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FINAL REPORT

Residential Substance Abuse Treatment for State Prisoners (RSAT) Partnership Process Evaluation

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FINAL REPORT
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A partnership between the Idaho Department of Corrections (IDOC) Residential Substance Abuse Treatment (RSAT) Program at the South Idaho Correctional Institution and the IDOC Bureau of Offender Programs and faculty and students in the Criminal Justice Department at Boise State University.

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EXECUTIVE SUMMARY

Drug and alcohol use and abuse are responsible for many social ills, including an association with criminal involvement and repeat offending. The Residential Substance Abuse Treatment (RSAT) program at the South Idaho Correctional Institution (SICI), which began accepting inmate clients in May 1997, was designed to fill some of the need for treatment of Idaho correctional populations. RSAT program design includes a 9 to 12-month treatment regimen for chronic substance abusers that addresses addiction and criminality. The intent was to create a structured environment with three treatment modalities including cognitive self-change and behavioral, 12-step programming set within a therapeutic community. Though not part of the program, aftercare is emphasized.

The SICI RSAT program, the first of its kind in Idaho, provided a unique research opportunity. Not only does the program integrate the three aforementioned treatment modalities, it includes the unprecedented goal of targeting substance-abusing parole violators and, in collaboration with the Parole Commission, in moving participants in and out of the program.

In this process evaluation of a viable, operating RSAT therapeutic community, we employed both qualitative and quantitative data collection techniques to construct a framework from which a full-blown outcome evaluation may be performed. We utilized a multi-method approach to address lessons learned from

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the research literature on correctional programming. Our research questions were centered on whether the program delivery: matched its stated goals and objectives; was consistent with identified successes in the literature; addressed the targeted population; was likely to result in reduced recidivism, costs and greater abstinence, or measurable behavioral changes; was solidly established so that an outcome evaluation might be conducted; was marred by any communication or other implementation barriers, and; whether it might be enhanced by the development of cooperative remedies to address any real or perceived barriers to successful implementation.

Data collection techniques included the review of archival materials, field observations, structured interviews of key participants and the administration of staff and inmate questionnaires on perceptions of program strengths and weaknesses. Normed assessment instrument outcomes were also analyzed.

We found that the SICI RSAT program was substantively and operationally sound in its content and delivery of services. Program content included in-depth programming on cognitive self-change, 12-step programming and the traditions, boundaries and reinforcement of behaviors that typify a therapeutic community. Attributes of this program that reflected successful programming in the literature included: cognitive processes and practice (e.g. journaling or thinking reports, CSC groups and process groups), pro-social modeling by staff and other inmates, intensive engagement in their own treatment by clients, external support

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within the IDOC from the Bureau of Offender Programs and outside the IDOC from the parole board and a therapeutic community environment. It is the research teams belief that this program, as we examined it, is likely to result in less recidivism and cost for taxpayers and that it is thus ripe for the implementation of an outcome evaluation to test this belief. As a means of improving upon an already strong program, we offered a number of recommendations in this report that we hope will serve to strengthen its operation by increasing the stability of staffing within the RSAT and enhancing the communication between major stakeholders and the aftercare program upon parole.

This evaluation project drew strength from an academic/practitioner partnership formed by the IDOC-Bureau of Offender Programs and BSU Criminal Justice. It is believed this partnership allowed for more accurate research insights into program processes, impacts and outcomes.

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FINAL REPORT

Residential Substance Abuse Treatment for State Prisoners (RSAT) Partnership Process Evaluation

INTRODUCTION AND LITERATURE REVIEW

INTRODUCTION

Drug and alcohol use and abuse are responsible for many social ills, not the least of which is an association with criminal involvement (Associated Press 1998; National Center on Addiction and Substance Abuse [CASA] 1998). According to a recent Bureau of Justice Statistics report, nationally about 47% of probationers, 60% of jail inmates, and 49% of state prison inmates were under the influence of drugs or alcohol at the time of their arrest or commission of their crime (Associated Press 1998). The authors of a report released by the National Center on Addiction and Substance Abuse at Columbia University revealed that "[d]rug and alcohol abuse and addiction are implicated in the incarceration of 80% -- 1.4 million -- of the 1.7 million men and women behind bars today"(CASA 1998). Idaho inmates are similarly afflicted with alcohol and drug use problems. Between 1993 and 1994, 1,139 inmates were surveyed at the Reception and Diagnostic Unit in the Idaho Department of Corrections (IDOC). Among these offenders, 23.7% had been using drugs, 43.3% had been using alcohol and 10.1% had been using both at the time of the commission of their offense (Cardenas 1996).

The Residential Substance Abuse Treatment (RSAT) program at the South

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Idaho Correctional Institution (SICI), which began accepting inmate clients in May 1997, is designed to fill some of the need for substance abuse treatment for Idaho correctional populations. The program is actually delivered by the Boise Care Unit (Compcare); a private contract provider of alcohol/drug treatment. RSAT program design includes an intensive 9 to 12-month treatment regimen for chronic substance abusers that addresses both addiction and criminality in a structured therapeutic environment.

A unique characteristic of the program is that parole violators with substance abuse problems are targeted for treatment. Significantly, the first year review of the RSAT operation indicates that the majority of such offenders have had alcohol or methamphetamine dependencies. In addition, the Idaho Parole Commission and the IDOC have engaged in a cooperative arrangement whereby successful completion of the program will likely result in the inmate receiving a parole date. This agreement also extends to the involvement of the parole revocation hearing officer in the selection of candidates for the program.

Another important and distinguishing feature of the RSAT plan is the use of a combination of modalities including cognitive self and behavioral change and 12-step programming in a curriculum that is divided into three month phases. There is a focus on identifying thinking and behaviors -- via group process, thinking reports, and journal writing -- which place the participant at risk of a relapse to substance abuse and/or criminal behavior. These activities all take place within

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the parameters of a therapeutic environment in a dedicated tier of the SICI (Cardenas 1996; State of Idaho 1998).

The Idaho Department of Correction has taken measures to ensure an aftercare/follow-up component of programming to ensure a greater probability of program success in reducing the use of illegal substances and reoffending upon release. Participant aftercare plans involve further programming and specialized caseloads. Most program graduates follow this track as part of their aftercare plan, while some graduates without resources may spend a transition period in a community work center. While on parole, RSAT graduates are to be exposed to a variety of programming including: transition from prison to parole, relapse prevention, substance abuse, and continuation of the Phase III cognitive restructuring and life skills.

Study of such a mixed modality program that integrates the cognitive and behavioral pieces and aftercare with the more traditional 12-step and TC components is promising. This is particularly so because of the emerging evaluation literature that supports the importance of addressing cognition, reinforcing the positive over the negative behaviors (and client involvement in this) and follow through in treatment upon release (Andrews, Zinger, Hoge, Bonta, Gendreau and Cullen 1990; Antonowicz and Ross 1997; Gendreau and Ross 1987, 1995; Henning and Frueh 1996; Inciardi 1995; McMurran 1995).

In an effort to ensure the basic integrity of this RSAT program, we engaged in

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a partnership arrangement between the IDOC Bureau of Offender Programs and Boise State University Criminal Justice faculty to perform a process evaluation. Included in this evaluation was a research design employing both qualitative and quantitative data collection techniques and construction of a framework from which a full-blown outcome evaluation may be performed (Lipton et al. 1997). We utilized a multi-method approach to address lessons learned from the research literature on correctional programming.

The establishment of effective methodologies to achieve habilitation and rehabilitation of persons prone to substance abuse, and subsequent involvement in high-risk and crime related activities, is key to reducing the incidence of crime in this country. As the research literature indicates, there are treatment programs that have had some success in both reducing recidivism and the cost of crime. In this final report on a process evaluation of a viable, operating RSAT therapeutic community, we hope to add to the growing list of the "dos and don'ts" of substance abuse programming so that the best attributes of it might be identified and applied elsewhere.

CORRECTIONAL PROGRAMMING LITERATURE

The literature on substance abuse and related programming is replete with research evaluations that indicate successful treatment programming can be designed and implemented in the correctional environment (Andrews et al. 1990; Applegate, Langworthy and Latessa 1997; Bowman, Lowrey and Purser 1997;

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Calco-Gray 1993; Field 1985; 1989; 1992; Finney, Moos and Chan 1981; Gendreau and Ross 1995; Hartmann, Wolk, Johnston and Colyer 1997; Henning and Frueh 1996; Inciardi 1995; Knight, Simpson, Chatham, Camacho 1997; Lipton 1998; Lipton, Falkin and Wexler 1992; Lockwood, McCorkel, Inciardi 1998; McMurran 1995; Office of Justice Programs 1998; Palmer 1995; Rice and Remy 1998; Siegal, Wang, Carlson, Falck, Rahman and Fine 1999; Wexler, DeLeon, Thomas, Kressel and Peters 1999). The most successful programs are those which combine the delivery of substantive knowledge in an environment that is suited to therapeutic change (Inciardi 1995; Lipton 1998; Lipton et al. 1992). Research also indicates that cognitive attributes, positive modeling, behavioral redirection, emotional therapy, a treatment environment engendering trust and empathy and intensive involvement in problem-solving by clients in their own treatment are also key to attaining actual behavioral change upon release (Andrews et al. 1990; Antonowicz and Ross 1997; Gendreau and Ross 1987, 1995; Henning and Frueh 1996; Inciardi 1995; McMurran 1995; Pollock 1997; Smith and Faubert 1990). Treatment programs directed at drug offenders also appear to achieve greater success in reducing recidivism when services were continued post release (Lipton 1998; McMurran 1995; Rouse 1991; Tims and Leukefeld 1992).

Of course, the promise of correctional programming has not always been realized. In the widely cited and influential review of correctional programming by Martinson (1974) and Lipton, Martinson and Wilks (1975), it was revealed that not

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much has worked to reduce the recidivism rate of their participants. More recent meta-analyses of correctional programming (e.g. Antonowicz and Ross 1997; Leukefeld and Tims, eds. 1992; Logan and Gaes 1993; Wright 1995) have also raised serious questions concerning the veracity of claims of success by correctional program proponents because the evaluation design and implementation is often flawed. As Antonowicz and Ross (1997: 313) indicate, after reviewing the published research on correctional programming from 1970 to 1991,

> One of our major findings was that there is not a large number of published, rigorously controlled studies. Many published studies have either inadequate control/comparison groups, do not report on sample size, and use sample sizes that are too small to enable statistical tests, or fail to examine outcome.

Moreover, of the 44 programs that had adequate research designs, they found that only 20 "were effective" (Antonowicz and Ross 1997: 313). Those programs that achieved some success in theirs and others meta-analyses (e.g. see Andrews et al. 1990; McMurran 1995) were stronger in the areas of conceptualization (programs with cognitive/behavioral models, structuring and role-playing). They included a greater variety of programming options and techniques, targeted factors that were actually related to criminal involvement and matched offender learning styles to complementary services.

Programs also falter because of external factors, some of which they have little or no control over. Leukefeld and Tims (1992) in the introduction to their

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edited monograph on the state of substance abuse programming in corrections caution that programs must be given time to succeed or fail on their merits. They proposed that in order to succeed, programs must have sustained adequate funding over a period of time and they must be designed with evaluation in mind. Such a design should be realistic in scope and timeline with respect to outcomes and subject participation (Leukefeld and Tims 1992; Schuiteman and Bogle 1996).

Similarly, Lipton and his colleagues (1992) found in their review of evaluations of two well studied correctional therapeutic community substance abuse programs, the New York Stay'n Out and the Oregon Cornerstone programs, that recidivism in crime and substance use decreased for participants as compared to control groups. They note, however, that the history of therapeutic community program demise over the past two decades is oftentimes tied to factors external to those programs such as administrative changes and funding reductions.

SICI RSAT TREATMENT COMPONENTS

The SICI therapeutic community treatment program was designed to achieve reduced recidivism of substance abusing offenders, and collaterally to decrease the costs of crime and re-incarceration for victims and taxpayers. It is believed that recidivism will be reduced, even for chronic offenders such as those in the SICI RSAT Program, when the treatment is conducted in a therapeutic community, employs cognitive self-change and behavioral strategies, intensively involves clients in their own problem-solving and development and contains a

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structured aftercare program.

The *therapeutic community* (TC) "[I]s a residential-based, substance abuse treatment modality incorporating the use of a social learning model based on peer support for pro-social values and behaviors" (CompCare 1998; Hartmann, Wolk, Johnston and Colyer 1997: 18). A key aspect of the TC is a recognition that a community can provide an individual with the strength, support and insight to make needed changes that would be much more difficult if that person were on their own.

> In this TC setting each individual has the opportunity to grow, as a community member, in ways not possible by going it alone. A community environment also allows its members to fight a common enemy and reach a common goal. In the RSAT program the common enemy is an addictive and criminal lifestyle. The common goal is personal change by learning new ways of 'Right Living' (CompCare 1998: 4).

Social learning theories provide the framework for effective cognitive-behavioral approaches to treatment (Gendreau 1993; NIC 1997). *Cognitive Self-Change and Behavioral Strategies* are utilized in this program to provide inmates with the ability to consider the thinking errors that lead to substance use/abuse and to provide them with the means to move down an alternate and less self destructive path (NIC 1997). Key concepts of this treatment method include cognition and modeling. There is a recognition of both the connection between "[t]he person (cognitive thought processes or awareness), the behavior and the environment" (NIC 1997: 12) and the importance of learning through positive modeling.

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The SICI RSAT program employs the following strategies to achieve a change in thinking and behavior: group process, thinking reports and journals. The group process is initially focused on providing clients with information so that they might better understand the connection between thinking and behavior. Next, the group focuses on individual identification of thinking errors and practicing interventions over a period of time so that these interventions might become part of alternate and more prosocial thought processes. The group process is structured by five guidelines: depersonalized staff authority that maintains control and adherence to rules; allowing the individual offender the authority on issues related to how they think and how they should think; focus on the basic steps of cognitive change; work to achieve cooperation between group members and staff; and, involvement of all group members in the process (Boise CareUnit 1997).

Thinking reports are used by individuals to objectively identify specific thoughts and feelings associated with high-risk behavior in a given situation. Journals are used to document the process that the individual is involved in thinking about and then reevaluating their behaviors and motivations. Additionally, both the thinking reports and the journals are to be regularly reviewed by staff and inmates as a means of measuring progress in treatment.

Inclusion of the *Minnesota Model of Chemical Dependency* (12 Step Program) is central to this RSAT regimen. The components of the program include the use

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of group and the use of recovering alcoholics/addicts as counselors. The program also utilizes individual counseling with professional staff, lectures, group reading, life history work, AA/NA attendance, twelve step work, and recreational and physical activity (Boise CareUnit 1997: 54).

The four key elements of this program are:

1. A belief that addicts can change their beliefs, attitudes, and behavior.
2. An understanding that addiction is a primary, chronic, multi-faceted disease characterized by loss of control of the use of substances in spite of negative consequences.
3. Long-term and short-term treatment goals are specified.
4. The principles of Alcoholics Anonymous and Narcotics Anonymous (AA/NA) are fundamental to recovery (Boise CareUnit 1997: 54).

Client Involvement in treatment is regarded as a prerequisite for successful rehabilitation/habilitation programming. In the SICI RSAT program, inmate/clients are intimately engaged in decisions regarding their own and each others treatment programming because they are involved in the selection of their own leaders or coordinators, problem solving related to their own high-risk behaviors, and maintenance of community and programmatic integrity through the use of "push-ups" and "pull-ups" to encourage or discourage behavior by group members (CompCare 1998).

Aftercare that provides a continuum of care for therapeutic community members is highly regarded by researchers as a means of ensuring a more prosocial transition for offenders (Bowman et al. 1997; Hartmann et al. 1997; McMurran 1995; Wexler et al 1999). The SICI RSAT program is engaged in

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solidifying the development of an aftercare program that will be structured and provide graduates with a continuum of care.

Participant aftercare plans will involve further programming on a designated and specialized caseload while on parole. As indicated in the preceding, some inmates without sufficient resources to parole immediately will also receive special supervision while at the Community Work Center, but most will parole within a short period of program completion. All program graduates will follow this track as part of their aftercare plan.

After paroling, graduates will enter community supervision, where they automatically are placed on the specialized substance abuse caseload. This caseload consists of high-risk offenders with histories of substance abuse. Furthermore, the substance abuse counselor at each district works closely with this caseload to ensure clients are receiving the counseling and programming they need, both in-house and through community agencies. All clients in supervision are allowed to take programming, however, clients on the specialized caseloads are given highest priority.

THE FIRST YEAR OF THE SICI PROGRAM

The Idaho Department of Corrections Bureau of Offender Programs Research Unit compiled some preliminary statistics on the first year of operation of the SICI RSAT Program (Dayley, Cardenas and Majors 1998). As of July 1998, there were 38 clients in the program and since May 1997, 100 inmates had participated in it.

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Sixteen people had completed the program and eleven had been terminated. The sociodemographic information on the 100 participants indicates that they had an average age of 34, were overwhelmingly white (80.9%), and a little over half had 12 years of education (52.6%). About 75% of the inmates had used alcohol or drugs before the age of 15 and the most popular of these substances were alcohol (36%) and methamphetamines (36%).

