations

Programs that hire staff based on key skills and values demonstrate better programmatic outcomes then programs that make decisions based solely on other factors (e.g., experience, education, time management, team player, punctuality, etc.). Staff hired by the CTC participate in a standardized process in which five interview questions are selected from eight predetermined questions. Moreover, interviewers are prohibited from asking probing follow-up questions during the interview process. While this process is meant to reduce bias, it simultaneously prevents staff from asking questions related to the skills and values they possess related to offender change. As a result, there is no consistent process to ensure that staff are hired based on skills and values related to behavioral change.

- ***Recommendation:*** Indicators of key skills and values can be (but are not limited to): strong support for offender treatment and change, empathy, fairness, life experiences, being non-confrontational but firm, problem solving, and prior training or licensure. Hiring practices should allow for the examination of these indicators. CTC staff should work with closely with HDSP and NDOC to determine if there is a way to augment the current interview process to ensure that staff possess values supportive of helping inmates with their change process are hired.

The frequency of staff meetings differ by program director. Dr. Oakman meets with her staff monthly, while Dr. Hoover meets with her staff every 6-8 weeks. While meetings are in place, neither frequency meets the CPC criterion. Furthermore, these meetings do not ensure that the inmates who are participating in CTC are reviewed as to their progress.

- ***Recommendation:*** Staff meetings should occur at least twice per month to discuss intakes, case reviews, problems, programming, and any other issues related to the delivery and execution of the program. This should be a consistent and formal practice for all staff.

Staff receive an annual evaluation that assesses staff on traditional employment indicators like providing clinical treatment under supervision, documentation, medication monitoring, psychology testing and reports, crisis intervention, statistical information gathering, meetings, work ethic, customer service and communication, and professionalism. However, this evaluation is lacking indicators for direct service delivery skills. 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:*** Annual reviews can include traditional employment indicators, but should also be supplemented to assess the service delivery skills of staff involved in behavioral change. Service delivery skills can include: assessment skills and interpretation of assessment results, communication skills, modeling of new behaviors, redirection techniques, behavioral reinforcements, group facilitation skills, and knowledge of the treatment intervention model and effective interventions.

All staff involved in providing group or individual services to clients should receive ongoing clinical supervision. While the state of Nevada does not require clinical supervision for certain class titles, evidence does demonstrate that programs that provide clinical supervision to staff who deliver services demonstrate better outcomes than programs that do not provide clinical supervision.

- ***Recommendation:*** A staff member who meets Nevada state standards and is licensed by the state should provide at least monthly clinical supervision. The clinical supervisor should meet at least once a month with all case managers and group facilitators to assist them in how they can improve in their service delivery and client interactions. This supervision should focus on how these staff can better incorporate cognitive behavioral interventions and core correctional practices into their daily interactions.

While new staff receive training on human resource policies, institutional rules, and department wide policies and practices, staff do not receive initial training on the CTC program or evidence-based practices. Moreover, staff do not receive 40 dedicated hours of yearly ongoing training related to evidence-based practices.

- ***Recommendation:*** New staff should receive a thorough training in the theory and practice of interventions employed by CTC. There should be formal training for all staff on the CTC series before any staff deliver that curriculum. In addition to the CTC curriculum, relevant topics include training on the principles of effective intervention, assessments, specific program components, group facilitation, core correctional practices, cognitive behavioral interventions, social learning, etc.

- ***Recommendation:*** Staff should be required to receive a minimum of 40 hours per year in formal training related to the program and service delivery (see topics listed above). Training in areas not directly related to service delivery (i.e., CPR, restraint, bloodborne pathogens, etc.), while required for different aspects of the job, should not be counted towards the CPC 40 hour criterion.

Programs that demonstrate staff support for the goals and values of behavioral change programs demonstrate greater reductions in recidivism than programs that do not. The site visit revealed that some staff at HDSP are not supportive of the CTC program. While the majority of the staff believe that the program is beneficial, some do not support the goals of the program.

- ***Recommendation:*** While some direct service delivery staff may have preferences for other programming (i.e., anger management, sex offender treatment, etc.), this does not preclude them for supporting the goals and values of behavioral change sought by CTC and running CTC as designed. The CTC program should review evidence-based practices and research findings related to behavioral change to educate and motivate staff.

Offender Assessment

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

Offender Assessment Strengths

The CTC program admits appropriate clients, as determined by the program. While clients are self-referred, very few (less than 20%) are inappropriate for the services provided by CTC. Those that may be inappropriate are the result of attending only for meritorious credit and are not truly motivated to fully participate in the program.