In the initial months of the RSAT program, a screening process was developed to make it more likely that participants who are committed to the TC philosophy are the only ones admitted to the designated tier and hence the program. However, the initial RSAT participants consisted largely of inmates who were already living on the tier. These inmates voluntarily entered the program, but were not subject to the strict screening process that is now in place. It is believed by IDOC staff that some early disciplinary problems, that have since been resolved, can be traced to the early lack of a screening process. Now the screening for RSAT participants involves more rigor, utilizing recommendations from Parole Officers, Revocation Hearing Officers, program and prison staff, an assessment tool and interviews to assure the most appropriate candidates receive treatment.

The first step in the referral process requires that a parolee that has violated parole due to drug or alcohol problems be recommended for RSAT by his parole officer. The revocation hearing officer reviews the situation and can approve or

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deny the recommendation. Final selection of program participants is made in the Reception and Diagnostic Unit by a treatment team based on the recommendations, the offenders' score on the Compu-13 (substance abuse assessment tool) and a face-to-face interview. The treatment team is comprised of representatives from the contract providers' on-site staff and SICI custody and treatment staff.

In the first two years there were difficulties in ensuring a flow of eligible inmates to the program and an adequate length of stay (Dayley et. al. 1998). As of July 1998 there were ten beds available and the average length of stay was only four months for all participants, but roughly nine months for program completers.

Many of these early difficulties are attributed to some communication lapses between and amongst the IDOC institution and field and community staff. A change in personnel for the private provider may have also led to a disjunction in the transference of knowledge. Early on there was some difficulty in ensuring that all stakeholders were well acquainted with program implementation issues. The IDOC staff, led by Mark Gornik, held several quarterly meetings to address just such glitches in information and to ensure that all understood the program goals, operation and needs. "As with any good program, RSAT went through a 'shakedown phase,' working out the rough spots, building policy and consensus while fully implementing all three programmatic modules" (Dayley et al. 1998:5).

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PROCESS EVALUATION ISSUES

As indicated by the literature, fashioning a valid evaluation of substance abuse programming is doable, but problematic (Anglin and Speckart 1988; Applegate et al. 1997; Chen and Rossi 1980; Field 1985, 1989; Finney, Moos and Chan 1981; Fletcher and Tims 1992; Henning and Frueh 1996; Inciardi, Martin, Lockwood, Hooper and Wald 1992; Incorvaia 1997; Knight et al. 1997; Lipton, Pearson and Wexler 1997; Pelissier and McCarthy 1992; Sannibale 1989; Siegal et al. 1999; Wexler and Williams 1986; Wexler, Falkin, Lipton and Rosenblum 1992; Wexler et al. 1999; Wolk and Hartmann 1996). Program evaluation entails the need to attend to the "process" of the treatment before the outcomes might be truly measured. As Wolk and Hartmann (1996: 70) indicate, "The primary goal of a process evaluation is to establish and maintain program integrity."

Establishing and maintaining program integrity requires rigorous examination of a number of program components and provider and participant activity and preparedness over a period of time (Inciardi et al.1992; Fletcher and Tims 1992; Lipton et al. 1997; Wolk and Hartmann 1996). It is to be expected that the initial graduates will not be as pure a product of the therapeutic community as will those who follow them a year or so later (Wolk and Hartmann 1996). This is true because the program will evolve once implemented and the staff will adjust and mature organizationally when they become accustomed to programmatic requirements.

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A process evaluation provides the opportunity for providers to become attuned to the basic strengths and weaknesses of the program during and after this initial implementation period. Key to this tuning process is attention to the details of program goals and objectives, admittance and release criteria and procedures, program requirements of inmates, treatment and custody staff training and perspective, program content connection to established and viable treatment protocols, prison administration involvement and support, parole board commitment, and provision for aftercare treatment (Inciardi 1992; Wexler and Williams 1986; Wolk and Hartmann 1996). The methods used to investigate such matters include: program visitation and observation; archival research on program manuals, policies, procedures, staff training, inmate assessment, intake and exit instruments; data review from the inmate management system; interviews of key actors; review of aftercare procedures and content; and, surveys of staff and inmates on their satisfaction with, and perceptions of, programmatic success.

RESEARCH AND STUDY DESIGN

RESEARCH QUESTIONS

In this 15 month process evaluation of a RSAT program at SICI we addressed in our research questions some of the issues raised by treatment and evaluation scholars in an effort to examine program efficacy. We highlighted and reinforced those concepts learned from the successful programs. We also constructed a

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solid research and data point rampart from which a subsequent outcome evaluation might be more fruitfully pursued in the future. Thus, our focus in the process evaluation was on the following research questions:

1. Whether the SICI RSAT three modality program as delivered conforms with its stated goals and objectives?

To answer this question we reviewed archival data, conducted field observations and interviewed key participants to determine the extent to which the treatment delivery matches the RSAT program plan. Based on the research on what works in correctional programming we asked and tried to answer a number of questions with this research: Is this a therapeutic community? Does it employ cognitive self-change and behavioral strategies? Does it intensively involve clients in their own problemsolving? Is there structured aftercare available?

2. Whether the SICI RSAT program as delivered conforms to what is known to be most successful in substance abuse treatment in correctional institutions? Whether the SICI RSAT program as delivered is likely to result in reduced recidivism, abstinence from drug and alcohol use and reduced costs of incarceration?

To answer these questions collectively we assessed this RSAT and compared it to other evaluated TCs around the country to determine whether this RSAT possessed the attributes which were most predictive of

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attaining success or failure for other RSATs. We assessed this RSAT's program design and delivery via archival review, observation and interviews. Research driven questions also included: Was it strong in conceptualization (cognitive/behavioral models, structuring and role-playing)? Were there a variety of programming options and techniques available? Is programming targeted and related to criminal involvement? Are offender's learning styles matched to services?

3. Whether the referral process identifies the targeted population?

   To answer this question we reviewed the IDOC assessment, referral and intake forms and processes to assure that appropriate parole violators with substance abuse dependencies were referred.

4. Whether SICI RSAT data, management, staffing and design will be suitably established within two years from the grant start date to allow for a full-blown outcome evaluation?

   To answer this question we reviewed the IDOC database to determine if all forms and relevant variables were included and we reviewed RSAT archival materials on personnel qualifications. We also asked how referrals were done.

5. What are the communication issues between the IDOC, Parole Commission, and contract providers that might interfere with program implementation and delivery?

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To answer this question we observed program delivery and we interviewed key participants as to their perceptions of referrals and program delivery and communication breakdowns. We also asked about communication issues.

6. What cooperative remedies have been, or might be, developed to address implementation and delivery difficulties?

To answer this question we observed program delivery, including attendance of any RSAT meetings held by Gornik or others to address program delivery issues and we interviewed key participants about their perceptions of how this RSAT might be or has been improved.

Methods

Simply put, we expected to enter this cooperative arrangement with the common goal of assessing the efficaciousness of program delivery and effects. In order to accomplish this with a high degree of validity and reliability in our process evaluation measures, employment of a research design that mixes qualitative and quantitative methodological approaches was called for (Babbie 1992; Cook and Campbell 1979; Emerson 1983; Majchrzak 1984; Maxfield and Babbie 1995; Miller 1991; Patton and Sawicki 1986; Posavac and Carey 1989).

ACTIVITIES COMPLETED

From June 1, 1999 through August 31, 2000 the research team engaged in a number of carefully orchestrated tasks.

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*June 1999 to August 1999 (3 months)

1) We reviewed the programs, protocols and practices as they relate to the literature on correctional programming and specifically: the constructs of an effective therapeutic community, the empirically based research on cognitive self change programming and the Minnesota Model, the relative value of the inmate assessment tools used.

2) We constructed content valid (based on the literature) observation, interview and survey instruments for use in data collection. Note that these were revised as observation data came in so that they might be more finely tuned to assess true program operation.

3) We reviewed the adequacy of resources devoted to the program and documented whether they are expended as planned by reviewing budget and expenditure materials (revisited in July 2000).

4) We documented the attributes and design of the therapeutic community at SICI: what are the goals and objectives of this program and how likely is it that the means taken to achieve these are measurable and linked to the stated goals and objectives (revisited in July 2000).

*September 1999 to June 2000 (10 months)

1) We observed program delivery on a random and frequent (at least once per week) basis using our standardized observation form.

*October 1999 to March 2000 (6 months)

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1) We documented the qualifications, training and skill levels of those involved in program delivery including: treatment, custody and inmate coordinators.

2) We continued the observations.

3) We administered the questionnaire to inmates.

4) We input and analyzed the observation data as we went along.

5) We analyzed the inmate questionnaire data and presented our findings at ACJS in March 2000.

6) We input and analyzed observation, interview and survey data and reviewed archival and assessment tool data (the latter entered and maintained by the IDOC).

***<u>April to June 2000 (3 months)</u>**

1) We completed interviews of ten key participants and actors involved in program delivery and participation using structured questions about program viability and effects.

2) We surveyed staff stakeholders on perceptions of program strengths, weaknesses, and opportunities for greater involvement and areas meriting improvement.

3) We reviewed the assessment tool findings of participant perceptions of programming and of the use of the pre and post assessment tests, including: the Criminal Sentiments Scale, the Compu-13 and the Intake Self-Rating Form.

4) We determined whether adequate data for statistical tests on program

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participants (including intake, assessment and exit instruments), program delivery and practices, follow-up and outcome measures (e.g. knowledge measures, thinking error measures, client graduation rate, numbers of clients served and their characteristics, self-reports of success, parole success, alcohol-drug assessments, arrest statistics, etc.) were archived by the IDOC or the Boise Care Unit.

5) We conducted our own statistical analysis of the criminal sentiments and Compu-13 data.

6) We asked for an extension of the grant until December 2000 so that we might present some of our findings at the American Society of Criminology meeting in San Francisco.

*<u>July to August 2000 (2 months)</u>

1) We wrote and submitted the final report to NIJ and the IDOC in disk and hard copy formats. Data gathering funded by this grant will also be submitted in SPSS-PC format.

EXPLANATION OF ACTIVITIES

<u>Archival information</u> on the program, its general protocols and practices, resources and expenditures, the basic constructs of the therapeutic community and personnel training and attributes was collected. We reviewed program descriptions, manuals and reports, correspondence, meeting minutes, contracts, RFPs, audits and the research literature on programming to determine

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congruence between program goals and objectives,.

The RSAT Inmate Handbook, inmate intake form, inmate assessment forms and lesson plans provided key information on program participants responsibilities, background and activities. Information included in the inmate intake form are the participant demographics, drug/alcohol use and treatment history, prison disciplinary adjustment, physical health, financial and employment records, relational issues and physical and sexual abuse history.

We assessed the outcomes from the assessment instruments (data that is entered and maintained by IDOC and the Boise Care Unit). Tools to measure suitability for treatment, need for treatment and behavioral modification are an integral part of the RSAT process. The tools should provide program staff with important information upon which to base treatment planning. The tools will not only determine who will and will not receive treatment, but also how well they fare and how they regard treatment. We reviewed whether these instruments indicated that the inmate was appropriate for RSAT treatment and then determine if those inmates in fact are in RSAT and if not, why not. In the case of the pre and post treatment measures, our analysis centered on whether inmates gained individually and as a group from their participation in RSAT. In other words, if the program is having a positive effect on the clients then the pre and post assessment tool scores should reflect that improvement.

The assessment process begins at the Reception and Diagnostic Unit of the

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IDOC, where all inmates, including potential RSAT participants, are administered the Compu-13. The Compu-13 is a compilation of thirteen validated instruments which are used to assess symptoms and consequences of alcohol and other drug use. The Compu-13 incorporates, among others, the following tests: the Michigan Alcohol Screening Test, the National Council on Alcoholism - Psychological and Behavioral Symptoms of Use, the DSMIII, the Cognitive Slippage Scale, and the MMPI. The advantage of the Compu-13 battery of tests is that it provides the client and evaluator with a diagnosis of the client's responses as compared with established and validated test norms. The results of the Compu-13 are used by the RSAT treatment/screening team to make a determination on eligibility for RSAT participation.

Also used in the SICI RSAT program, after program admittance and as a basis for treatment planning, is the Criminal Sentiments Scale. This is a pre-treatment/post-treatment tool to measure attitudes, beliefs and thinking patterns. The scale is divided into three areas related to pro-social attitudes. The attitudes are reflected in responses to items on Law, Courts and Police, Tolerance of Law Violations and Identification with Criminal Others. It is believed that anti-social attitudes in these areas may be connected to violent and criminal behavior.

We determined <u>whether the data collection and information systems were adequate</u> to allow for the assessment of data relevant to in-program, exiting program and community corrections aftercare success.

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We conducted field observations of program delivery in both the Cognitive Change Program and Minnesota Model-Based Chemical Dependency Treatment Modules in each of the three phases (lasting three months each) of the therapeutic community environment. We constructed and used structured observation sheets to ensure uniformity in data collection. These observation sheets required the observer to assess: program content, teaching techniques used, client opportunities for involvement, and general atmosphere of the therapeutic community.

We administered a questionnaire to inmates regarding their perceptions of program operation. As client Involvement in their own treatment is regarded as a prerequisite for successful rehabilitation/habilitation programming, we decided to administer a questionnaire to inmates that was gauged to measure their perceptions of the RSAT program. In the SICI RSAT program inmate/clients are intimately engaged in decisions regarding their own and each others treatment programming because they are involved in the selection of their own leaders or coordinators, problem solving related to their own high-risk behaviors, and maintenance of community and programmatic integrity through the use of "push-ups," "pull-ups" and " haircuts" to encourage or discourage behavior by group members (CompCare, 1998).

We also administered a questionnaire to staff regarding their perceptions of program operation. (Schuiteman and Bogle 1997). Such questions allowed the

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staff to anonymously comment on all aspects of the program content, delivery and effect using likert scaled items. The 75 items also included an open ended section for further commentary. This instrument was also developed in light of the research regarding the appropriate content and delivery of substance abuse programming in a therapeutic environment.

We interviewed key actors using structured interview questions to ensure uniformity in data collection. Actors that were interviewed included the program director, the program counselors/teachers and the program security staff. We conducted ten interviews of about 15 to 30 minutes duration. Questions asked were open-ended regarding actor perceptions of program content, delivery and areas of program strength and weakness.

PROCESS EVALUATION FINDINGS AND ANALYSIS

Entry and Exit Information and Success Measures

METHOD

During the months of April and June 2000, a review of documentation related to entry and exit procedures of the RSAT program was done. The review was initiated with the expectation that it would provide insight as to whether the proper offenders are being selected for the program and to determine what the status was of program graduates and noncompleters.

As mentioned previously in the program description, parole officers and

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parole commission hearing officers refer offenders to the RSAT program if they are relatively low-risk parole violators with chronic substance abuse problems having at least 18 months until completion of sentence. Officers also consider whether the parole violator has a positive attitude towards treatment and good potential to obtain resources after release. Those offenders slated for RSAT via referrals are given a drug and alcohol assessment upon entering the prison system. The assessment score, along with additional information, is then reviewed by institutional and program staff. If chosen for RSAT, the offender is placed on the designated RSAT tier and completes a self-report inmate intake form as well as pre-tests that measure both attitude and knowledge. He will take a matched post test upon competing the program. Given this process, the researchers focused specifically on 5 items that document RSAT entry and exit procedures.

1) referral information from POs and Parole Commission which initiates the selection process for program candidates,
2) the Compu13 which is the drug and alcohol assessment used by the IDOC upon intake into the prison system
3) the intake form which is a self-report questionnaire given upon entry that captures background information about the offender
4) the Criminal Sentiments Scale which an attitude assessment given to offenders upon exit and entry of the program
5) the pre-post tests given upon entry and exit into Cognitive Self Change I and Drug and Alcohol Education I courses within the RSAT curriculum.

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FINDINGS

Demographics

In order to examine these 5 items, a review of the individual paper and computer files of RSAT participants was done. We were able to ascertain that the Idaho Department of Corrections does keep adequate records on their inmates so that RSAT inmates might be compared to non-completers or non-RSAT inmates in a future outcome evaluation. The computer files consisted mainly of a registration log, which lists the participant's name, offender number, entry and exit dates, and type of crime, basic demographic information, and status on parole. The current data on the SICI RSAT indicates that most of the inmates are white (83%), in their thirties (mean of 34), stay an average of 182 days, with completers finishing in 297 days (see Table 1).

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Table 1

RSAT Demographics	**(N)**	**%**
Black	(4)	2%
White	(198)	83
Hispanic	(22)	9
Native American	(16)	7
Age		
Mean	34	
Range	20-62	
Total RSAT Program Exits		
Completed	(86)	44%
Dropped	(39)	20
Terminated	(68)	35
Average Length of Stay		
Completed	297 days	
Dropped	64	
Terminated	105	
Average for all	182	
Length of Stay for those Terminated or Dropped		
0-90 days	(68)	64%
91-180 days	(22)	21
181-270 days	(12)	11
271+days	(5)	5

Length of Stay for those Terminated or Dropped		
0-90 days	(68)	64%
91-180 days	(22)	21%
181-270 days	(12)	11%
271+days	(5)	5%

As indicated in Table 2, 51% of those who did complete the program are currently on parole (as of March 2000) and 37% have since violated their parole. Of those 32 RSAT inmates who have violated their parole, the vast majority (76%) took at least 91 days and 29% of these took at least 181 days to violate their parole. For those still on parole, 48% have been on parole for 270 plus days.

The IDOC data also allows us to track which district in the state inmates are paroling to and the percentage of RSAT inmates that are violated in such districts

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(see Table 2). These data indicate that the vast majority of inmates currently on parole are in the two most populous districts (3 and 4). Predictably, a greater percentage of the violators are in these districts (72%), but for district 4 where the greatest population concentration is, 58% of the RSAT inmates are paroled there, but only 36% are violated there.

Table 2
RSAT Inmates Current and Parole Status

	(N)	%
Current Status		
Parole	(44)	51%
Violated	(32)	37
History	(9)	10
CWC	(1)	1
Total	86	
Length of Time before Violation		
0-90 days	(8)	25%
91-180 days	(15)	47
181-270 days	(5)	16
270+ days	(4)	13
Total	32	
Length of Time on Parole		
0-90 days	(6)	14%
91-180 days	(15)	47
181-270 days	(7)	16
270+ days	(21)	48
Total	44	

Number Paroled Compared to the Number Violated by District

	#Paroled	#Violated	%Violated
1	2	0	0%
2	1	1	100
3	13	5	38
4	50	18	36
5	4	1	25
6	3	1	33
7	9	6	67
Total	86	32	

Referral Information

Upon initiating the file review, the researchers quickly discovered that no referral information is kept in the individual or computer files. Neither RSAT

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program staff, SICI counseling staff, IDOC intake staff, or the referring officers maintain this information. Referral forms once developed are either not being used or are not kept. Consequently, program staff are not privy to specific information used by the referring officer to decide whether to recommend a given offender.

Although no specific referral data is available, some information regarding the selection of RSAT participants can be gleaned by examining the registration log of all attendees. A simple analysis of this information reveals that the offenders in the program are indeed parole violators and those that graduate have appropriate sentence lengths allowing them to move out of the therapeutic community and directly onto parole, which is an important program goal. The referral process, therefore, may very well be working. However, the lack of documentation reflects a lack standardization of the process and supports the possibility of word of mouth and offender initiated referrals.

Compu-13

As discussed previously, the Compu-13 is a compilation of thirteen validated instruments used to assess symptoms and consequences of alcohol and drug use. It is administered to new offenders as they enter Idaho's prison system and only to parole violators who have new or pending charges or are slated for RSAT through the referral process. In a group setting with a drug and alcohol counselor present, offenders complete the written, self-report

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questionnaire. The answers are electronically tallied resulting in a computerized printout showing a suggested problem classification of either "no evidence of problem," "possible problem," "probable problem," or "definite problem" for each offender (Accountables). The printout also graphs the results of all Compu-13 tests, includes a statement summary of responses to specific Compu-13 questions, and identifies appropriate treatment recommendations.

During the file review portion of this process evaluation, the Compu-13 scores of 135 RSAT participants were compiled. The scores indicated that 129 of those participants were classified as having a "definite" problem and 6 were classified with a "probable" problem. Similarly, 125 participants were recommended to residential treatment while 10 received no such recommendation. A basic analysis of this data suggests that the offenders entering RSAT do indeed have substance abuse problems warranting placement in an intensive treatment environment. In the few instances where only "probable" problems and no residential treatment recommendations were found, the professional discretion of parole officers and substance abuse clinicians likely outweighed the assessment results. Such overrides appear to be happening at an acceptable ratio. In addition, literature suggests that the Compu-13 is more likely to show that an offender has a less severe problem than what they report and is less likely to show false positive classifications (Accountables).

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In analyzing the drug and alcohol assessment scores, a secondary finding was noted. The data revealed that 71 Compu-13 assessments were administered to RSAT participants prior to their entry to the program (range of 1 to 174 days), 63 were administered after entry (range of 1 to 1305 days), and one was not dated. While the dates of testing do not discount the severity of substance abuse problems for RSAT entrants, the fact that so many assessments were done after offenders entered the program supports the belief that a standardized referral process is missing.

Intake Form

The found after the file review that the RSAT intake form was completed and present in RSAT participant files. This form is a lengthy self-report questionnaire given upon entry to the program that captures a wide variety of information about the offender including his criminal, social, vocational, and substance abuse histories. While the information reported on the form is likely to be used frequently for individual counseling, the data is not stored collectively. Therefore, it can not be used to provide summary information about the RSAT offender population or assist in analysis of variables that may affect program performance. If information from the form were compiled, there are several open-ended questions that may cause difficulty when trying to group like responses.

Criminal Sentiments Scale

Upon entering RSAT, participants are also scheduled to complete an initial

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attitude assessment called the Criminal Sentiments Scale. The Scale was originally selected for use based on research showing it as one of the few suitable measures of criminal attitude and included in the program design based on established criminological theory suggesting that "criminal sentiments, as measured by the Criminal Sentiments Scale, are consistently related to criminal behavior" (Rettinger 1992; Simourd 1997). While the scale has research, diagnostic, and other practical applications, it is used only as a pre and post test measure of attitude within the RSAT program. Participants retake the Scale just prior to leaving the program so that exit and entry scores can be compared. Since a change in attitude is expected to be manifest in a change in behavior (Rettinger 1992), the Criminal Sentiments Scale serves as an intermediate and possibly predictive measure of the ultimate program goal of reduced recidivism.

Like the intake form, Criminal Sentiments Scale scores were not being stored collectively prior to this process evaluation. However, the researchers were able to pool information from individual participant files. A review of this data revealed that the Criminal Sentiments Scale has not been used from the onset of the RSAT program. The documentation also suggests that it was not until several months after the program implementation that it was administered in a routine and consistent manner. Moreover, several tests were scored incorrectly, some were not dated, and others did not appear to have been given upon immediate entry into the program. Despite these problems, the researchers

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were able to re-score the necessary tests and compile an adequate sample of scores to allow for analysis with respect to what is known about the Criminal Sentiments Scale.

The Criminal Sentiments Scale consists of 41 items that measure criminal sentiments on three subscales: Attitude Towards Law, Courts, and Police (LCP), Tolerance for Law Violations (TLV), and Identification with Criminal Others (ICO).

CRIMINAL SENTIMENTS SCALE SUGGESTED RANGES

	Low	Moderate	High
LCP	<80	81-90	>90 (higher scores=more pro-social attitudes)
TLV	<22	23-29	>30 (lower scores=more pro-social attitudes)
ICO	<15	16-19	>20 (lower scores=more pro-social attitudes)

Pro-social attitudes are associated with lower scores for the TLV and the ICO measures while the opposite is true for the LCP. Research has established

CRIMINAL SENTIMENTS SCALE NORMS				
Subscale	Offenders	Psychiatric	Non-Offenders	Students
LCP	78.5 (12.4)	84.3 (15.5)	91.8 (11.8)	93.2 (9.7)
TLV	28.8 (6.4)	24.7 (6.8)	23.6 (4.8)	24.2 (4.7)
ICO	18.3 (3.8)	16.5 (3.9)	14.8 (3.0)	14.8 (3.3)

norms as well as suggested ranges for each of the subscales. RSAT participants scores were first compared with these guidelines and then analyzed to identify changes over time.

For this process evaluation, a total of 110 pre tests and 45 post tests were compiled. The numerical range showing the highest and lowest score, average, standard deviation, and median of all 110 pretests and all 45 post tests were

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calculated and are presented. In addition, the number and percentage of scores which fall into each of the suggested ranges are included.

110 PRE TESTS										
Subscale	Range	Average	Std Dev	Median	High		Moderate		Low	
LCP	56-122	90.8	12.8	92.5	61	55.5%	25	22.7%	24	21.8%
TLV	13-38	23.5	5.1	24	13	11.8%	50	45.5%	47	42.7%
ICO	7-23	15.9	2.8	16	9	8.2%	57	51.8%	44	40.0%

45 POST TESTS										
Subscale	Range	Average	Std Dev	Median	High		Moderate		Low	
LCP	76-121	100.7	11.9	97	36	80.0%	7	15.6%	2	4.4%
TLV	12-32	19.4	4.6	19	2	4.4%	10	22.2%	33	73.3%
ICO	6-20	14.2	2.9	14	2	4.4%	12	26.7%	31	68.9%

The comparison of the available Criminal Sentiments Scale pre test scores to the established norms reveals that the criminal sentiments of participants entering RSAT are more closely aligned with those of non-offenders than with any other category assessed. Approximately half of the RSAT scores on all three subscales fall with the most pro-social attitude range. More surprising, however, is the summary of post test scores. These scores suggest that the attitudes of participants exiting RSAT are far more pro-social than any of the other normed categories. Respectively, 80, 73.3 and 68.9 percent of these scores fall within the most pro-social attitude range on the LCP, TLV, and ICO subscales. While RSAT participants tend to be low-risk offenders and thus might be expected to be less criminal oriented than more serious offenders, both pre and post test scores are in ranges which suggest their responses might have been affected by external means. Factors previously cited as influencing scale scores are anxiety,

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personal attributes, and the common theory holding that offenders are more amenable to prison standards upon entry and exit (Rettinger 1992). The reason why RSAT scores reflect such elevated pro-social sentiments is not clear. However, the fact that there was a marked improvement in attitudes from pre-test to post test is quite apparent.

In order to more accurately explore attitude change, the scores of the 45 post tests were paired with their corresponding pre-test scores. Once some of the available pre test scores were excluded (these were current RSAT participants who had not yet taken the post test), the pre test measure of criminal sentiments of RSAT participants appears even more pro-social. Positive change in attitudes from entry to exit is still clearly evident.

45 PRE TESTS										
Subscale	Range	Average	Std Dev	Median	High		Moderate		Low	
LCP	68-122	94.3	11.9	95	30	66.7%	9	20.0%	6	13.3%
TLV	14-33	22.9	4.9	23	6	13.3%	17	37.8%	22	48.9%
ICO	7-21	15.1	2.9	16	2	4.4%	22	48.9%	21	46.7%

45 POST TESTS										
Subscale	Range	Average	Std Dev	Median	High		Moderate		Low	
LCP	76-121	100.7	11.9	97	36	80.0%	7	15.6%	2	4.4%
TLV	12-32	19.4	4.6	19	2	4.4%	10	22.2%	33	73.3%
ICO	6-20	14.2	2.9	14	2	4.4%	12	26.7%	31	68.9%

A simple comparison of the summary of the 45 pre and post test scores shows an increase of 6.42 mean points on the LCP scale and decrease of 3.45 and .91 on the TLV and ICO scales, presenting a universal shift towards a more pro-social attitude. When comparing pre to post test scores, the percentage in the most pro-social range increased from 66.7% to 80% on the LCP scale, 48.9% to 73.3%

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on the TLV scale, and 46.7% to 68.9% on the ICO scale.

In a final analysis of attitude change, the percent change from pre to post test on all three subscales for each offender was calculated. As expected, the average percent change from individual pre test to matched post test also revealed a positive shift in attitude.

% CHANGE FROM PRE TO POST TEST					
Subscale	Low	Median	High	Average	Std Dev
LCP	21.7%	8.0%	31%	7.6%	0.12
TLV	-60.6%	-17.4%	41.2%	-13%	0.20
ICO	-62.5%	-6.3%	58.3%	-3.9%	0.21

However, it should be noted that when individual tests were singled out, the scores of some participants did reflect attitude change in an anti-social direction. For example, the average percent change on the TLV subscale was –13% suggesting that RSAT participant had a more pro-social attitude toward law violations upon leaving the program (recall that on the TLV and ICO scales lower scores=more pro-social attitudes). However, at least one participant realized a 41.2% increase in his score, meaning that his attitude was measured as 41.2% more criminally oriented after treatment.

Further exploration of the Criminal Sentiments Scale and its use in the RSAT program is surely warranted and could produce useful findings. For example, if these scores are indeed found to be valid measures of attitude, they may offer insight into how a low-risk offender's attitude towards criminal others may change as a result of being placed in intensive treatment with more

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sophisticated criminals. Such in-depth analysis could not be done as part of this process evaluation. This general review of findings, however, does indicate that RSAT participants have more pro-social attitudes upon completing the RSAT program. Clearly, this is a promising sign that the program is experiencing some level of intermediate success.

The finding that RSAT scores are outside the established norms must be considered. However, literature suggests that if the factors propelling both pre and post test scores into higher pro-social ranges were controlled, measurements of a positive shift in attitude would still be found and would, therefore, still be predictive of reduced recidivism (Rettinger 1992).

Pre and Post Tests of Program Material

Pre and post tests are also used within the RSAT program to measure information retention of required course work. Upon entering the program, all RSAT participants are tested on material that will be presented in the first phase of Cognitive Self Change (CSC) and Drug and Alcohol Education (D&A) classes included in the RSAT curriculum. Then, after participating in these classes for approximately three months, they are given the same test again. The purpose of these measures is twofold. First, a post test score of 70% or more serves as criteria for phase movement. Second, the pre and post test scores can be compared to demonstrate changes in awareness of cognitive and substance abuse issues.

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While compiling the pre and post test information during the file review, the researcher found problems similar to those related to the Criminal Sentiments Scale administration. Once again, it appeared that pre and post tests had not been used routinely since RSAT's inception and that, at one time, only a post test was administered. In addition, some tests were not dated which made their identification as a pre or post test troublesome. Because of these difficulties, only pre tests with corresponding post tests were further analyzed.

The scores (shown as percentages of 100) of 57 CSC pre and post test combinations and 61 Drug and Alcohol Education pre and post test combinations were compiled. Again, the numerical range including the highest and lowest score, mean, standard deviation, and median of all tests were calculated and are presented.

57 CSC SCORES				
Type	Range	Average	Std Dev	Median
Pre	45-95	78.9	9.4	79
Post	74-95	89.7	5.6	90

61 D&A SCORES				
Type	Range	Average	Std Dev	Median
Pre	41-90	65.9	10.7	64
Post	63-97	85.8	6.4	86.5

Based on these scores, it appears that participants are able to comprehend and retain phase one RSAT course material. In fact, based on pre test scores, many appear quite knowledgeable about cognitive and substance abuse issues upon entry in the program. Assuming the CSC and D&A tests are of equal difficulty, this is even truer of the cognitive material. Despite this finding, an

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increase from pre to post test is clearly apparent and the analysis of percent change quite straightforward. The average percent change from pre to post test for the cognitive material was 15.5% while the average percent change for the substance abuse material was 33.2%. In no cases was there a decrease in score from pre to post D&A test and in only 3 cases did such CSC scores decrease.

% CHANGE FROM PRE TO POST TEST					
Material	Low	Median	High	Average	Std Dev
CSC	-11.9%	11.9%	111.1%	15.5%	0.18
D&A	1.2%	27.6%	107.3%	33.2%	0.22

The increased pre and post test scores are promising in two regards. First, they suggest that the proper course work is being delivered to RSAT participants in a way that they can understand and absorb. Second, they suggest that the program is experiencing some level of intermediate success by imparting cognitive and D&A material. Their use as a predictor of future lifestyle change, however, is rather limited.

ANALYSIS

With the exception of the officer referral form, there has been improvement in the way RSAT exit and entry procedures are documented since the start of the program. The researchers determined from the file review that the initial use and documentation of forms and tests used within the RSAT program were done rather haphazardly, but are now much more consistent and routine. Standard procedures to ensure that all paperwork is dated and that all tools are uniformly

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administered are still needed and should, perhaps, be added to the program manual. Such issues are likely to be addressed through the current program audit. However, special attention must be given to the documentation of the referral process, including its relationship to Compu-13 testing.

The RSAT program has also experienced improvements in the collection and storage of exit and entry data since its inception. Basic information about RSAT participants was already being stored collectively and now pre and post data will be added as a result of this process evaluation. However, attempts to move more of the information stored in individual participant files, particularly data from the intake form, should be made so that it can be easily referenced by program staff and used as a control in analyzing program performance and conducting program research. Additional funding to combat the lack of administrative and research staff assigned to these duties is anticipated within the next year.

Overall, a review of the 5 items that document the entry and exit data suggest that they are appropriate for use with the RSAT program. The referral and intake form as well as the Compu-13 provide information about participants so that they can be properly selected and assessed. The Cognitive Self Change and Drug and Alcohol Education pre and post tests serve as standard intermediate measures of program performance, while the Criminal Sentiments Scale, despite concerns already identified, acts as a second intermediate

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measure by identifying change in attitudes related to criminal behavior. These items are of minimal program cost and, where appropriate, correctional literature supports their use. If program administrators were to enhance exit and entry procedures, however, they might consider using something other than self-report assessments and implementing ongoing participant surveys that solicit feedback on the program.

As part of this process evaluation and file review, a simple analysis of the available data from the exit and entry tools was done. The findings offer promising insights into whether the right offenders are being selected and whether the program is achieving preliminary success. However, further analysis is warranted and may render interesting and useful results. A closer investigation of knowledge based pre and post test scores, for example, may help establish a more appropriate threshold for phase movement given that many participants already score over the required 70% upon entering the program.

Furthermore, investigation of the Criminal Sentiments Scale may reveal why RSAT offender scores are outside established norms. Most importantly, further analysis of data compared with actual parole violations or recidivism rates will help determine whether intermediate measures are indeed predictive of success after release and could, therefore, be used to clearly identify a participant's readiness to graduate.

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Observation Data on Operation, Content, Program Delivery

METHODS

Members of the research team conducted seventy-one program observations over a period of forty-two weeks. There was an average of 1.69 observations per week. The programs observed were chosen randomly and the observations were made without prior notice to the therapeutic community. The nature of the observations included twenty different program areas with the majority of the observations in Cognitive Self-Change classes (36.6%), Process Groups (11.3%), Minnesota Model Twelve Step Programs (9.8%), the Morning Meetings (7.0%), and Encounter Groups (5.6%). In addition, the intake process and disciplinary actions were observed several times. Some programming, because of its temporary nature, was only observed once. These other observations equaled 29.7% of the total.