Effective risk, need, and responsivity assessment tools are an essential component of effective intervention for all individuals involved in the criminal justice system. Risk assessment tools are a crucial piece of evidence-based correctional programming as these assessment scores assist in determining which clients are suitable for services as well as determining duration and intensity of treatment services, based on risk level. Need assessment scores are also crucial as they determine which criminogenic need areas clients have, whereas 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). The CTC program reviews self-referred clients for the NRAS risk and need assessment results. The NRAS is a valid, standardized, and objective instrument that produces a risk level and a survey of dynamic criminogenic needs.

It is important that programs target higher risk clients for services. As a result, programs should strive to ensure that moderate and high risk clients are admitted to the program, and low risk clients are not admitted (or extremely limited and separated from the population). At the time of the assessment, approximately 80% percent of clients were high or moderate risk on the NRAS.

Offender Assessment Areas in Need of Improvement and Recommendations

The program lacks written, established guidelines for excluding clients that may not be appropriate for services. Programs that are able to identify and exclude participants that are inappropriate for services have better programmatic outcomes that programs that lack exclusionary criteria.

- ***Recommendation:*** The CTC program should develop exclusionary criteria appropriate for the services provided by the CTC program. This criteria should be written into program policy and followed by all staff. Examples of exclusionary criteria that are appropriate for CTC include only accepting those inmates that score as moderate to very high risk on the NRAS. That is, the CTC program should exclude low risk offenders from programming. Another potential exclusionary criteria is limiting participation to those inmates who demonstrate criminal thinking as a significant criminogenic need on the NRAS. That is, since the CTC program focuses on addressing criminal thinking, it stands to reason that only those who demonstrate criminal thinking as a prominent criminogenic need (as measured on the NRAS criminal thinking domain, or if a separate criminal thinking needs assessment is adopted and administered). Thus, those that score low in criminogenic

thinking would be excluded from treatment. Exclusionary criteria should be based on clinical/community/legal criteria.

The CTC program does not conduct any responsivity assessments to measure a participant's engagement in treatment or potential barriers to the delivery of services.

- ***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.). If the program intends to have a DBT component, then care should be given to how individuals will be assessed for personality disorders that can be screened into DBT. The assessment of these results can be used to make decisions on how staff, clients, and the program work together. Examples of relevant responsivity tools include: the Texas Christian University (TCU) Client Self-Rating Scale, TCU Client Evaluation of Self at Intake/Treatment, Beck's Depression, Test of Adult Basic Education (TABE), and University of Rhode Island Change Assessment (URICA).

Treatment Characteristics

The Treatment Characteristics domain of the CPC examines whether the program 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 justice-involved participants in new prosocial thinking and skills, and the provision and quality of aftercare services. Other important elements of effective intervention include matching the participant's risk, needs, and personal characteristics with appropriate programs, intensity, and staff. Finally, the use of relapse prevention strategies designed to assist the participant in anticipating and coping with problem situations is considered.

Treatment Characteristics Strengths

While the program does target non-criminogenic need areas such as accountability and non-directive empathy, the program also targets criminogenic needs. These criminogenic targets include: criminal thinking, decision making, substance abuse, belief systems, and emotional regulation. As a result, the CTC program focuses at least 50% of its effort on those characteristics associated with recidivism (criminogenic needs). Related, in targeting these criminogenic needs, the treatment approach utilizes a cognitive model.

All treatment groups are conducted by direct service delivery staff from beginning to end and the inmates are not involved in providing any of the interventions or services.

Treatment Characteristics Areas in Need of Improvement and Recommendations

To further reduce the likelihood that participants will recidivate, the ratio of criminogenic needs targeted to non-criminogenic needs should at least be 4:1 (80% criminogenic). As mentioned above, although the program targets a number of criminogenic needs, it also targets a number of non-criminogenic needs (i.e., accountability and non-directive empathy), resulting in a ratio of 5:2 (71% criminogenic). The emphasis of programming should greatly favor criminogenic needs as these are most likely to reduce recidivism.