There were primarily three people who completed observations on the research team. These members prepared themselves by reading numerous manuals regarding therapeutic communities and conducted two to three pretest observations. These pretests required that two to three researchers use the form to rate the same event and then compare observations to ensure standardization in this process. Two members of the team also had some therapeutic community training and one member was trained in Cognitive Self-Change. In addition, one team member had taken several classes toward the attainment of her Alcohol and

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Drug certificate.

The original instrument used in the observations was a fourteen item Likert scale questionnaire. After nineteen observations were completed and assessed, five questions were added as a means of improving upon the content validity of the instrument. The instrument was divided into three main categories: Program Content and Delivery, Program Leader and Involvement Issues and Therapeutic Atmosphere. Each item was measured on a scale of one through seven with one signifying "poor" and five "excellent." "Not applicable" was assigned number six and "don't know" number seven. The n varied with each question because the "not applicable" and "don't know" responses were reassigned to "missing" in the final analysis, and were not used to calculate means and standard deviations. The numbers used to calculate the findings in Tables 4-6 were based on observer ratings of one through five ("poor to excellent"). In addition, the instrument provided an area for observer comments and an area to record information concerning the specific nature of the observation.

FINDINGS AND ANALYSIS

Analysis of the data revealed that all areas within the Program Content and Delivery category (see Table 5) were rated as "good," or 4 or above, except two which were evaluated as "adequate." Clarity of Program Delivery, with a mean of 4.19 was found to be consistently good. The Organization of Program Delivery areas, although rated adequate to good, received the lowest ratings in this

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category. Observers felt there was generally a clear beginning, middle and end to the programs and rated this aspect of the delivery as good with the mean of 4.10. The transitions were only adequately clear (3.97) and the analysts found that some programs did not consistently end on time (3.93). Areas under the Substance of Program heading were assessed the highest ratings. The contents of the observed programs were generally found to reflect the handbook material and were measured as good to "excellent" (4.37), as was the announced subject matter (4.32).

Table 3
Program Content and Delivery

Clarity of Program Delivery	
N	64
Mean	4.19
Standard Deviation	.69
Organization of Program Delivery	
Was there a beginning, a middle and an end?	
N	61
Mean	4.10
Standard Deviation	.79
Were the transitions clear?	
N	43
Mean	3.97
Standard Deviation	.87
Did it end on time?	
N	43
Mean	3.93
Standard Deviation	.87
Substance of Program	
Did content reflect announced subject matter?	
N	38
Mean	4.32
Standard Deviation	.66
Did content reflect handbook material?	
N	35
Mean	4.37
Standard Deviation	.65

Ratings in the category, Program Leader and Involvement Issues, (see

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Table 4) were also between adequate (3) and good (4). The Program leaders were generally staff from Compcare, but members of the therapeutic community and inmates from the IDOC were also involved in facilitation. Preparation of the Program Leader, the lowest rating in this category, was consistently evaluated as between adequate and good with a mean of 3.92 and a standard deviation of .65. Inmate Opportunity for Involvement was rated as good (4.28) as was Actual Inmate Involvement (4.14). This suggests that the observers thought that inmates did take advantage of the opportunity to participate. Prosocial Modeling of the Program Leader was the highest rated area in this category with a mean of 4.40. Quality of Program Leader received mixed results with two areas rated adequate and two areas rated good. The observers apparently felt that the program leader did a "good" job of keeping the program on point (4.05), but was rated "adequate to good" in engaging the participants (3.97). The program leader was also evaluated as adequate to good in moving the program along (3.97), but was seen as doing a good to excellent job of being engaged in program delivery (4.23).

Table 4
Program Leader and Involvement Issues

Preparation of Program Leader	
N	64
Mean	3.92
Standard Deviation	.65
Inmate Opportunity for Involvement	
N	65
Mean	4.28
Standard Deviation	.93
Actual Inmate Involvement	
N	65
Mean	4.14
Standard Deviation	.83

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Table 4 continued

Prosocial Modeling of PL	
N	45
Mean	4.40
Standard Deviation	.89
Quality of PL Involvement	
Did the PL keep the program on point?	
N	65
Mean	4.05
Standard Deviation	.91
Did the PL engage most participants?	
N	63
Mean	3.97
Standard Deviation	.98
Did the PL move the program along?	
N	65
Mean	3.97
Standard Deviation	.98
Was the PL engaged in program delivery?	
N	62
Mean	4.23
Standard Deviation	.95

The results from the third category were similar to categories one and two with the Therapeutic Atmosphere of the RSAT program (see Table 5) evaluated as adequate to good. The sense of trust in the therapeutic community received the lowest ratings with a mean of 3.86. This is an interesting finding because it is possible that the sense of trust would have an effect on all areas evaluated in this third category. The sincerity of involvement was also assessed as only adequate to good (3.94). In addition, analysis of the data indicated that the community members' ability to complain about treatment issues without negative repercussions was only adequate (3.88). Observers felt that inmates were taken out of their comfort zone in a positive way and evaluated that area as good (4.16). The highest rating in this category, also measured as good was the sense of community or family (4.23).

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Table 5
Therapeutic Atmosphere

General Therapeutic Atmosphere of the Program	
Was there a sense of trust?	
N	70
Mean	3.86
Standard Deviation	.89
Were people sincere in their involvement?	
N	70
Mean	3.94
Standard Deviation	.90
Were there negative repercussions to complaints?	
N	49
Mean	3.88
Standard Deviation	.81
Was removal from comfort zone done positively?	
N	43
Mean	4.16
Standard Deviation	.72
Was there a sense of community or family?	
N	47
Mean	4.23
Standard Deviation	.87

Inmate Questionnaire Information

METHODS

The inmate questionnaire was created by the researchers after a review of the literature, and revised after observation of the program operation. Correctional personnel analyzed the instrument items for face validity and offered numerous suggestions for revision. We were particularly interested in how the inmate participants perceived the content of the various components of the program and the delivery of that content, how the inmate coordinators and staff treatment personnel were viewed, whether the inmates thought the tools of a true TC were present and operating well, whether communication lines were open and positive, and what their perception was of the quality of services delivered and the likely

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effect of those services on participants.

A 51 item Likert scaled instrument was created to measure these perceptions of the RSAT program. Inmates were also asked to provide some demographic information, queried regarding their substance use and abuse, and given the opportunity to provide written comments about the strengths and weaknesses of the program.

The questionnaire was distributed to all participants at one meeting in fall 1999. Neither treatment or security staff were apprised of the content of the questionnaire, nor were they present at the time of the administration. The questionnaire was administered by one of the researchers on the project. Completion of the questionnaire was voluntary and no information that would allow us to identify a particular inmate was solicited. Forty-two of the 45 inmates present at the meeting chose to fill out the questionnaire. There were 48 inmates in the RSAT program, of these, three were unable to attend the meeting. Excluding these three inmates, we achieved a response rate of 95.5%, or virtually every inmate enrolled in the program.

For this analysis a total of 13 of the original 51 items were reverse coded for ease of interpretation. Thus, for all items, the higher the mean, the more positive the assessment of a given program component.

FINDINGS AND ANALYSIS

The inmate demographics (see Table 6) at the time of the questionnaire

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administration reveal that the RSAT inmates were overwhelmingly White (85.7%) and non-Hispanic (88.1%). This is reflective of the Idaho population generally. RSAT inmates ranged in age from 20 to 50. Roughly half (45.2%) were between the ages of 20 and 29. A significant portion (26.2%) were at least 35 years old. In accord with national level data, the RSAT inmate population is relatively undereducated. Approximately three quarters (76.2%) had no more than a high school diploma or GED, and none had a four year college degree.

Table 6
Respondent Demographics

Race	N	%
White	36	85.7
Black	1	2.4
Multiracial	2	4.8
Other	2	4.8
Ethnicity	**N**	**%**
Hispanic	3	7.1
Non-Hispanic	37	88.1
Age	**N**	**%**
20-24	10	23.8
25-29	9	21.4
30-34	12	28.6
35+	11	26.2
Mean age: xx		
Age range: 20-50		
Education	**N**	**%**
Less than HS diploma	4	9.5
HS diploma	28	66.7
Some college	6	14.3
AA degree	4	9.5
College degree	0	0

The majority (83.4%) of respondents were in either Phase One or Phase Two (see Table 7). The amount of time spent in RSAT ranged from one month to nine months, with a roughly equal distribution across the first six months of the

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program. Advanced RSAT inmates (those in the Third Phase) may become inmate coordinators. Inmate coordinators lead some of the group meetings and act as facilitators and leaders. At the time of the questionnaire administration there were four inmates designated as coordinators.

Table 7
Respondent RSAT Data

Months in RSAT	N	%
1	5	11.9
2	7	16.7
3	5	11.9
4	4	9.5
5	5	11.9
6	7	16.7
7	3	7.1
8	2	4.8
9	2	4.8
RSAT Phase	N	%
First	17	40.5
Second	18	42.9
Third	6	14.3
CSC Program	N	%
CSC 1	17	40.5
CSC 2	19	45.2
CSC 3	6	14.3
RSAT Status	N	%
Participant	23	54.8
Coordinator	4	9.5

The RSAT inmates were asked several questions regarding their substance abuse history prior to incarceration. As one would expect given this population, we found that alcohol and drug use were common among the respondents (see Table 8). What is interesting is the amount of drug and alcohol use to which the respondents admitted. Only one inmate claimed to have never used drugs. A majority (59.5%) of inmates reported that they got high daily prior to

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incarceration, while another 16.7% got high at least once a week. Only 16.7% of the inmates got drunk on a daily basis, although 38.2% consumed alcohol daily. These data suggest that drugs are the substance of choice among this population.

Table 8
Respondent Prior Substance Abuse

Alcohol Use Prior	N	%
Never	4	9.5
1 drink per month	8	19.0
1-2 drinks per week	13	31.0
1-2 drinks per day	7	16.7
3-5 drinks per day	2	4.8
got drunk daily	7	16.7

Drug Use Prior	N	%
Never	1	2.4
1 fix per month	9	21.4
1-2 fixes per week	7	16.7
1 fix per day	25	59.5

Rel. Sub. Abuse & Crime	N	%
Never high	3	7.1
Sometimes high	12	28.6
Always high	27	64.3

We next performed a reliability analysis on the fifty-one Likert scale items. The alpha for the entire scale was a robust .9324 (see Table 9). This is a very high reliability score, and it indicates that the items are likely related (Babbie, 1992). We also performed a reliability analysis on portions of the survey instrument, each of which was intended to measure a particular aspect of the RSAT program. These include: perceptions of program content and delivery (13 items after 2 were removed), perceptions of treatment leader and involvement issues (8 items

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after 1 was removed), perceptions of the therapeutic atmosphere (16 items), and perceptions of quality of service (11 items). The alpha for each of these portions ranged from .7017 to .8466, as reported in Table 9.

Table 9
Reliability Analysis

Scale	Alpha
Entire 51 item instrument	.9324
Subscale #1 Perceptions of Program Content and Delivery (Items 12-26: 17 & 21 out)	.7454
Subscale #2 Perceptions of Treatment Leader and Involvement Issues (Items 27-35, 31 out)	.7017
Subscale #3 Perceptions of the Therapeutic Atmosphere (Items 36-51)	.8466
Subscale #4 Perceptions of Quality of Service (Items 52-62)	.8405

We next examined the responses to the four subscales by selected age, education, and RSAT status, in an effort to determine which characteristics influenced inmate perceptions of the RSAT program. The results are displayed in Table 10, below. As the data in Table 10 reveal, neither age nor education had a significant effect on inmate perceptions on any of the four subscales. The only variable which did show a statistically significant relationship was RSAT phase. Inmates in the first RSAT phase had a higher mean score than those in the second phase on subscale #1 and subscale #4. Inmates in the third RSAT phase had a higher mean score than those in the second phase on subscale #1 and

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subscale #3. Closer examination of the impact of RSAT phase on perception reveals an interesting phenomena: inmates in the second phase score consistently lower than those in either phase #1 or phase #3. The result is a U-shaped curve, similar to the U-shaped curve often found in studies on prisonization and inmate socialization (Berk, 1968; Garabedian, 1963; Wellford 1967; Wheeler, 1961). Wheeler (1961) measured the attitudes of inmates who had spent varying degrees of time in prison, to determine if the amount of prisonization differed based on the amount of time served. He found that inmate attitudes tended to conform to staff norms and expectations at both the beginning and near the end of their sentence. He felt that the U-shaped curve could be explained by the inmate's response to prison--at first the inmate internalizes the societal rejection implicit in his status as a convict, resulting in lower self-esteem. After a period of time, the inmate adjusts his picture of himself and begins to reject social conformity and adopt support for the inmate subculture, which rejects conventional values. This allows the inmate to restore his self-esteem.

Table 10
Means, Standard Deviations, and F Ratios in Analysis of Variance (One-way Classification) of Subjects' Responses to Survey Instrument

Subscale #1: Perceptions of Program Content and Delivery

Age category	N	Mean	Std. Dev.	F	p
20-24	4	48.3	5.74		
25-29	7	51.1	7.46		
30-34	12	50.7	9.06		
35+	10	52.8	3.33	.431	.732

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Table 10 (continued)

Education	N	Mean	Std. Dev.	F	p
HS or less	24	52.1	5.76		
Some college	9	48.6	8.99	1.793	.190

RSAT phase	N	Mean	Std. Dev.	F	p
Phase 1	13	54.9*	3.95		
Phase 2	14	46.5**	7.27		
Phase 3	6	53.7	4.23	8.183	.001

Subscale #2: Perceptions of Treatment Leader and Involvement Issues (Table 10 continued)

Age category	N	Mean	Std. Dev.	F	p
20-24	9	32.3	3.67		
25-29	9	31.6	5.61		
30-34	12	32.5	5.57		
35+	10	33.6	4.06	.287	.834

Education	N	Mean	Std. Dev.	F	p
HS or less	30	33.0	4.22		
Some college	10	31.0	5.98	1.404	.243

RSAT phase	N	Mean	Std. Dev.	F	p
Phase 1	17	34.1	3.75		
Phase 2	17	30.9	5.60		
Phase 3	6	32.7	3.50	1.945	.157

Subscale #3: Perceptions of the Therapeutic Atmosphere

Age category	N	Mean	Std. Dev.	F	p
20-24	6	55.3	8.89		
25-29	6	54.8	14.08		
30-34	10	57.0	12.02		
35+	8	59.6	8.50	.271	.846

Education	N	Mean	Std. Dev.	F	p
HS or less	21	57.1	10.00		
Some college	9	56.6	12.70	.016	.901

RSAT phase	N	Mean	Std. Dev.	F	p
Phase 1	14	59.3	6.87		
Phase 2	11	51.1**	13.5		
Phase 3	5	63.2	6.80	3.317	.052

Subscale #4: Perceptions of Quality of Service

Age category	N	Mean	Std. Dev.	F	p
20-24	7	44.4	6.40		
25-29	7	44.3	7.57		
30-34	11	44.5	6.22		
35+	7	46.6	4.23	.223	.880

Education	N	Mean	Std. Dev.	F	p
HS or less	25	45.3	5.71		
Some college	7	43.3	7.16	.624	.436

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Table 10 continued

RSAT phase	N	Mean	Std. Dev.	F	p
Phase 1	15	47.1*	4.67		
Phase 2	12	42.0	7.03		
Phase 3	5	45.2	4.76	2.650	.088

* statistically significant differences between Phase 1 and Phase 2 at the .10 level.
** statistically significant differences between Phase 2 and Phase 3 at the .10 level.

We next conducted a regression analysis. We entered the variables alcohol use, drug use, and months in RSAT into five regression equations: the entire 51 item scale, and the four subscales. We performed a stepwise backward elimination on each equation. Barring only one exception, nothing remained in any equation. The exception was Model #3 (subscale #2). In this model alcohol use remained in the equation, with an adjusted R square of .161.

Table 11
Regression on the entire instrument and the four subscales
Model #1: All Perceptions Model (items 12-62. by alcohol use. drug use. months in program).

Model #2: first subscale (items 12-26. by alcohol use. drug use. months in program).

Model #3: second subscale (items 27-35. by alcohol use. drug use. months in program).

Model $3: third subscale (items 36-51. by alcohol use. drug use. months in program).

Model #5: fourth subscale (items 52-62. by alcohol use. drug use. months in program).