- ***Recommendation:*** In order to increase the density of appropriate program targets, it is recommended the CTC work to increase the amount of service time related to criminogenic need areas and decrease the amount of time spent on targets not directly linked to criminal behavior. The program should ensure that group and individual sessions stay focused on the core areas designated on the NRAS and that time spent on these core areas significantly outweighs time spent on other targets by a ratio of 4:1. Appropriate criminogenic targets for change include (but are not limited to): antisocial thinking and beliefs, antisocial peers, substance abuse, and pro-criminal personality factors such as poor anger management, poor problem solving ability, and constructive (prosocial) use of leisure time. A way for the CTC program to meet this criteria would be to also target criminogenic needs in 1-on-1 sessions using cognitive behavioral techniques like thought-behavior links, skills streaming, and role play. Targeting criminogenic needs using CBT methods would significant increase CTC's target density. Moreover, CTC should lessen their focus on non-criminogenic targets of non-directive empathy and accountability, and place more focus on criminogenic targets of criminal thinking and emotional regulation.

The CTC program does not develop case plans for each participant in the program, nor is CTC an element of the HDSP case plan. Case plans should be developed based on the results of the NRAS assessment. The objectives listed in case plans should be specific to the assessment results and should utilize/emphasize skills being taught in programming (e.g., coping skills, thinking, etc.).

- ***Recommendation:*** Case/treatment plans should be derived from the review of the client's needs and individual goals, based on standardized and validated risk/need/responsivity assessments in relation to how CTC can assist them in meeting their goals. These individualized case plans should be developed by the case manager or CTC program staff and the participants and be regularly updated in case management meetings. The plans should include targets for change, and strategies for achieving the change based on skills being taught throughout the program including what the client is responsible for completing and what the program staff are responsible for assisting the client with. CTC case plans do not necessarily need to be separate case plans, rather they can be incorporated into a client's larger case plan (as long as they are individuals and based on the NRAS).

The most effective programs are based on behavioral, cognitive behavioral (CBT), and social learning theories and models. CTC aims for a primary modality of treatment that is cognitive-behavioral. However, the program is built on a cognitive modality (i.e., it does not incorporate behavioral strategies) and is delivered via non-effective modalities (i.e., process oriented group). The program does target antisocial thinking, but does not incorporate appropriate modeling, skill building, or graduated practice (i.e., behavioral techniques).

- ***Recommendation:*** The CTC program should implement a comprehensive program model based on social learning and cognitive behavioral theories and approaches. This model should also be reflected in the program manual, group interventions, case management sessions, individual sessions, and in all other interactions with participants.

    - Additional focus in CTC should be on teaching participants to identify and replace antisocial thinking and choices with prosocial ones (i.e., cognitive restructuring). Cognitive restructuring can be taught through behavior chains, rules tools, thinking

reports, and cost-benefit analysis. Observation of the group offered missed opportunities to focus on antisocial thinking and replacing those thoughts with prosocial thoughts.

The length of time over which services are delivered is important. The most effective interventions last between three and nine months. The current program is designed to be completed in six weeks.

- ***Recommendation:*** CTC program could increase the time needed to complete the program by incorporating more opportunities in groups to target criminogenic needs, teach skills needed to reduce recidivism, and practice skills in increasing amounts of difficulty. Furthermore, individual sessions with the facilitator could be held to ensure that graduated practice can occur.

While in the program, it is important that the clients are supervised and closely monitored within the context of the goals of the program. For programs that operate in institutions like CTC, this means that program participants should be separated from the general population that is not receiving CTC. Currently, the CTC program is housed across numerous buildings that contain program participants and general population inmates.

- ***Recommendation:*** The program should attempt to work with the administration and determine the feasibility of eventually housing CTC participants together so they are bunked with other inmates in CTC or similar programming.

While CTC has a manual for the delivery of the groups itself (i.e., three books that layout 29 sessions), the Mental Health & Programs Unit lacks a detailed manual that specifies all major aspects of the CTC program.

- ***Recommendation:*** The Mental Health & Programs Unit should develop and follow a detailed program manual. In addition to the CTC group sessions, the manual should include a program description, philosophy, admission criteria, assessment practices, scheduling, case planning, phase advancement (or CTC program advancement across the series), behavior management, completion criteria, discharge planning, and aftercare. Once the manual is created, it should be followed by all staff.

Effective correctional programs inform service delivery using the risk, need, and responsivity levels of the client. For example, effective programs are structured so that lower-risk participants have limited exposure to their higher risk counterparts. Research has shown that mixing low risk participants with moderate or high risk participants can increase the risk of recidivism for low risk participants. Low risk participants may be negatively influenced by the behavior of high risk participants, thereby increasing their risk of recidivism. Review of program materials, case files, and interviews revealed that CTC does accept low risk clients, and but does not separate risk levels across groups.

- ***Recommendation:*** If the program accepts clients that are classified as low risk by the NRAS, then efforts should be made to ensure that low risk clients are not mixed with higher risk clients. If the CTC continues to accept low risk clients, then low risk groups should

be formed specifically for low risk clients to avoid exposing these clients to higher risk individuals in a group setting.