Model	Unstandardized	Coefficients	Standardized coefficients	t	Adjusted R square	Sig.
	B	Std. Error	Beta			
Model #1						
Constant	175.736	39.129		4.491		.001
Months	-1.514	2.784	-.139	-.544		.595
Alcohol	4.504	4.239	.284	1.062		.306
Drugs	2.451	8.790	.075	.279	.000	.784
Model #2						
Constant	58.862	6.728		8.005		.000
Months	-.712	.526	-.252	-1.353		.187
Alcohol	3.122E-02	.866	.007	.036		.972
Drugs	-3.475E-02	1.436	-.005	-.024	.000	.981

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Model #3						
Constant	32.359	2.140		15.121		.000
Months	.-670	.292	-.346	-2.296		.028
Alcohol	.851	.450	.285	1.892	.161	.067
Model #4						
Constant	58.597	12.331		4.752		.000
Months	.335	.869	.077	.385		.703
Alcohol	.843	1.370	.126	.615		.544
Drugs	-1.726	2.890	-.125	-.597	.000	.556
Model #5						
Constant	41.008	6.729		6.094		.000
Months	-.126	.479	-.051	-.264		.794
Alcohol	.869	.765	.229	1.135		.267
Drugs	.337	1.368	.049	.246	.000	.807

These findings indicate that those in the program longest have a negative view of this particular portion or the treatment and leader and involvement issues subscale. Conversely, those with the most serious pattern of alcohol abuse are more likely to view these subscale items in a positive light. Notably, the effect of these two variables, negative for months in the program and positive for alcohol abuse, are fairly constant for all the models (with the exception of months on Model #4), albeit not statistically significant. As this particular subscale includes items concerned with the preparation of treatment leaders, the participation of inmates and staff and the assistance and encouragement that inmates provide to each other, closer examination of the particular atmosphere of the treatment environment is merited. The finding on alcohol is actually a positive one for the program, again indicating that those who perhaps need the program most are also those who value this portion of it most. However, we would note that the

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number of inmates who indicated they were what we would characterize as heavy drinkers included only 9 inmates out of the 42 respondents.

In addition to answering the Likert scale questionnaire items, the RSAT inmates were asked to identify the strengths and weaknesses of the RSAT program. Responses to these two items revealed a variety of complaints and positive comments. A content analysis of the responses revealed that the most commonly listed strengths included: the narcotics anonymous and alcoholics anonymous meetings (15 responses), the counselors (11 responses), the feelings of fellowship among the community members (9 responses), the support system (8 responses), and the therapeutic community atmosphere (8 responses).

The most commonly listed weaknesses included: the presence of people (inmates) who retaliated against others (8 responses), the prison location of the TC (5 responses), petty requirements and rules (5 responses), and poor CSC instructors (5 responses).

Staff Perceptions of RSAT Programming

METHODS

The staff questionnaire was created by the researchers after a review of the literature, and revised after observation of the program operation. The instrument items were analyzed for face validity. Procedures included separate readings of the instrument by the authors and several correctional administrators. Items that did not seem to adequately address an issue were revised per the suggestions of

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the readers. We were particularly interested in how the staff perceived the content of the various components of the program and the delivery of that content, whether the staff thought the tools of a true therapeutic community were present and operating well, whether communication lines were open and positive, and staff perception of the quality of services delivered and the likely effect of those services on participants.

A 54 item Likert scale instrument was created to measure these perceptions of the RSAT program. Staff were also asked to provide some demographic information, queried regarding their position, age, gender, education, and length of service, and given the opportunity to provide written comments about the strengths and weaknesses of the program.

The questionnaire was distributed to staff at three meetings in Spring 2000. Neither treatment nor security staff were appraised of the content of the questionnaire prior to the administration of the questionnaire. The questionnaire was administered by two of the researchers on the project. Completion of the questionnaire was voluntary and no information that would allow us to identify a particular staff member was solicited. There were some difficulties in obtaining the participation of all staff, as a number of staff appeared to be unaware of the scheduled survey administration. Others expressed some reluctance to participate as they had just participated in a DOC-sponsored audit of the RSAT program. Eventually 43 staff completed the survey, out of 50 asked to participate.

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This is a response rate of 86% of those contacted; however it must be noted that an undetermined number of staff were not contacted due to the confusion surrounding the administration of the questionnaire. Additionally, a number of staff failed to fill out the entire survey, instead marking "not applicable" or "don't know" on a significant number of items. Thus the findings must be viewed with some caution.

Each of the 54 Likert scale items had a five point range for responses, from 1 ("not true") to 5 ("very true"). Respondents could also indicate "not applicable," "don't know," or not answer the question. For the analysis, for all items, the higher the mean, the more positive the assessment of a given program component.

FINDINGS

The staff demographics (see Table 12) reveal that the RSAT staff are overwhelmingly White (85.7%). This is reflective of the Idaho population generally, and matches the composition of the RSAT inmate population. Slightly more than three quarters (76.2%) of the staff are male. RSAT staff range in age from 23 to 63, with a mean age of 45.1. The mean age of the staff is 15 years greater than the mean age of RSAT inmates. Less than half the staff have a four year college degree (39.5%), but most (83.7%) have at least some college education.

The Idaho RSAT program is intended to last nine to twelve months, and

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consists of three distinct phases. The majority (83.4%) of inmates are in either Phase One or Phase Two, with the mean number of months in the program for all inmates at 4.3. Interestingly, more than two-thirds (69.4%) of staff indicated they have been associated with the RSAT program for three months or less. This suggests a high degree of turnover amongst staff, a potential source of concern. Respondents were asked to describe their primary function. Almost half (48.6%) described themselves as non-security staff of some type, while 51.4% described themselves as security staff. The RSAT wing is staffed with a combination of DOC security, support staff, and COMPCARE counselors. The vast majority of respondents (84.6%) are employed by the DOC, with the remainder employed by COMPCARE.

Respondents were asked several questions regarding their level of training in the various components of the RSAT program, including, CSC training, TC training, and drug/alcohol training. Roughly the same number of respondents have received training in each of these components (37.2% on CSC, 41.9% on TC and drug/alcohol). Clearly, then, staff other than the COMPCARE counselors have received training.

Table 12
Respondent Demographics

Race	N	%
White	36	85.7
Black	2	4.8
Other	4	9.5

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Table 12 continued

Gender	N	%
Male	32	76.2
Female	10	23.8

Age	N	%
20-29	3	7.9
30-39	8	21.0
40-49	12	31.6
50+	15	39.5
Mean age = 45.13		
Age range: 23-63		

Education	N	%
HS diploma	7	16.3
Some college	13	30.2
AA degree	6	14.0
College degree	17	39.5

Position	N	%
Counselor	6	14
Security	19	44.2
Support/other	12	27.9

Time with RSAT	N	%
0-3 months	25	69.4
3-12 months	4	11.2
12+ months	7	19.4

Training/Hours	N	%
CSC training	16	37.2
TC training	18	41.9
Drug/Alcohol training	18	41.9

We next performed a reliability analysis on the fifty-four Likert scale items. As reported in Table 13, the alpha for the entire scale was found to be a robust .9581 (Babbie, 1992). There were four sections of the survey. These included: perceptions of program content and delivery (12 items), perceptions of preparation and involvement (11 items), perceptions of the therapeutic atmosphere (18 items), and perceptions of quality of service (8 items).

After performing the reliability analysis on the entire scale, we proceeded

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to conduct an analysis of the responses to the individual items. As indicated in Table 13, most of the respondents were generally positive in their assessments of the RSAT program operation, although there were several points of concern noted.

Table 13
Mean Responses to Items on Inmate Questionnaire
N=11-29

16. **The group presentations I have observed or participated in are usually well organized with a clear beginning, middle and end.**
Mean=3.76, SD=1.18

17. **The contents of programs I have observed or participated in rarely reflect the announced subject matter.**
Mean=1.70,SD=1.10

18. **Inmate coordinators are fully prepared to lead the AM and PM discussions.**
Mean=3.94,SD=1.24

19. **The group meetings rarely end on time.**
Mean=1.61,SD=.96

20. **Lifting weights and other physical activity helps therapeutic community (TC) members to stay focussed on changing their lives for the better.**
Mean=3.04,SD=1.33

21. **Cognitive self change groups are useful in that they help inmates to reflect upon their behavior and their thought processes.**
Mean=3.88,SD=1.11

22. **The morning meetings force inmates to focus on their attitudes and their treatment.**
Mean=3.24,SD=1.03

23. **The morning meeting creative energy and learning experience exercises are useful in building a sense of community in the program.**
Mean=3.65,SD=1.14

24. **The presentations in group don't always reflect the handbook material for that day.**
Mean=2.27,SD=.78

25. **The AA/NA meetings are usually not that helpful in advancing the treatment goals of inmates.**
Mean=2.00,SD=1.03

26. **When I give a pull-up to an inmate, I am really showing responsible concern for that person.**
Mean=3.91, SD=1.24

27. **The PM closure meetings help inmates to put together all the information learned in that day.**
Mean=3.2, SD=1.01

Perceptions of Preparation and Involvement: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

28. **I have received enough formal training to prepare me to lead CSC groups.**
Mean=2.69,SD=1.74

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Table 13 continued

29. **I've received enough formal training to prepare me to effectively work in a therapeutic community.**
Mean=2.92,SD=1.55
30. **Treatment staff have access to sufficient materials in the RSAT office, such as books, manuals, films and other relevant materials, to use as RSAT resource materials.**
Mean=3.33,SD=1.19
31. **Correctional staff have access to sufficient materials in the RSAT office, such as books, manuals, films and other relevant materials, to use as RSAT resource materials.**
Mean=2.75,SD=1.24
32. **Inmates have access to sufficient materials in the RSAT class rooms or office, such as books, manuals, films and other relevant materials, to use as RSAT resource materials.**
Mean=3.53,SD=.99
33. **Every effort is made by treatment staff to encourage inmates to participate in groups and meetings.**
Mean=3.84,SD=1.11
34. **RSAT inmates sometimes discourage other RSAT community members from sticking with their treatment program.**
Mean=2.55, SD=1.15
35. **Non-RSAT inmates sometimes discourage RSAT community members from sticking with their treatment program.**
Mean=4.11, SD=.97
36. **Treatment staff are usually not that involved in program delivery.**
Mean=1.87, SD=.88
37. **The inmates are usually very involved in program delivery.**
Mean=3.71, SD=1.10
38. **Inmate coordinators usually reinforce pro-social or anti-criminal behavior, even in the living unit.**
Mean=3.25, SD=.72

Perceptions of the Therapeutic Atmosphere: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

39. **There is usually a sense of trust between correctional staff and inmates in this program.**
Mean=2.69, SD=1.12
40. **Inmates are afraid to complain to correctional staff about treatment issues for fear that they will not be allowed to remain in the program.**
Mean=2.24, SD=1.27
41. **Inmates are afraid to complain to treatment staff about treatment issues for fear that they will not be allowed to remain in the program.**
Mean=2.47, SD=1.54
42. **Pull-ups are given only when the behavior of an inmate warrants it.**
Mean=3.12, SD=1.22
43. **Haircuts are given only when a TC member is in danger of failing in the program.**
Mean=3.13, SD=1.60
44. **Correctional staff here freely give push-ups.**
Mean=2.16, SD=1.30
45 **Encounters are scheduled with a TC member only when his negative behaviors need to be addressed by other community members.**
Mean=3.31, SD=1.20

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Table 13 continued

46. **There is usually a sense of trust between treatment staff and TC members in this program.**
Mean=3.23, SD=1.10
47. **Inmates generally are not sincere in their participation in this program.**
Mean=2.50, SD=1.14
48. **When an inmate has a problem in sticking with his treatment program there are correctional staff here who will try and help him.**
Mean=3.24, SD=1.35
49. **When treatment staff complain to their supervisors about legitimate treatment issues, their comments are taken seriously.**
Mean=3.23, SD=1.02
50. **When inmates complain about legitimate treatment issues, their comments are usually ignored.**
Mean=1.77, SD=1.10
51. **Inmates are afraid to complain to correctional staff about treatment issues for fear that they will not be allowed to remain in the program.**
Mean=2.44, SD=1.31
52. **When an inmate has a problem in sticking with his treatment program, there are treatment staff here who will try and help him.**
Mean=3.86, SD=.97
53. **When correctional staff complain to their supervisors about legitimate treatment issues, their comments are taken seriously.**
Mean=3.12, SD=1.21
54. **Each RSAT TC member has a mentor in the program that helps him stick to his treatment plan.**
Mean=4.06, SD=.97
55. **Treatment staff here freely give push-ups.**
Mean=3.47, SD=1.13
56. **This RSAT community makes me feel like I am part of a close knit and supportive community.**
Mean=2.38, SD=1.50

Perceptions of Communication and Consistency Issues: On a scale of 1 to 5 please indicate your rating regarding the following communication and consistency issues.

57. **How would you rate the level of positive communication between treatment staff and inmates in this program?**
Mean=3.47, SD=1.26
58. **How would you rate the level of positive communication between inmates in this program?**
Mean=3.46, SD=1.18
59. **How would you rate the level of positive communication between treatment and correctional staff?**
Mean=3.17, SD=1.26
60. **How would you rate the level of consistency in delivery of treatment by staff?**
Mean=3.48, SD=1.21
61. **How would you rate the level of consistency in delivery of security by DOC personnel?**
Mean=3.67, SD=1.27

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Quality of Services: On a scale of 1 to 5 please indicate your perception of the truth of the following statements regarding the knowledge and skills that inmates gain from participation in this RSAT program.

62. **Generally speaking, RSAT graduates are more knowledgeable about drug and alcohol abuse after completing this program.**
Mean=4.18, SD=.82
63. **Inmates do not possess more skills or abilities to help them avoid substance abuse after having completed this program.**
Mean=1.85, SD=1.32
64. **Inmates who complete this program are more likely to avoid criminal thinking errors once back in the community.**
Mean=2.96, SD=1.16
65. **Even inmates who complete a portion of this RSAT program are likely to be more successful when on parole than are people with substance abuse problems who didn't participate in this program.**
Mean=3.11, SD=1.18
66. **Even inmates who complete a portion of this RSAT program are more likely to avoid alcohol or drug abuse in the future than are people with substance abuse problems who didn't participate in this program.**
Mean=3.08, SD=1.26
67. **Communication problems involving inmate referrals to this program occur frequently.**
Mean=3.21, SD=.79
68. **Because of the focus on cognitive self-change here, it is likely that inmate RSAT graduates will be less likely to engage in crime on parole than those inmates who didn't graduate from this RSAT program.**
Mean=3.33, SD=1.14
69. **Typically, inmates referred to this program fit the criteria for it.**
Mean=3.50, SD=.88

The majority of positively phrased items had a mean score in excess of 3.0, and those that were negatively phrased had a mean score of less than 2.0 indicating the respondents found the statement generally true. Several items dealing with perceptions of program content and delivery had higher mean scores, including item #15 (organized), item #17 (coordinators), item #20 (reflect), item #22 (energy), and item #25 (concern). These mean scores suggest that respondents have a generally positive view of program content and delivery.

Several items dealing with preparation and involvement issues also had higher mean scores, including item #31 (access), item #32 (encourage), item #36

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(delivery). Other items in this subscale had lower mean scores, however, including item #28 (effectively work), item #30 (correctional access), item #34 (non-RSAT discourage), and item #37 (reinforce). This suggests that perceptions of staff regarding the degree of preparation and involvement are mixed, at best, and there are some areas of concern.

Perceptions of the therapeutic atmosphere in the RSAT program are also mixed. While staff indicated that treatment staff are generally helpful and supportive (item #51, item #40, item #49), they also indicated that there is a lack of trust (item #38, item #45) and that some procedures are not used appropriately (item #41, item #42). Respondents also had some disagreement with the statement "This RSAT community makes me feel like I am part of a close knit and supportive community" (item #55).

Staff were generally neutral to slightly positive in their perceptions of consistency of delivery and communication (items #56-#60). The mean scores on all of these items were between 3.17 and 3.48. Some might view these scores as somewhat low, however.

Regarding the quality of services provided, respondents were again mixed in their assessment of the RSAT program. Respondents believe that inmates do gain valuable information and skills in the program (items #61, #62, #64, #67). They did note some problems with communication regarding inmates referrals (item #66, item #68), however.

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Staff Interview Information

METHODS

On June 12, 13 and 23, 2000, ten structured interviews of six Compcare and four IDOC security staff who are involved in the program on a daily basis were conducted by one of the process evaluation research team members. Each interviewee was asked the same 18 questions and then the Compcare staff were asked three additional questions and the security staff were asked another two. The interviewee was also given an opportunity to add any comments. Interviewees were asked not to discuss the questions or their responses until all interviews were completed.

The interview questions were devised to provide the researchers with another source of information regarding the operation of the program from those who are involved in its daily delivery. Many of the questions are similar to those asked in the inmate and staff questionnaires and on the observation sheets. Some of the interview questions were also added as a means of following up on issues that had arisen in the context of the observations or the IDOC audit and/or were raised after the inmate and staff questionnaire data was reviewed.

Before the interview began, the interviewee was advised of the likely length of the interview (15 to 30 minutes), the nature of the interview and the fact that confidentiality and anonymity were guaranteed. They were also told that participation in the interview process was completely voluntary and that their

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failure to participate would not be individually noted, nor would it lead to any negative repercussions for them. All staff informed of these issues were willing to fully participate.

ANALYSIS

Responses to the questions were randomly arranged and excerpted (see Appendix E) so that no response could be attributed to a given staff member. As the data indicates, there are some general patterns of perception that emerged from these interviews.

The descriptors offered by interviewees for this program would indicate that those who are most intimately familiar with its operation – from the staff perspective – had mostly positive things to say about it. For instance, most of the interviewees thought that the content of the program was exceptional and unique, that the staff were qualified, that the atmosphere of the TC is professional and open, that the relationship and communication between custody and treatment staff was productive, that aftercare plans were adequate, that treatment plans were individualized and that any repetition that might exist in the program was beneficial to the clients. However, the interviewees were also candid about some issues that they think merit attention to improve the substance and delivery of the program.