A program should vary the dosage and duration of service according to the client's risk level. The program does not provide more intensive services to higher risk participants. Clients who are at higher risk for recidivism by definition have more criminogenic needs. These clients should be required to attend additional services, dictated by the needs identified on the NRAS risk and need assessment tool. Thus, clients identified overall as high risk for recidivism should have longer and more intense services than those identified as moderate risk. Research indicates that participants who are moderate risk to reoffend need approximately 100-150 hours of evidence-based services to reduce their risk of recidivating and high risk participants need over 200 hours of services to reduce their risk of recidivating. Very high risk or high risk people with multiple high need areas may need 300 hours of evidence-based services. Only 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 towards the dosage hours. While it is unreasonable for CTC to solely meet this dosage, CTC should be used as one facet to meet these dosage levels.

- ***Recommendation:*** The program directors should work with HDSP to develop treatment tracks for different risk levels that build towards sufficient dosage prior to release. Based on our calculation, CTC would count towards 36 dosage hours in this track. Different tracks should be developed for moderate and high risk offenders with different requirements for dosage hours. Client dosage hours should be tracked and included as part of the completion criteria.

Offender needs and responsivity factors like personality characteristics or learning styles should be used to systematically match the client to the type of service for which he/she is most likely to respond. These assessed characteristics can also be used to assign staff and offenders together as programs have better outcomes when they staff are matched to clients based on assessed need and/or responsivity factors. CTC does not use the results of a needs assessment to refer clients to programming or to match of staff and clients. Instead, the yard an inmate is housed on determines group placement. And clients are assigned to specific staff on that yard based on who is on the wait list when the CTC program is being formed.

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

- ***Recommendation:*** Need and/or responsivity factors should be used to match inmates to their group facilitators. For example, a client with substance abuse issues should be matched with a staff member with substance abuse credentials. Or, a client who lacks motivation is matched with a staff who excels in motivational interviewing techniques. CTC should work towards implementing responsivity assessments (as described above) and use both responsivity and need assessment results to match clients and staff.

Moreover, programs that assign staff to groups based on skills, education, experience, or training have better outcomes than programs that do not. Staff at CTC are assigned to groups based on schedule, and some staff who have no interest in CTC facilitate the groups.

- ***Recommendation:*** The CTC program directors should assign staff to deliver programming based on skills, experience, education, training, and then expressed interest.

Clients do not have formal mechanisms to provide program input. Programs that have formal process in place for clients to provide the program feedback on their likes and dislikes demonstrate better outcomes than programs that lack this formalized procedure.

- ***Recommendation:*** The CTC program should create formal procedures to solicit client feedback on a regular basis. Examples can include caseload meetings, elected representatives, suggestion boxes, or feedback forms, to name a few. Any suggested changes made by clients must be approved by the program directors before they are implemented.

With regard to reinforcers and punishers, the program can increase its adherence to the evidence by improving the use and process of administration of positive and negative consequences. Programs for criminal justice clientele should identify and apply appropriate reinforcers. While CTC has established some appropriate reinforcers (i.e., verbal praise, meritorious credit), there is not a menu of available reinforcers or when to use them. That is, the program has not established a thorough enough array of reinforcers for use to encourage positive behavior in and out of the program. Similarly, the administration of reinforcers also needs to be improved. Rewards are most valuable when they are received as close in time to the target behavior as possible and when the target behavior is directly linked with the reward. Further, the research is also clear that rewards need to outweigh sanctions (i.e., punishers) by a ratio of 4:1. Finally, program staff do not receive any formal training in the administration of rewards (or punishers).

In addition to appropriate rewards, a good behavior management system has a wide range of negative consequences available to promote behavioral change and are appropriately applied. The CTC program has established very few punishers available for use, and the program has no formal protocol for administering them. Staff are also not trained on how to properly administer effective negative consequences. For example, there is no formal policy concerning negative effects that may occur after the use of punishment. Policy and training should alert staff to issues beyond emotional reactions such as aggression towards punishment, future use of punishment, and response substitution. CPC recommendations in this area are designed to help programs fully utilize a cognitive-behavioral model.

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

    - CTC should enhance its reinforcement protocol to include a wider range of appropriate reinforcers. In addition to reinforcers already employed by the program such as verbal praise and sentence credit, other examples include: tangible reinforcers (e.g., food, books, etc.), awards, raffle tickets, increased TV time,

increased recreation time, and extra shower time to name a few. It is recognized that the institution may have policies in place as to what is acceptable/accessible as reinforcers. Therefore, CTC staff should work with the institution to determine what is possible when expanding their reinforcement menu.

- Reinforcers should be monitored to ensure they are being consistently applied, administered as close in time to the desired behavior as possible, and staff link the reward to the desired behavior. For key target behaviors, staff should have the client articulate the short-term and long-term benefits of continuing that behavior.

- The program should strive for a 4:1 ratio of reinforcers to punishers. The program can increase its ratio by using reinforcement in informal contacts, in groups, and in individual sessions.

- An appropriate range of punishers should be used to extinguish antisocial behavior and to promote behavioral change in the future by showing the offenders that behavior has consequences. Appropriate punishers include: verbal warning, verbal disapproval, written warning, a behavior contract, loss of points or privileges, or formal write-up to name a few. Removal from program should only be reserved only for when all other options have been used. Shaming and treatment activities (e.g., more group, thinking report, etc.) should never be used as punishers.

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

- Staff should understand punishment may result in certain undesirable outcomes beyond emotional reactions and be trained to monitor and respond to these responses.

- There should be a written policy to guide administration of rewards and punishers. All staff should be trained in the behavior management system and be monitored to ensure they are using the system consistently and accurately. This training should include the core correctional practices of effective reinforcement, effective disapproval, and effective use of authority.

Effective programs have established criteria that clearly outline the completion criteria for the program. Successful completion should be defined by progress in acquiring pro-social behaviors, attitudes and beliefs while in the program as well as documented (i.e., behavioral assessment instrument, checklist of behavioral/attitudinal criteria, detailed treatment plan) progress towards meeting individualized treatment goals. In comparison, to successfully complete the CTC

program, a client simply must attend the groups, participate in group, and complete homework. There is no emphasis on direct measurement of the acquisition of prosocial behaviors.

- ***Recommendation:*** The CTC program should establish written guidelines for successful completion. These guidelines should be tied to individualized progress in acquisition of the target behaviors taught in the program. In addition to client progress observed by staff in meeting their individualized treatment plan goals and objectives, progress should also be linked to some objective assessment such as the Texas Christian University Criminal Sentiments Scale (TCU CTS), which can be utilized as pre-, mid-, and post-test measure of client progress or reassessment of the NRAS. Clients should also be informed of these guidelines and their progress toward meeting target behaviors as they move through the curriculum.

Effective correctional programs have a completion rate between 65% and 85%, ensuring the program is neither too difficult nor arbitrarily easy to complete. The CTC program does not consistently track its completion rate for the program. Estimates gathered during the site visit ranged from a 50% completion rate to a 95% completion rate.

- ***Recommendation:*** The CTC program should track its completion rate to ensure that it is meeting the CPC criterion, falling between 65% and 85% successful completion. Those who are regarded as unsuccessful or successful by program staff should be counted in this rate. In addition, those that leave the program because of housing changes (i.e., they did not elect to leave the program and program staff did not remove them from the program) should be included as unsuccessful. While the program staff may not be involved in housing decisions, it is nevertheless a decision that impacts programming and treatment dosage.

- ***Recommendation:*** Keeping track of the percent of people who have to leave the program do to administrative or security related decisions (i.e., housing moves) may also help inform administration of the breadth of this issue and its difficulty for program staff.

If correctional programming hopes to increase participant engagement in prosocial behavior, participants have to be taught skills in how to do so. This includes new thinking skills and new behaviors. At the time of the site visit, none of the group services incorporated the correct format for teaching new skills as outlined by social learning theory.

- ***Recommendation:*** Structured skill building should be routinely incorporated across the program. Staff should be trained to follow the basic approach to teaching skills which includes: 1) defining skill to be learned; 2) staff selling the skill/increasing participant motivation for the skill; 3) staff modeling the skill for the participants; 4) participant rehearsal of the skill (applying that skill to their specific life circumstances or high risk situations or role-playing; every client should practice that skill); 5) staff providing constructive feedback; and 6) client practicing the skill in increasingly difficult situations and being given staff feedback/generalizing the use of the skill to other situations. 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 client.

- ***Recommendation:*** Overall the program can benefit from ensuring that cognitive restructuring and structured skill building be split anywhere from a 50/50 to 70/30 range across the service targets.

Group size falls outside the required range of the CPC. The required range for groups is 8 to 10 per facilitator. Given the issues with housing moves and the rule regarding groups needing 5 or more participants to run, groups at the CTC program routinely begin with 15-20 participants.