A common refrain in response to several of the questions was that treatment and custody, but particularly treatment staff, are not fully trained in CSC and TC

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operation. This inadequacy hampers the ability of staff to fully deliver the treatment and to maintain the high level of functioning of the TC. A related issue was the inability to adequately pay staff so that the most qualified can be attracted to the program and can then be persuaded to stay with it. These twin problems are also related to some issues with short staffing that the program has experienced, turnover and the inability to attract a staff member who is currently in recovery.

Another issue that arose again and again in the interviews was the need to ensure that there is more cross-pollination of information between custody and treatment staff. This lack of communication can sometimes manifest itself in expressions of distrust. Though treatment and custody staff were more likely to believe that the people who worked daily with the program (themselves) had established an understanding, there was some doubt about whether the rest of the custody staff, with the exception of the warden's administrative personnel, were fully supportive of it. Attendance at each other's meetings, more CSC and TC training for custody staff, more security attending some treatment programs and more social gatherings that combined the two groups were some of the suggestions offered by both custody and treatment interviewees.

A third issue was regarding the combination of RSAT and Non-RSAT inmates on the same grounds. Many staff regarded the virtually unavoidable contacts between RSAT and Non-RSAT inmates as presenting an unacceptable challenge

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to the RSAT inmates' ability to finish their program. Therefore, several of the suggestions for improvement of the program focused on isolating the RSAT program somewhere else. However, a few of the interviewees noted that this challenge was a fitting test of the resolve and strength of the RSAT inmate to resist the same kinds of temptations he is likely to face in the "real" world.

Finally, although most of the interviewees thought that the aftercare plan for the RSAT program was "adequate," they also thought there was much room for improvement. The main concern was that there was not enough contact between the RSAT treatment staff and the community corrections personnel. Nor was there the belief that there was adequate follow-up and follow-through in treatment once an inmate "graduated" from the program and was paroled.

The interviews were concluded with questions regarding effectiveness of the program. Several of the staff interviewees regarded the TC and the CSC components of the SICI as the "most effective." Most couldn't think of a portion of the program that was particularly ineffective. In fact, all but one interviewee thought that the program represented a prudent investment for taxpayers. If additional programming was to be added, the Compcare staff recommended the inclusion of anger management, relationship/family and parenting classes, sex abuse classes and communication skills.

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RESEARCH QUESTIONS, RECOMMENDATIONS, CONCLUSIONS AND DISSEMINATION PLAN

RESEARCH QUESTIONS AND THE FINDINGS

A review of the process evaluation research questions and study findings allows us to more specifically pinpoint the areas of strength and weakness that were identified in the course of this process evaluation. A general finding that should be stated at the onset of this section is that the analysis of these multiple process evaluation data sources would indicate that the RSAT program at SICI is framed in such a way that inmate clients are likely to be exposed to, and indoctrinated with, prosocial and anti-substance abuse knowledge and understanding that will enable them to successfully complete parole. Moreover, it is the assessment of these evaluators that the cognitive self-change and drug and alcohol abuse programming provision, in the context of a viable and robust therapeutic community, provides a unique and innervating spur for inmate clients to adopt the mental and behavioral tools that will allow them to be drug and alcohol free upon parole.

RESEARCH QUESTION #1:"Whether the SICI RSAT three modality program as delivered conforms with it stated goals and objectives?"

We found that for the most part it does. The inmate and staff questionnaire, staff interviews, field observations and administrative archival data all indicate that there are set programmatic components to each portion of the program and the program delivery is reflective of the stated goals and objectives of the program. The program is constructed to operate in the context of a therapeutic community and it functions as one. Cognitive self-change and behavioral strategies are employed in a number of venues and inmate clients are

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engaged in a number of ways in their own habilitation. The TC is maintained and enhanced through multiple strategies and techniques that are employed by treatment personnel and inmate clients such as: the use of push-ups, pull-ups, TPRs or haircuts (where negative behaviors and attitudes are confronted by the whole community), AM and PM community meetings and community building exercises. There is aftercare available, however, as we note in the recommendations, this is one area which warrants greater attention and devotion of resources.

RESEARCH QUESTION #2: "Whether the SICI RSAT program as delivered conforms with what is known to be most successful in substance abuse treatment in correctional institutions? Whether the .... program as delivered is likely to result in reduced recidivism, abstinence from drug and alcohol use and reduced costs of incarceration?"

We would also answer these questions largely in the affirmative. The SICI RSAT program does match programmatic features that are known to render success upon parole and thus reduce recidivism and additional correctional expenditures: the program is particularly strong in the cognitive self change area where treatment manuals exist and are adhered to. Our observations indicate that process groups allow clients to relate their concerns and issues to others, to role-play, and to confront others, and their own, thought processes and resulting behaviors. Programming, particularly the cognitive portion which focuses on criminal thinking errors, does address criminal behaviors.

Moreover, comparison of the pre and post criminal sentiments test scores data indicates that the attitudes of the participants are more prosocial after involvement in the program. However, there might be some improvement in the number of programming options provided

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as indicated by the staff interview findings. We also found that counseling staff instability may sometimes hamper the ability of the program to match learning styles to services.

RESEARCH QUESTION #3:"Whether the referral process identifies the targeted population?"

The entry and exit data analysis indicates that the appropriate targeted population is being referred as per the third research question Our analysis indicates that these data are now maintained in the files and accessible to the researchers and to IDOC program personnel.

RESEARCH QUESTION #4: "Whether the SICI RSAT data, management, staffing and design will be suitably established within two years from the grant start date to allow for a full-blown outcome evaluation".

Although we determined after analysis of file and computer data on inmates that greater standardization in administration of tests and maintenance of referral information is certainly warranted, we were able to locate the pertinent information to conduct this analysis. As file management has improved, we also expect that the data would be readily available for a full-blown outcome evaluation.

As the data from the observations, the inmate and staff questionnaires and staff interviews indicated, however, there are continuing issues related to training, staff retention and staff qualifications that should be attended to. The DOC audits and the staff interviews do reflect the fact that staffing for the program has somewhat stabilized over the past few years. However, as the staff interview and questionnaire and archival data indicate, staff turnover, perhaps related to low pay and part time hours, may have impaired the ability of the staff to deliver consistent treatment over the process evaluation period.

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RESEARCH QUESTION #5: "What are the communication issues between the IDOC, Parole Commission, and contract providers."

The staff interview data indicates that the level and tenor of communication between and amongst the correctional and treatment staff is generally regarded in a positive light. The parole commission appears to appreciate the RSAT program and its objectives as they have cooperated in giving program graduates their parole dates. As indicated by the interview data, the RSAT treatment staff were particularly impressed by the support they perceive from correctional staff who work directly with the program and by administrative staff at the prison. There were some suggestions for improvement in communication and understanding that were proffered by staff and those will be reviewed again in the recommendations delineated in this document.

RESEARCH QUESTION #6: "What are the cooperative remedies that might be developed to address any real or perceived barriers to successful implementation."

There have been a number of cooperative remedies developed to address implementation and delivery difficulties. Namely, the IDOC conducts their own yearly audit of the program. During the auditing process a number of referral, communication, file management, staff training and aftercare issues have been raised. Mark Gornik, Director of the Bureau of Offender Programs, has chaired several quarterly meetings to address these difficulties and to enhance communication. At such meetings nearly all of the issues raised in this process evaluation have been recognized and debated. As a result of such discussions, the IDOC is planning on enhancing the aftercare services provided to clients, a hundred bed RSAT TC facility is planned, and referrals to the RSAT program were standardized after the first two

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years of program operation.

RECOMMENDATIONS AND CONCLUSIONS

Our general conclusion is, as supported by our process evaluation data from five sources and employing multiple methods over the course of 15 months (as discussed at length in the foregoing), that the SICI RSAT is framed and operated in a manner that befits its organizational and programmatic mandates to deliver substance abuse and cognitive self change programming in a therapeutic community environment. Content included in-depth programming on cognitive self-change, 12 step programming and the traditions, boundaries and reinforcement of behaviors that typify a therapeutic community. Attributes of this program that reflected successful treatment in the literature included: cognitive processes and practice (e.g. journaling or thinking reports, CSC groups and process groups), prosocial modeling by staff and inmate coordinators, intensive engagement in their own treatment by clients, the presence of a therapeutic community environment and external support within the IDOC from the Bureau of Offender Programs and the administrators at the Southern Idaho Correctional Institution and outside the IDOC from the parole board. It is the research team's belief that this program is likely to result in less recidivism and cost for taxpayers and that it is thus ripe for the implementation of an outcome evaluation to test this belief.

As a means of improving upon an already strong program, and based on our analyses of the data in the foregoing, we offer a number of recommendations in this report.

- Our first recommendation is that the program continue in its current form.
- Secondly, we recommend, based on our analysis of the data, that more cognitive self-

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change and therapeutic community training be provided to both the treatment providers and the correctional staff at SICI.

- Thirdly, we recommend that correctional staff at SICI be provided with educational programming that will enhance their understanding of the RSAT program and its TC environment.
- Fourth, we recommend that the pay for treatment personnel be commensurate with their qualifications and skills.
- Fifth, we recommend that a counselor be hired who is in recovery.
- Sixth, we recommend that the client file data be maintained so that ongoing analysis of all aspects of the program, including an outcome evaluation, is possible. Specifically, we recommend that referral decisions and justifications be documented in inmate files.
- Seventh, and relatedly, we recommend that IDOC and Compcare personnel ensure that all entry and exit measures are administered in a standardized format - at the same time - in the classification process and are provided as documentation in the inmate files.
- Eighth, we recommend that additional programming that addresses the collateral needs of inmate clients be offered, such as: anger management, relationship management, parenting and dealing with sexual abuse.
- Ninth, implement ongoing and impartially administered participant questionnaires.
- Tenth, include more "trust building" exercises between and amongst the inmate clients as a means of reinforcing the community.
- Eleventh, we recommend that opportunities (e.g. meetings, training sessions or even

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social events) be created that will enhance the positive communication and interactions between counselors and correctional officers.

- Twelfth, we recommend that the TC environment be strengthened with structural and environmental changes, such as: moving the program to more isolated quarters, employing the use of softer furnishings and less institutional paint and accouterments, establishing a resource library and allowing the gathering in a common area on an informal basis. We believe, based on the literature on TCs and that on other innovative correctional environments, such as podular/direct supervision jails, that such changes will convey the clear message that this is a community and treatment oriented environment, as well as a correctional one.
- Fourteenth, we recommend that aftercare be provided for inmates on a statewide basis.
- Fifteenth, we recommend that quarterly meetings be continued for all involved stakeholders.
- Sixteenth, and finally, we recommend that an outcome evaluation of this RSAT program be done in the near future.

Plan to Disseminate the Results

As specified by the NIJ we disseminated the results of this research, in both the interim and final report forms, the financial reports, and copies of the automated data set funded by this grant. Included in these materials were hard copy and diskette versions of: a summary of 2,500 words, a full technical report, clean copies of all automated data sets (including our observation and questionnaire data sets). We also presented the inmate questionnaire findings at

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the annual year 2000 meeting of the Academy of Criminal Justice Sciences and presented a comparison of those findings with staff questionnaire responses at the American Society of Criminology meeting in November 2000. We plan on presenting additional results at the 2001 ACJS meeting (this meeting will not be funded by the grant). It is also likely that we will present these findings to corrections workers at the 2001 annual Idaho Correctional Association meeting. Included in these reports and presentations will be our assessment of the strengths of this program and how it might be improved upon.

We also plan to publish these results in journals that are likely to be read by researchers on corrections and treatment (e.g. *The Prison Journal, Federal Probation, The Journal of Offender Rehabilitation*). In fact, the ACJS paper on inmate perceptions of the program has been accepted for publication in an upcoming issue of the *Journal of Offender Rehabilitation.* We have another paper in progress in which we compare the inmate perceptions of another RSAT program in Idaho with the SICI RSAT inmate perceptions. We would also like to publish the results of this research in a practitioner magazine (e.g. *Corrections Today*) to ensure that the practitioner audience is made aware of the relative value of this program.

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APPENDIX A:

RSAT OBSERVATION SHEET--2

1. **Observer Name:** ______________________
2. **Date** (month/day/year):___________
3. **Time of observation:**___________
4. **Place within SICI if other than RSAT tier:**______________________
5. **Name of program leader (PL) observed:** ______________________
6. **Title of program observed** (if not a formal program indicate the event/situation observed):____

____

7. **PL status** (circle the correct one) Compcare/DOC/Inmate **and name** ____________________________
8. **PL position:**______________________
9. **Number of participants:** ______
10. **Others present?** (if yes, please explain):

____

11. **Nature of Observation** (please circle correct answer):

a. Cognitive Self-Change (explain the type)

____

b. Minnesota Model 12 Step Program (explain the type)

____

c. Individual Interaction (e.g. pushup/pullup - explain the type)

____

d. Morning Meeting
f. Process Group
g. Meditation
h. Other (please explain):____

____

Program Content and Delivery: ***On a scale of 1 to 5 please evaluate the attributes of this observation.***

12. **Clarity of Program Delivery** (Was it easy to understand what the PL was trying to convey?)

1.........2.........3.........4.........5 6 7
Poor Adequate Excellent NA DK

13. **Organization of Program Delivery - 1** (Was there a beginning, a middle and an end?)

14. **Organization of Program Delivery - 2** (Were the transitions between sections clear?)

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15. **Organization of Program Delivery - 3** (Did it end on time?)

16. **Substance of Program - 1** (Did the content reflect the announced subject matter?)

17. **Substance of Program - 2** (Did the content reflect the handbook materials?)
Other Comments:

___

___

___

___

Program Leader and Involvement Issues: ***On a scale of 1 to 5 please evaluate the attributes of this observation.***

18. **Preparation of PL** (Did the PL appear prepared?)

19. **Inmate Opportunity for Involvement** (Were inmates encouraged to participate by the PL?)

20. **Actual Inmate Involvement** (How would you rate inmate involvement?)

21. **Modeling of PL** (Did the PL model prosocial [non-criminogenic behavior])

22. **Quality of PL Involvement -1** (Did the PL keep the program on point?)

23. **Quality of PL Involvement - 2** (Did the PL engage most participants?)

24. **Quality of PL Involvement - 3** (Did they move the program along?)

25. **Quality of PL Involvement - 4** (Was the PL engaged in program delivery?)
Other Comments:

___

___

___

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Therapeutic Atmosphere: ***On a scale of 1 to 5 please evaluate the attributes of this observation.***

26. **General Therapeutic Atmosphere of the Program - 1** (Was there a sense of trust?)

27. **General Therapeutic Atmosphere of the Program - 2** (Did it appear that people were sincere in their involvement?)

28 **General Therapeutic Atmosphere of the Program - 3** (Could people complain or respond negatively about treatment issues without negative repercussions?)

29. **General Therapeutic Atmosphere of the Program - 4** (Were people taken out of their comfort zone in a positive way?)

30. **General Therapeutic Atmosphere of the Program - 5** (Did inmates act as if they belong to a community or a family?)

Other Comments:

____
____
____
____

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APPENDIX B:

SICI RSAT Staff Questionnaire

In this questionnaire we will ask key program stakeholders, such as treatment and custody staff, questions that will provide the RSAT process evaluators with a general sense about how the RSAT program at SICI is operating. Although participation in answering these questions is **completely voluntary** and **anonymous** (we do not need your name on this survey) we would ask you to kindly respond to these questions so that the RSAT program might be delivered in the most effective manner.

Demographics:

1. **Status** (please circle the correct answer): Compcare/DOC

2. **Position** (please indicate what the actual title of your job is): ____________________

3. **Staff (DOC OR COMPCARE) months working RSAT (0 to 36):** ______

4. **Gender** (please circle the correct answer):
   a. Male
   b. Female

5. **Race** (please circle the answer that best describes you):
   a. White
   b. Black (African-American)
   c. Asian
   d. American Indian
   e. Multiracial
   f. Other __________

6. **Ethnicity** (please circle the answer that best describes you):
   a. Hispanic
   b. Non-Hispanic

7. **Age:** ______

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8. **Education** (please circle the correct answer):
   a. 8 years or less
   b. Less than High School or GED
   c. High School or GED
   d. Some College or Technical Degree
   e. Associates Degree
   f. Bachelor's Degree
   g. Masters Degree or more

9. **Have you completed a formal (not on the job) training course on Cognitive Self Change?** (please circle the correct answer):
   a. yes
   b. no

10. **If you answered "yes" to question number 9, about how many hours of formal training have you received in CSC? _____ (if you answered "no" to question number 9 mark NA in this space).**

11. **Have you completed a formal (not on the job) training course on Therapeutic Communities?** (please circle the correct answer):
   a. yes
   b. no

12. **If you answered "yes" to question number 11, about how many hours of formal training have you received on TCs? _____ (if you answered "no" to question number 11 mark NA in this space)**

13. **Have you completed a formal (not on the job) training course on drug/alcohol programs?**
(please choose the correct answer):
   a. yes
   b. no

14. **If you answered "yes" to question number 13, about how many hours of formal training have you received on drug/alcohol programs? _____(if you answered "no" to question number 13 mark NA in this space)**

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15. **Which of the following statements best describes your contact with the RSAT Program at SICI (please circle the best answer)**

a. I have contact with RSAT inmates or the program on a daily basis.
b. I have contact with RSAT inmates or the program on a regular basis (at least one to two times per week).
c. I have contact with RSAT inmates or the program occasionally (at least one to two times per month).
d. I very rarely have contact with RSAT inmates or the program.
e. I never have contact with RSAT inmates or the program.