- ***Recommendation:*** Groups should not exceed 8 to 10 clients per active facilitator at the start of the curriculum and routinely end with at least 65% of those who started the group.

The CTC program does not develop formal discharge plans for all clients of the CTC program.

- ***Recommendation:*** Formal discharge plans should be developed upon termination from the program. These plans should include any referrals to other services (in the community or institution), progress in meeting target behaviors and goals, and noted areas that need continued improvement. These plans can be used to inform additional programming needed within the institution or upon release. They should be shared with the HDSP caseworker and the client.

Research demonstrates that aftercare is an important component of effective programs in order to help clients maintain long-term behavior change. The CTC program does not currently have an aftercare component.

- ***Recommendation:*** All clients should be required to attend a formal aftercare period in which continued treatment and/or supervision is provided. High quality aftercare includes planning that begins during the treatment phase, reassessment of offender risk and needs, requirement of attendance, evidence-based treatment groups or individual sessions, and duration and intensity is based on risk level.

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 CTC program lacks a formal management audit system. Internal quality assurance mechanisms are important for programs to ensure that they are operating the way they are intended to operate.

- ***Recommendation:*** The CTC program 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 CTC, and (3) clients are provided feedback on their progress in the curriculum. With regards to observation of

staff service delivery, this needs to be consistently done by each program director and there should be documented feedback provided to the staff based on the observations of the program director. In regards to client feedback, this can take the form of biweekly, monthly, or quarterly (or other time frames) meetings where the client 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 clients.

The program does not have a formal process to solicit client satisfaction with the program. Programs that collect formal client feedback on service delivery and use that information to inform programming have better programmatic outcomes than programs who lack this process.

- ***Recommendation:*** The CTC program should develop a consistent process to solicit client feedback on the program. This can be done through monthly surveys or exit surveys/interviews. The program should use the information gathered from this process to inform potential programmatic changes.

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

- ***Recommendation:*** The CTC program should formalize a period reassessment process in which objective, standardized reassessment takes place. This can include pre- and post-testing using a standardized need assessment tool that may be adopted (for example, the Texas Christian University Criminal Thinking Scales). Having a subjective assessment (e.g., professional judgement) is not sufficient to meet this requirement.

The program does not track recidivism of its participants after completion of the program. Additionally, the program has not undergone a formal evaluation comparing its treatment outcomes (recidivism) with a risk-control comparison group. Finally, the program does not work with an internal or external evaluator that can provide regular assistance with research/evaluation.

- ***Recommendation:*** Recidivism—in the form of re-arrest, re-conviction, or re-incarceration—should be tracked at 6 months or more after release from prison. If there is a significant amount of time between program completion and release from prison, then the program is encouraged to measure recidivism as institutional misconducts. The program can do this on its own, or work with NDOC to secure these data.

- ***Recommendation:*** In relation to the formal evaluation, a comparison study between the program's outcome and a risk-controlled comparison group should be conducted and include an introduction, methods, results, and discussion section. This study should be kept on file.

- ***Recommendation:*** CTC should consider working with NDOC to identifying an evaluator who is available to evaluate available data. Evaluation must be the main focus of their position. Alternatively, CTC 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 CTC) so that fiscal remuneration is limited to payment for analysis and reporting. Another option is to 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).

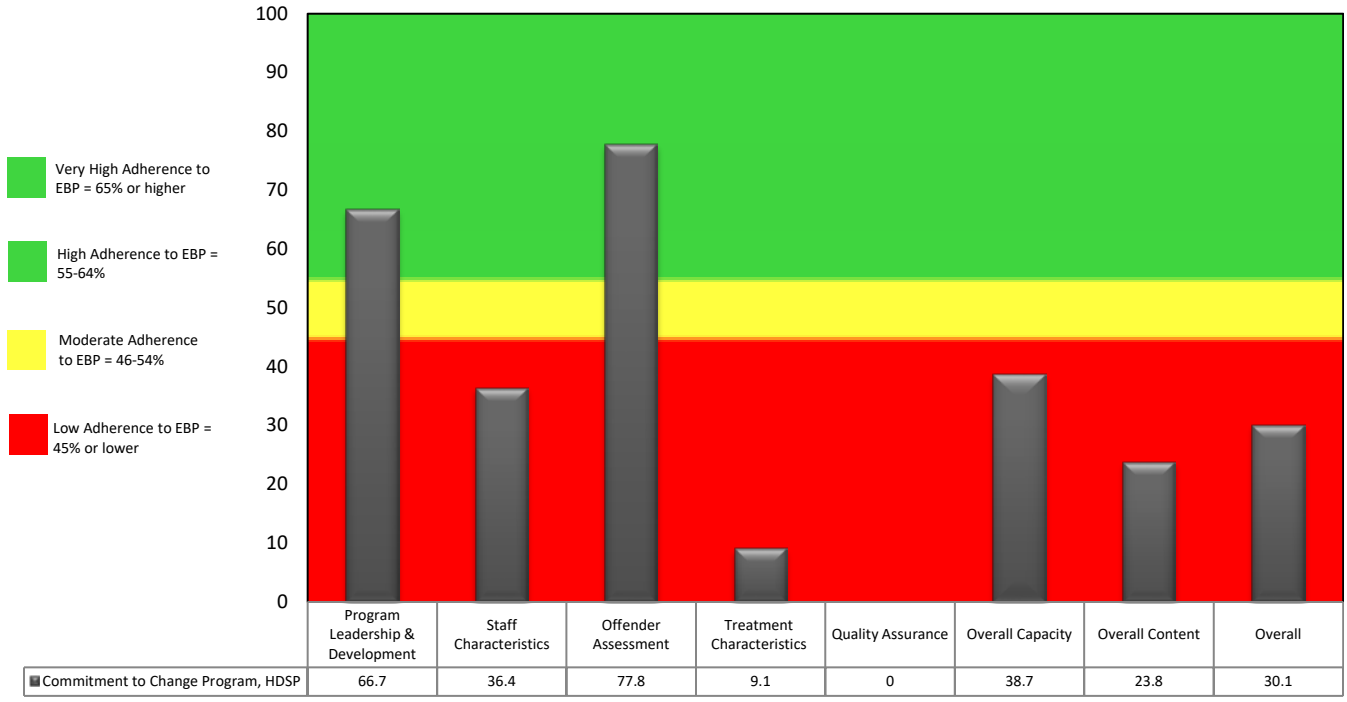
OVERALL PROGRAM RATING AND CONCLUSION

The program received an overall score of 30.1% on the CPC 2.0. This falls into the Low Adherence to EBP category. The overall capacity area score designed to measure whether the program has the capability to deliver evidence based interventions and services for the participants is 38.7%, which falls into the Low Adherence to EBP category. Within the area of capacity, the program leadership and development domain score is 66.7% (Very High Adherence to EBP), the staff characteristics score is 36.4% (Low Adherence to EBP), and the quality assurance score is 0.0% (Low Adherence to EBP). The overall content area score, which focuses on the substantive domains of assessment and treatment, is 23.8%, which falls into the Low Adherence to EBP category. The assessment domain score is 77.8% (Very High Adherence to EBP) and the treatment domain score is 9.1% (Low Adherence to EBP).

It should be noted that the program scored highest in the Assessment Domain. While recommendations have been made in each of the five CPC domains, most of the areas in need of improvement relate to the Treatment Characteristics and Quality Assurance Domains. These recommendations should assist the program in making the necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all “areas needing improvement” at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systemically address them. UCCI is available to work closely with the program to assist with action planning and to provide technical assistance as needed. Evaluators note that the program staff are open and willing to take steps toward increasing the use of evidence-based practices within the program. This motivation will no doubt help this program implement the changes necessary to bring it further into alignment with effective correctional programming.