Note to Respondents: **If you never have contact with RSAT inmates or the program you may wish to circle 6 ("Not Applicable") for some or all of questions 16 to 69.**

Perceptions of Program Content and Delivery: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

16. **The group presentations I have observed or participated in are usually well organized with a clear beginning, middle and end.**

1..........2..........3..........4..........5			6	7
Not True	Somewhat True	Very True	NA	Don't Know

17. **The contents of programs I have observed or participated in rarely reflect the announced subject matter.**

18. **Inmate coordinators are fully prepared to lead the AM and PM discussions.**

19. **The group meetings rarely end on time.**

20. **Lifting weights and other physical activity helps therapeutic community (TC) members to stay focussed on changing their lives for the better.**

21. **Cognitive self change groups are useful in that they help inmates to reflect upon their behavior and their thought processes.**

22. **The morning meetings force inmates to focus on their attitudes and their treatment.**

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23. The morning meeting creative energy and learning experience exercises are useful in building a sense of community in the program.

24. The presentations in group don't always reflect the handbook material for that day.

25. The AA/NA meetings are usually not that helpful in advancing the treatment goals of inmates.

26. When I give a pull-up to an inmate, I am really showing responsible concern for that person.

27. The PM closure meetings help inmates to put together all the information learned in that day.

Perceptions of Preparation and Involvement: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

28. I have received enough formal training to prepare me to lead CSC groups.

29. I've received enough formal training to prepare me to effectively work in a therapeutic community.

30. Treatment staff have access to sufficient materials in the RSAT office, such as books, manuals, films and other relevant materials, to use as RSAT resource materials.

31. Correctional staff have access to sufficient materials in the RSAT office, such as books, manuals, films and other relevant materials, to use as RSAT resource materials.

32. Inmates have access to sufficient materials in the RSAT class rooms or office, such as books, manuals, films and other relevant materials, to use as RSAT resource materials.

33. Every effort is made by treatment staff to encourage inmates to participate in groups and meetings.

34. RSAT inmates sometimes discourage other RSAT community members from sticking with their treatment program.

35. Non-RSAT inmates sometimes discourage RSAT community members from sticking with their treatment program.

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36. Treatment staff are usually not that involved in program delivery.

37. The inmates are usually very involved in program delivery.

38. Inmate coordinators usually reinforce pro-social or anti-criminal behavior, even in the living unit.

Perceptions of the Therapeutic Atmosphere: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

39. There is usually a sense of trust between correctional staff and inmates in this program.

40. Inmates are afraid to complain to correctional staff about treatment issues for fear that they will not be allowed to remain in the program.

41. Inmates are afraid to complain to treatment staff about treatment issues for fear that they will not be allowed to remain in the program.

42. Pull-ups are given only when the behavior of an inmate warrants it.

43. Haircuts are given only when a TC member is in danger of failing in the program.

44. Correctional staff here freely give push-ups.

45 Encounters are scheduled with a TC member only when his negative behaviors need to be addressed by other community members.

46. There is usually a sense of trust between treatment staff and TC members in this program.

47. Inmates generally are <u>not</u> sincere in their participation in this program.

48. When an inmate has a problem in sticking with his treatment program there are correctional staff here who will try and help him.

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49. When treatment staff complain to their supervisors about legitimate treatment issues, their comments are taken seriously.

50. When inmates complain about legitimate treatment issues, their comments are usually ignored.

51. Inmates are afraid to complain to correctional staff about treatment issues for fear that they will not be allowed to remain in the program.

52. When an inmate has a problem in sticking with his treatment program, there are treatment staff here who will try and help him.

53. When correctional staff complain to their supervisors about legitimate treatment issues, their comments are taken seriously.

54. Each RSAT TC member has a mentor in the program that helps him stick to his treatment plan.

55. Treatment staff here freely give push-ups.

56. This RSAT community makes me feel like I am part of a close knit and supportive community.

Perceptions of Communication and Consistency Issues: On a scale of 1 to 5 please indicate your rating regarding the following communication and consistency issues.

57. How would you rate the level of positive communication between treatment staff and inmates in this program?

58. How would you rate the level of positive communication between inmates in this program?

59. How would you rate the level of positive communication between treatment and correctional staff?

60. How would you rate the level of consistency in delivery of treatment by staff?

61. How would you rate the level of consistency in delivery of security by DOC personnel?

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Quality of Services: On a scale of 1 to 5 please indicate your perception of the truth of the following statements regarding the knowledge and skills that inmates gain from participation in this RSAT program.

62. Generally speaking, RSAT graduates are more knowledgeable about drug and alcohol abuse after completing this program.

63. Inmates do not possess more skills or abilities to help them avoid substance abuse after having completed this program.

64. Inmates who complete this program are more likely to avoid criminal thinking errors once back in the community.

65. Even inmates who complete a portion of this RSAT program are likely to be more successful when on parole than are people with substance abuse problems who didn't participate in this program.

66. Even inmates who complete a portion of this RSAT program are more likely to avoid alcohol or drug abuse in the future than are people with substance abuse problems who didn't participate in this program.

67. Communication problems involving inmate referrals to this program occur frequently.

68. Because of the focus on cognitive self-change here, it is likely that inmate RSAT graduates will be less likely to engage in crime on parole than those inmates who didn't graduate from this RSAT program.

69. Typically, inmates referred to this program fit the criteria for it.

RSAT Strengths and Weaknesses

70. Please identify three strengths of the RSAT treatment program.

1. ______________________________

2. ______________________________

3. ______________________________

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71. Please identify three weaknesses of the RSAT treatment program?

1.______________________________

2.______________________________

3. ______________________________

Other Comments

72. Please choose one of the two programs (Cognitive Self-Change or the 12-Step Minnesota Model) that you think is most likely to have the effect of reducing an inmate's substance abuse in the future.
(program)____

(please
explain)____

73.Please choose one of the two programs (Cognitive Self-Change or the 12-Step Minnesota Model) that you think is most likely to have the effect of reducing an inmate's criminal behavior in the future.
(program)____

(please explain)

74. Please identify any improvements that might be made in this RSAT program.

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75. Please comment on the length of the RSAT Program at SICI. Do you think a nine to twelve month program is enough time? Or do you think the RSAT program is too short or too long and why do you think so?

____

____

____

____

76. Please provide any additional comments that you believe will assist the process evaluators in understanding how well this treatment program operates.

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APPENDIX C:

SICI RSAT Client Questionnaire

In this questionnaire we ask key program stakeholders, such as yourself, questions that will provide the RSAT process evaluators with a general sense about how the RSAT program at SICI is operating. Although participation in answering these questions is **completely voluntary** and **anonymous** (we do not need your name on this survey) we would ask you to kindly respond to these questions so that the RSAT program might be delivered in the most effective manner.

Demographics:

1. **Status** (please circle the correct answer):
Coordinator/Participant

2. **Number of months in SICI RSAT program:** ______

3. **Which cognitive self change program are you currently in?** (please put an X in front of the correct answer)
_____CSC 1
_____CSC 2
_____CSC 3
_____Other (please explain) ______________________________

4. **Which phase of the RSAT program are you currently in?** (please write in the correct phase)
Phase ______

5. **Race** (please circle the answer that best describes you):
   a. White
   b. Black (African-American)
   c. Asian
   d. American Indian
   e. Multiracial
   f. Other ____________

6. **Ethnicity** (please circle the answer that best describes you):
   a. Hispanic
   b. Non-Hispanic

7. **Age:** ______

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8. **Amount of Education** (please circle the answer that best describes you):

a. 8 years or less
b. Less than High School or GED
c. High School or GED
d. Some College or Technical Degree
e. Associates Degree
f. Bachelor's Degree
g. Master's Degree or more

9. **Use of Alcohol Prior to Incarceration** (please circle the answer that best describes you):

a. I never used alcohol before incarcerated this last time.
b. I had about a drink once per month before incarcerated this last time.
c. I had a drink or two per week before incarcerated this last time.
d. I had a drink or two per day before incarcerated this last time.
e. I had three to five drinks per day before incarcerated this last time.
f. I would drink to get drunk daily, or as often as I could, before incarcerated this last time.

10. **Use of Illegal Drugs Prior to Incarceration** (please circle the answer that best describes you):

a. I never used illegal drugs before incarcerated this last time.
b. I had about a fix a month of illegal drugs before incarcerated this last time.
c. I had a fix or two per week of illegal drugs before incarcerated this last time.
d. I got a fix every day, or as often as I could, of illegal drugs before incarcerated this last time.

11. **Relationship Between Substance Abuse (Alcohol or Illegal Drugs) and Criminal Behavior** (please circle the answer that best describes you):

a. I was always high or drunk when I committed a crime.
b. I was sometimes high or drunk when I committed a crime.
c. I was never high or drunk when I committed a crime.

Perceptions of Program Content and Delivery: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

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12. It is usually easy to understand what the staff treatment personnel are trying to say in groups.

1..........2...........3............4...........5 6 7

Not True Somewhat True Very True NA Don't Know

13. Presentations by staff treatment personnel are usually well organized with a clear beginning, middle and end.

14. The content of a program rarely reflects the announced subject matter.

15. Inmate coordinators are fully prepared to lead the AM and PM discussions.

16. The group meetings rarely end on time.

17. Lifting weights and other physical activity helps me to stay focussed on changing my life for the better.

18. Cognitive self-change groups are useful in that they help me to reflect upon my behavior and thought processes.

19. The morning meetings force me to focus on my attitude and my treatment program.

20. There is sometimes not enough handbook material to help us prepare for groups.

21. The morning meetings creative energy and learning experience exercises are useful in building a sense of community in the program.

22. The AA/NA meetings are usually not that helpful in my treatment.

23. When I give a pull-up to another community member, I am really showing responsible concern for that person.

24. The PM closure meetings help me to put together all the information I learned in that day.

25. People who commit criminal acts while abusing alcohol and drugs rarely make errors in criminal thinking.

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26. My treatment program has pointed out the barriers I put up to avoid changing in a positive way.

Perceptions of Treatment Leader and Involvement Issues: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

27. The treatment staff personnel are usually prepared to lead groups.

28. The inmate coordinators are usually prepared to lead the AM and PM groups.

29. Inmates are usually encouraged to participate by the staff treatment personnel or by inmate coordinators.

30. Other RSAT inmates sometimes discourage me from sticking with my treatment program.

31. Non-RSAT inmates sometimes discourage me from sticking with my treatment program.

32. The staff treatment personnel or inmate coordinator usually keeps the program moving along.

33. The staff treatment personnel are usually not involved much in program delivery.

34. The inmates are usually very involved in program delivery.

35. Inmate coordinators usually reinforce pro-social or anti-criminal behavior, even in the living unit.

Perceptions of the Therapeutic Atmosphere: On a scale of 1 to 5 please indicate your perception of the truth of the following statements.

36. There is usually a sense of trust between correctional staff and inmates in this program.

37. Inmates are afraid to complain to correctional staff about treatment issues for fear that they will not be allowed to remain in the program.

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38. Inmates are afraid to complain to treatment staff about treatment issues for fear that they will not be allowed to remain in the program.

39. Pull-ups are given only when the behavior of a TC member requires it.

40. Haircuts are given only when a TC member is in danger of failing in the program.

41. Encounters are scheduled with an inmate only when his negative behaviors need to be addressed by other community members.

42. If I have a problem with sticking to my treatment program there are correctional staff here I can go to for help

43. If I have a problem with sticking to my program there are treatment staff here I can go to for help.

44. There is usually a sense of trust between staff treatment personnel and inmates in this program.

45. I have an inmate mentor in the program who helps me stick to my treatment plan.

46. Treatment staff here freely give push-ups.

47. Generally inmates are <u>not</u> sincere in their participation in this program.

48. When inmates complain about legitimate treatment issues, their comments are usually ignored.

49. Correctional staff here freely give push-ups.

50. The pull-ups I've received from this program have taught me how to change in a positive and non-criminal way.

51. This RSAT program makes me feel like I am part of a close knit and supportive community.

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Perceptions of Communication and Consistency Issues: On a scale of 1 to 5 please indicate your rating regarding the following communication and consistency issues.

52. How would you rate the level of positive_communication between treatment staff and inmates in this program?

53. How would you rate the level of positive_communication between inmate participants in this program?

54. How would you rate the level of consistency in delivery of treatment services by staff treatment personnel?

55. How would you rate the level of consistency in delivery of security services by correctional personnel?

56 How would you rate the level of physical safety you feel in this program?

Quality of Services: On a scale of 1 to 5 please indicate your perception of the truth of the following statements regarding the knowledge and skills that inmates gain from participation in this RSAT program.

57. Generally speaking, inmate graduates are more knowledgeable about drug and alcohol abuse after completing this program.

58. Inmates do not possess more skills or abilities to help them avoid substance abuse after having completed this program.

59. Inmates who complete this program are more likely to avoid criminal thinking errors once back in the community.

60. Even inmates who complete a portion of this RSAT program are likely to be more successful when on parole than are people with substance abuse problems who didn't participate in this program.

61. Even inmates who complete a portion of this RSAT program are more likely to avoid alcohol or drug abuse in the future than are people with substance abuse problems who didn't participate in this program.

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62. Because of the focus on cognitive self-change programming here, I will be less likely to commit crime while on parole, than will those who didn't graduate from this RSAT program.

RSAT Strengths and Weaknesses

63. Please identify three strengths of the RSAT treatment program.

1. ______________________________

2. ______________________________

3. ______________________________

64. Please identify three weaknesses of the RSAT treatment program?

1. ______________________________

2. ______________________________

3. ______________________________

Other Comments

65. Please choose one of the two programs (Cognitive Self-Change or the 12-Step Alcohol and Drug Program) that you think is most likely to have the effect of reducing a person's substance abuse in the future.
(program) ______________________________

(please explain)

____

____

____

____

66. Please choose one of the two programs (Cognitive Self-Change or the 12-Step Alcohol and Drug Program) that you think is most likely to have the effect of reducing a person's criminal behavior in the future.
(program) ______________________________

(please explain)

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67. Please identify any improvements that might be made in this RSAT program.

____
____
____

68. Please comment on the length of the RSAT Program at SICI. Do you think a nine to twelve month program is enough time? Or do you think the RSAT program is too short or too long and why do you think so?

____
____
____

69. Please provide any additional comments that you believe will assist the process evaluators in understanding how well this treatment program operates.

____
____
____
___

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APPENDIX D:

STAKEHOLDER INTERVIEW

NOTIFY ALL POTENTIAL INTERVIEWEES THAT PARTICIPATION IS COMPLETELY VOLUNTARY AND THAT THEIR RESPONSES WILL BE KEPT IN CONFIDENCE AND WILL NOT BE REVEALED EXCEPT IN THE AGGREGATE TO ANYONE OUTSIDE THE RESEARCH TEAM.

LET THEM KNOW THAT THE INTERVIEW SHOULD TAKE ANYWHERE FROM 15 TO 30 MINUTES.

ASK THEM NOT TO DISCUSS THE QUESTIONS OR THEIR RESPONSES TO ANYONE INVOLVED IN RSAT PROGRAMMING (TREATMENT/CUSTODY OR PARTICIPANT)

1. **Date** (month/day/year): ______________________

2. **Interviewer Name:** _________________________________

3. **Interviewee Name:** _________________________________

4. **Interviewee Position:** ______________________________

5. **What is your perception of the substance of the program content?** (is there much there, is it always covered, what subjects might be covered well, what subjects might need more time, what parts of the program, if any, might be a waste of time)

6. **What do you think about the qualifications of the people involved in program delivery?** (of the program leaders, inmate leaders)

7. **What do you think about the delivery of the program?** (about the consistency of treatment delivery)

8. **How would you characterize the working relationship between treatment and custody staff?** (1 being poor and 7 being excellent)

9. **How would you characterize the communication between treatment and custody staff?** (1 being poor and 7 being excellent)

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10. **Why did you give the relationship and communication scores that you did?**
-First the relationship score

-How about the communication score

11. **Do you think that the inmates who graduate from this program have an adequate aftercare plan set up? Why or why not?**

12. **How individualized are the treatment plans? Do they focus mostly on substance abuse? How are criminality issues handled in treatment planning?**

13. **Now I want to ask you about how well the setting for this RSAT program works. For instance, how well do the RSAT and Non-RSAT inmates interact?**

14. **Relatedly, do you think that sometimes the security focus of the prison conflicts with the treatment needs of the RSAT (or visa versa)? Why or why not?**

15. **What are the most effective portions of this RSAT treatment program?**

16. **What are the least effective portions of this RSAT treatment program?**

17. **How cost efficient do you believe this RSAT program is?** (explain)

18. **What would you recommend to improve the TC at SICI?**

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ADDITIONAL QUESTIONS JUST FOR COMPCARE

A. What do you think about the program content in terms of repetition of material? Do you think there is too little or too much repetition?