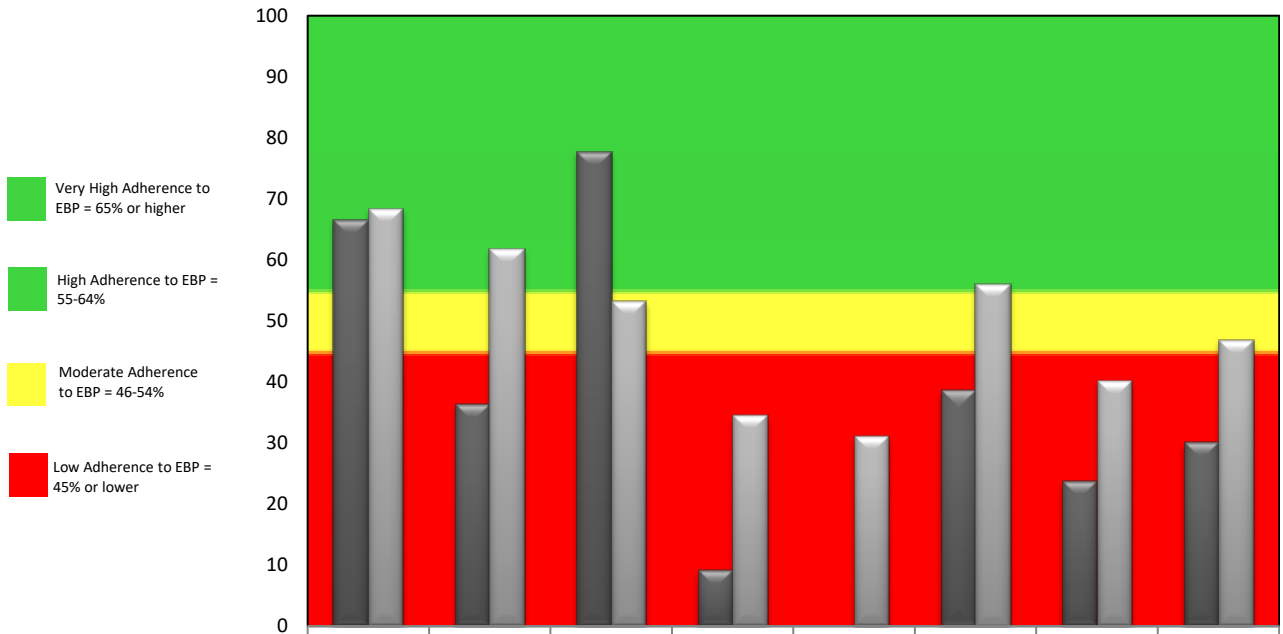
As outlined in the cover letter attached to this report, please take the time to review the report and disseminate the results to selected staff. Although we have worked diligently to accurately describe your program, we are interested in correcting any errors or misrepresentations. As such, we would appreciate your comments after you have had time to review the report with your staff. If you do not have any comments, you can consider this to be a final report.

Figure 1: Commitment to Change Program, HDSP CPC Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
Commitment to Change Program, HDSP	66.7	36.4	77.8	9.1	0	38.7	23.8	30.1

Figure 2: Commitment to Change Program, HDSP CPC Scores Compared to the CPC Average Scores



	Program Leadership & Development	Staff Characteristics	Offender Assessment	Treatment Characteristics	Quality Assurance	Overall Capacity	Overall Content	Overall
Commitment to Change Program, HDSP	66.7	36.4	77.8	9.1	0	38.7	23.8	30.1
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), the UC School of Criminal Justice, or the UC Center for Criminal Justice Research (CCJR). We now use the UCCI designation.

[ii] The CPC is modeled after the Correctional Program Assessment Inventory (CPAI) developed by Paul Gendreau and Don Andrews. The CPC, however, includes a number of items not included in the CPAI. Further, items that were not positively correlated with recidivism in the UCCI studies were deleted.

[iii] A large component of this research involved the identification of program characteristics that were correlated with recidivism outcomes. References include:

Holsinger, A. M. (1999). *Opening the 'black box': Assessing the relationship between program integrity and recidivism.* Doctoral Dissertation. University of Cincinnati.

Lowenkamp, C. T. (2003). *A program level analysis of the relationship between correctional program integrity and treatment effectiveness*. Doctoral Dissertation. University of Cincinnati.

Lowenkamp, C. T. & Latessa, E. J. (2003). Evaluation of Ohio's Halfway Houses and Community Based Correctional Facilities. Center for Criminal Justice Research, University of Cincinnati, Cincinnati, OH.

Lowenkamp, C. T. & Latessa, E. J. (2005a). *Evaluation of Ohio's CCA Programs.* Center for Criminal Justice Research, University of Cincinnati, Cincinnati, OH.

Lowenkamp, C. T. & Latessa, E. J. (2005b). *Evaluation of Ohio's Reclaim Funded Programs, Community Correctional Facilities, and DYS Facilities.* Center for Criminal Justice Research, University of Cincinnati, Cincinnati, OH.

[iv] Several versions of the CPAI were used prior to the development of the CPC and the subsequent CPC 2.0. Scores and averages have been adjusted as needed.

[v] Programs we have assessed include: male and female programs; adult and juvenile programs; prison-based, jail-based, community-based, and school-based programs; residential and outpatient programs; programs that serve prisoners, parolees, probationers, and diversion cases; programs that are based in specialized settings such as boot camps, work release programs, case management programs, day reporting centers, group homes, halfway houses, therapeutic communities, intensive supervision units, and community-based correctional facilities; and specialized offender/delinquent populations such as sex offenders, substance abusers, drunk drivers, and domestic violence offenders.