B. Should the RSAT program include any other treatment would you be interested in trying?

C. Do you think that the resources devoted to the program are adequate? Is there adequate staffing for instance?

ADDITIONAL QUESTIONS JUST FOR SECURITY

A. How well do you understand what occurs in the RSAT program?

B. Is it your perception that the RSAT program is well run or not? Why or why not?

18. Other comments by interviewee:

19. Other comments by interviewer:

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APPENDIX E:

STAFF INTERVIEW RESPONSES

"What is your perception of the substance of the program content? (is there much there, is it always covered, what subjects might be covered well, what subjects might need more time, what parts of the program, if any, might be a waste of time)" included:

The community part of it is highly beneficial as is the TC approach. Some staff could use more training on the cognitive self-change piece. The chemical dependency piece should include more emphasis on the technical chemical effects of drugs and alcohol.

The program as a whole is good. It adequately covers all areas. We could have more in-depth treatment, but that would require more one on one work.

The substance of the program is not at the level of quality that it should be. There is just not enough ongoing training on TC and CSC that there needs to be to get and keep the staff at the point where they should be. The turnover of staff has compromised the integrity of the program.

I think the program is great and that's why I work here. I believe in it.

The program is very good. The combination of the CSC and the drugs and alcohol programs is very powerful. This program incorporates aspects that you don't see in other programs and they get 9 months of it.

I can't really say. I'm going to start sitting in on the classes they provide in order to gain a better understanding of it.

I think the 9 to 12 month time-line is sufficient.

Hard to say because I don't sit in on the classes that often. I have sat in on a few intakes.

The inmates told him/her that they wish there was more on drugs and alcohol, but he/she thinks it is possible that they could be missing the whole concept of the program

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I think this is the most exciting program. The combination of all programs is extremely potent. The time gives us the chance to work on behaviors.

"What do you think about the qualifications of the people involved in the program delivery" the responses were:

They are pretty good based on the feedback from the inmates.

They are good. I respect all my colleagues here, they are all professionals.

We have a really good group of people working in the RSAT program. Everyone has different specialties which complements each other's strengths. Nobody is afraid to ask if they have a question. People feel free to talk.

He/she doesn't feel qualified to judge this. The staff seem professional and seem to have most of the answers that people request.

Not sure because not sitting in on classes, if was would have a better idea. From what I know they seem competent, based on personal interactions.

The qualifications of the staff are adequate. It is just so difficult to find someone who meet all the necessary qualifications. He/she thinks we sometimes become a training ground for the state.

Don't know. Bruce (the director) explains everything and keeps people abreast of events.

It is very difficult to get qualified people, it is hard finding them, especially for what we pay. We pay a starting rate yet we need people who are not just qualified in one area, but people who are qualified in all areas. Usually people are lacking in the CSC knowledge. It takes a year working in the program to get up on CSC. But this is as good as we are going to get because of the salary and because there aren't that many people out there with the qualifications. Several current staff are lacking sufficient CSC knowledge.

We have great people delivering the program and they all seem qualified.

The qualifications of staff are good. We could always use more knowledge/skills/training, but thinks it is adequate.

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"What do you think about the delivery of the program (about the consistency of program delivery)?" included:

We could use some help in consistency. We kick some people out for the same thing that we have allowed some of the Phase III people to stay in for.

We are pretty good in this area. Some things like being short staffed have hampered our ability to be consistent, but we're at least about average. Thinks that once they are full staffed they will be excellent in this area.

As long as I've been here it has been consistent. The guys know what to expect.

Thinks it is no good having inmates teaching inmates. If the program is worth having then it is worth having staff do all the teaching.

Staff turnover has affected consistency in a negative way.

Thinks members are treated fairly but some inmates believe there are favorites.

He/she thinks it is pretty straightforward.

Seems very consistent and the same and fair for all. There are no pets for staff, nor are staff extra friendly to one or another inmate.

The consistency could probably be improved. Being short staffed has hurt us and right now he/she is the only one who has been through white bison. We need more training for the different programs. We need everyone trained on everything.

The feedback he/she hears is that they are fair. There were some weak staff members but those are gone.

There has not been consistent treatment delivery because the tasks change, they shift and rotate. Just as we build up a rapport, then clients might be shifted to a new case manager.

"How would you characterize the working relationship between treatment and custody staff? (1 being poor and 7 being excellent)" and to question number 6 "Why did you give the relationship score that you did?" the responses were:

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6 - very good because I've worked with them and we agree on what to do. People don't try to dominate and seem to support each other. We come to agreement on inmate misconduct and good behavior.
2 - we don't have a security representative in the weekly staff meetings. Feels supported by about 30% of the security staff. Still has to fight the belief by security that "They're inmates and they don't deserve anything." Does feel supported by the warden and the deputy warden.
6 to 7- we have no problems. They wrote a letter thanking Mink for a response (security). They learned they can rely on us.
6 - really good, he/she appreciates what security do as just completed the CO training.
6 - for people we work with regularly, including the warden and deputy warden, but 5 for others.
7 - but there are too many opinions about how the program is working. People like sergeants and above think that the program is being manipulated. Some old time COs haven't bought into the program.
5 – good because anytime have a question Bruce is willing to explain. Not a 6 or 7 because nothing is perfect. We have mixed custody. Staff think that RSAT inmates get special treatment and they do and need to.
5 – We are working on inviting security into the process. The younger officers are curious about the program. Couple officers think that prison is prison and punishment. But we have proven ourselves and they have begun to trust us.
7 – There are no problems between us. I've always felt supported and protected. Security are always right there and concerned and interested.
5 – The working relationship is good. I've been surprised at how supportive security staff is. Seems like they assign people here who are amenable.

"How would you characterize the communication between treatment and custody staff? (1 being poor and 7 being excellent)" and to question number 7 "Why did you give the communication scores that you did?" included:

6 – Treatment staff will tell you what is going on. Bruce and John and all those people will tell you.
5 – They (security staff) tell us what they see, but we don't always remember to tell them.
5 – They are always available for us. Thinks that more social gatherings (picnics etc.) would help to improve relationships. Just to make more friendly. There are no conflict and we are just all focused on what we are doing.
7 – They learned to tell us ahead of time to get us involved first if they feel they will be pushing someone pretty hard.
6 - Very good because generally if there is something we don't know (security) they let us know and visa-versa. Custody try to make treatment aware. The crisis notification form that we send between treatment and custody seems to help.

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3 – Don't have security in our (treatment's) weekly staff meetings, but Bruce goes to the security meetings. Sometimes we don't notify security about things right off the bat.
7 – Has confidence in all the COs. No problems. But then that is the way I was trained.
5 – The communication between us has gotten better. Helps that the department hearing officer asks what we (treatment) want to do about an infraction. But there are still a few officers that think prison is only for punishment. Some officers have made comments about RSAT being a RAT program.
4 -- This rating reflects a drawback on our part because we are not security minded. We don't get them in the loop soon enough. Sometimes we act like we are just separate groups. Thinks that they are improving in this area though.
7 – Everyone knows how the tier works. We use community mentors to control people. Community controls the others.

"Do you think that the inmates who graduate from this program have an adequate aftercare plan set up? Why or why not?" included:

Don't think they do have an adequate plan. It would help to have counselor led aftercare.

Instead of them topping out there should be at least six months at a CWC so the ropes are let off them gradually. Classes start fading away.

Yes there is an adequate plan. It is not excellent and in part that is because we don't work with parole officers on what's available. Three-fourths of the plan is the same for everybody.

We do our best. It varies whether they have a good plan. We demand it, but it gets real iffy because they don't always follow through.

Adequate yes, but it can be improved. It's not the same statewide. Depends on where you parole out to as to whether there are programs available.

Doesn't think that they do. There are not enough funds available in Idaho for halfway houses. Was told in TC training that aftercare was not sufficient.

No, they're going right back to the same people. They become accustomed to the RSAT way and not what they have when they go out there.

I don't know so can't say.

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The plan we send them out with I think is adequate. But we are not involved in what happens when they leave.

Negative, because know of two or three who came back after they went through the program.

"How individualized are the treatment plans? Do they focus mostly on substance abuse? How are criminality issues handled in treatment planning?" included:

Don't know.

They do have specific plans. Mostly the focus is on substance abuse, their TC plan and 3 or 4 more issues that apply to everyone. Then there are individual issues. Crime issues are handled adequately, especially through CSC.

Thinks the plans deal more with personalities and thought processes, whereas the inmates want drug and alcohol treatment.

We are trying to treat substance abuse and don't deal too much with criminality.

A chunk of the plan is the same for programming. But then everybody has their own issues so 80% of the plan is individual. Criminality aspects refer back to CSC. The substance abuse part of question is answered yes and no because they are tied in. Criminality is dealt with through the individualized use of CSC. We are going to do more individualized plans for criminality issues. We probably have not done enough.

Everybody gets certain types of treatment. From there we go to the autobiography of their life and things to deal with. Then the treatment plan addresses those issues. Through the CSC have to look at their criminal history and what drives the behavior.

Yes, have to, but the plan hits every aspect including relationships and child abuse, etc. She/he deals with criminality issues and the CSC covers it.

I don't know so can't say.

Yes the plan deals with the three areas and then their own problems. TC and substance abuse first, then in Phase II they deal with the scope and consequences. Then they apply what they've learned in process groups and in step work.

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Don't know.

"Now I want to ask you about how well the setting for this RSAT program works.

For instance, how well do the RSAT and non-RSAT inmates interact?" include:

Thinks it can work here. It is a challenge for the inmates so they have a chance to fail to succeed. Would love it if it was a separate unit. But the inmates won't live in a vacuum outside so why in here.

He/she doesn't see the RSAT and NonRSAT interactions. But knows that the NonRSAT inmates try to get the RSAT inmates in trouble. Thinks that total separation would be great.

Thinks it is the worst thing to have the program set here. The inmate code still is stuck with the RSAT inmates and many get kicked out because of it and the pressure they get from other inmates.

They aren't supposed to interact but they do. We hold them accountable but since they are around it happens. They are not supposed to leave the tier without a taxi (another RSAT inmate).

They don't interact well together. Not supposed to. When they do interact it is because the RSAT inmates are doing what they shouldn't or because the NonRSAT inmates are giving the RSAT inmates shit. There is more contamination with the interaction.

Stinks because according to the contract they're not supposed to interact at all. Hard to enforce. Don' interact well – could do better.

Don't like it. Ideally would have a separate compound. Have to go through teasing by others. Some have quit because of the peer pressure.

Best unit to have them in on this compound. The NonRSAT inmates make snide remarks and try to aggravate the RSAT inmates. NonRSAT inmates consider them rats. Not good to have them on the same compound intermingling.

At first thought it was a negative thing. But more he/she thinks about it thinks it is a positive thing because they are going to have to face the same type of thing on the outside.

Doesn't work well. Too much animosity between the RSAT security staff and

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others. Because there are different rules for RSAT inmates. It creates hard feelings between the inmates. Still have to socialize with other inmates on the compound.

"Relatedly, do you think that the security focus of the prison conflicts with the treatment needs of the RSAT (or visa versa). Why or why not?" included:

Has to be a happy medium. Need both. No reason why security staff can't be trained to fit into RSAT.

Thinks they have to be blended like we're doing. Because they are still inmates and wards of the court so have to have a security emphasis with treatment.

Yes security consider them inmates and interfere. Staff that have not had TC training will go out of their way to catch an RSAT inmate.

Sometimes it does conflict. But he/she thinks that is good as they need to remember where they are (reaching rock bottom) and humbling themselves.

No doesn't think there is a conflict. Thinks that security has to be in place and appreciates it.

Doesn't think they are in conflict. Sometimes one hampers the other, but we just need to be mindful of each other.

Yes they do conflict.

It does because security can interfere with RSAT operation indirectly.

Yes sometimes it does conflict. A lot of COs don't think the inmate is going to make it and so that negatively affects them. The COs get that negative attitude from the instructors in the academy. They treat inmates as if they will fail.

Don't think it does. The treatment staff sometimes forgets the security focus. There is not conflict but it does restrict some treatment.

"What are the most effective portions of this RSAT treatment program?"

included:

TC

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TC as the CSC and AA could go through on their own, but the TC makes them other centered.

Reaction of inmates with counselors and the guidance by people who are normal. This guidance creates the situation where they see what is normal.

Breaking them down and getting them to admit that the most important thing is drugs and then bringing them back up.

CSC and TC

TC and CSC for sure because they identify risky thoughts and they are given 9 months to develop interventions.

These guys being accountable for each other. The haircuts, where it is understood that you are not ratting somebody out but are helping them to correct some behavior.

The combination of TC, CSC, Drug/Alcohol education and process groups is so powerful.

The combination of TC, drug/alcohol and CSC works well.

Doesn't know.

"<u>What are the least effective portions of this RSAT treatment program</u>?"

included:

Don't know.

Don't know of any.

Setting a date for when they are done. He/she doesn't think they should know their date. A date should not be an incentive for completion.

Don't know.

The 12 step program. Getting people to come in from the community is hard. Not having someone on staff who is in recovery is a real weakness.

Don't know.

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Doesn't really think there is (a weakness). There seems to be a purpose to all of it.

All of them are effective to a point. AA is more old hat for most so may have less of an impact whereas the CSC and the TC are new for them.

More staff monitoring of Phase II and III.

I wish we had another couple of counselors to do client meetings and paperwork.

The responses to the question "How cost efficient do you believe this RSAT program is (explain)" include:

Cheap. Could easily do more. We save so much if we can turn just one person around. We save families, communities and others.

It is very cost effective based on the success rates.

Told by others that it is cost efficient.

I don't know how much it costs per inmate, but treatment is always cost effective for everyone.

In my opinion it is money out the window. There is no return on it because we haven't changed the environment the inmate is going back to. Their behavior started young and the whole family does it and we can't give them a new family.

Thinks we do a good job for the money we get from the government. The taxpayers get their moneys worth because of the intensity of the modalities, the client to staff ratios and the thoroughness of the treatment.

Since it is based on a 67% success rate, she/he thinks it is pretty cost effective.

If one guy out of 48 goes out and makes it then that is cost effective.

It is very cost efficient if the numbers we heard are right. If have a success rate of 66% then it is cost efficient.

Don't know.

"What would you recommend to improve the TC at SICI?" include:

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Move it and get it out of a minimum institution.

More CSC and TC training for treatment and custody.

Training in advanced TC. Go to other TCs and see what they do. There is so much to know and experience, but we don't have enough training so can't pass that along.

More counselors.

Can't tell cause don't get that involved in the TC.

Training and change the setting, he/she would have it separate and maybe in a work release.

Staff go through advanced TC, get staff fully trained.

Create a new unit to separate them from the general population.

Isolation from the prison population.

More continuity, more follow-through. We are shifting clients around too much.

Compcare staff additional questions and responses included:

"What do you think about the program content in terms of repetition of material?

Do you think there is too little or too much repetition?"

Doesn't think that repetition is an issue as everyone gets through the cycle.

Don't think there is too much repetition. We have to go over the material again because maybe we didn't deliver the right information because they didn't get it the first time. There is a need for repetition.

The amount of repetition is just about right. If we did it more people would get turned off by it.

Don't think there is too much repetition. Usually only at the end of a phase does the client hear the same material again. The amount of repetition is about right

For Phase I thinks repetition is good. There is a lot of it in this phase but thinks

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that is okay. In the upper phases there shouldn't be repetition.

Doesn't know enough to comment, but knows there is repetition of material.

"Should the RSAT program include any other treatment programs?"

A grief group because so many have lost kids and family members. A sexual abuse group. And we need a psychologist that will really see them. Someone who cares in that area.

Anger management classes would be beneficial as would a communication skills class as can only do so much on role modeling.

Acupuncture, detox and stress programming.

They need access to family, but doesn't really need to be included in RSAT, but maybe a family type program. Also they could use anger, relationship and sexual abuse programming.

We needs groups with significant others prior to parole. Also anger management, relationship and parenting courses.

Anger management, communication and relationship skill building programming would be useful.

"Do you think that the resources devoted to the program are adequate? Is there adequate staffing for instance?"

There is not adequate staffing. We need more people to do the paperwork, follow-up and monitoring.

The counselors are not paid enough. The staffing is adequate to get the job done, but could use more staff.

No there is not adequate staffing. There is not enough money from the Bureau of Offender Programs or Compcare. They want way too much for the resources they give. There are unrealistic expectations.

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We don't pay staff enough and that is the major source of staff turnover. We are fighting for staff to get more as we are trying to get Master's level people for 13 or 14/hr. There is burnout so we are always replacing people.

Don't know. The COs are not paid enough.

No the resources are not adequate as we need more counselors.

IDOC additional questions and responses included:

"How well do you understand what occurs in the RSAT program?"
He/she knows what some classes are about but not exactly what is going on in classes. He/she tries to know what is going on and asks people in the community what they think.

Has been to the TC course and has sat in on a few classes, but otherwise is not that involved.

Has limited knowledge because just started working with the RSAT program.

Knows something from TC and has observed them. He/she is familiar with the jargon.

"Is it your perception that the RSAT program is well run or not? Why or why not"?
Generally well run. Thinks this has a lot to do with Bruce Wells-Moore being there as he has the skills and background.

Overall thinks it is run well given the setting.

Thinks it is run well from all indicators.

Yes it is run as well as it can be under the conditions they're in right now. Thinks the counselors need to spend a few days in class that teaches them the security aspects of the job. They wait too long to report problems, but are getting better.

Responses to the "Other comments by interviewee" question included:

Look at how much staff is here and how much they say they are here. Need the feedback and lines of communication to be improved among staff. Michelle does a wonderful job of handling things, but we also need more staff.

There is not enough teamwork between the Bureau of Offender Programs people and Compcare.

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