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The Process Evaluation of the Residential Substance Abuse Treatment Program at the Minnesota Department of Corrections-Red Wing Facility

FINAL REPORT

(RSAT Grant 99-RT-VX-K007)

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HISTORY OF THE PROCESS EVALUATION

Marquette University, with consultation from the Center for Addictions and Behavioral Health Research (CABHR), in partnership with the Minnesota Correctional Facility at Red Wing (MCF-Red Wing), was awarded funding for a process evaluation of the MCF-Red Wing Residential Substance Abuse Treatment (RSAT) through the *Local Evaluations of the Residential Substance Abuse Treatment for State Prisoners Program (1998)* grant from the National Institute of Justice. Prior to the Process Evaluation award the MCF-Red Wing RSAT program received operating funds granted by the National Institute of Justice. Operating funds continued to be received for this RSAT. This RSAT program provides interventions to incarcerated, male adolescents and lasts 9-12 months. The RSAT program was implemented in May 1998 with the intent of including an evaluation component designed to evaluate the quality of the service delivery systems.

The MCF-Red Wing was responsible for overseeing the entire program as it relates to treatment. Marquette University with consultation from the CABHR served as the lead-collaborating independent evaluator for the MCF-Red Wing RSAT program. Marquette University was responsible for overseeing the treatment process evaluation. Both the MCF-Red Wing and Marquette University were responsible for the training and supervision of their respective staffs.

Goals and Objectives of the Process Evaluation

(Process Evaluation Mission Statement)

The mission of the process evaluation was to evaluate the integrity of the Minnesota Correctional Facility-Red Wing Residential Substance Abuse Treatment (RSAT) program service delivery system in order to (a) provide feedback designed to enhance the existing strengths of the RSAT program and improve any existing or potential weaknesses and (b) prepare for a subsequent outcome evaluation.

Overview of Process Evaluation Model

The CIPP model of program evaluation (Hadley & Mitchell, 1995) was used as the foundation of the evaluation of the MCF-Red Wing RSAT program. The acronym is drawn from the four types of assessments identified by the model: (a) context, (b) input, (c) process, and (d) product. This conceptual model performed two important functions: First, it offered a structure that brought order to the mass of issues, data, problems, and decisions. Second, the model reduced the likelihood that crucial variables or aspects were overlooked.

The following guidelines were used to bolster the accuracy of the evaluation of the MCF-Red Wing RSAT program (Hadley & Mitchell, 1995; Lambert & Hill, 1994): (a) clearly determine, both from a programmatic and research perspective, what is being measured so that replication is possible, (b) measure change from numerous perspectives (i.e., residents, staff, administrators, and objective observers) with several kinds of rating scales and methods, (c) employ system-based measures, and (d) examine the patterns of change over a period of time.

METHOD

Participants

Residents

Resident-participants in this study were male juvenile offenders incarcerated at the MCF-Red Wing who have been determined to have significant substance abuse problems as an aspect

of their delinquency. Referral for participation in the RSAT Program is determined based on the results of the facility's substance abuse screening.

During the course of the Process Evaluation there were approximately 30 residents involved in the RSAT Program at any one time. A total of 69 residents participated in the RSAT Program during the course of evaluation. All RSAT program residents were required to participate in all aspects of the program. All residents who were at the facility at the time of the 4 focus groups participated in the focus groups. The RSAT participants had an average age of 17 years old and have various racial/ethnic backgrounds.

All MCF-Red Wing residents have been committed to the Commissioner of Corrections. Therefore, informed consent to participate in the process evaluation was obtained from the Commissioner of Corrections. Residents were informed of the nature and purpose of the process evaluation. Policies and procedures regarding confidentiality were presented to residents.

Staff

A total of four caseworkers (one resigned mid-way into the evaluation and a new caseworker was hired), one chemical dependency counselor, and two teachers (one resigned mid-way into the evaluation and a new teacher was hired) participated in all aspects of the process evaluation. Two corrections Officers participated in interviews. Ten Corrections Officers participated in the CIES administration.

Administrators

Three administrators (Program Director, Caseworker Supervisor, Substance Abuse Coordinator) participated in focus groups, interviews, and the CIES.

Procedures

Several investigative approaches that were utilized addressed issues across all four domains (i.e., context, input, process, product): (a) individual and group interviews with staff, administrators, and residents, (b) review of documents (i.e., RSAT grant, chart reviews, program manuals, and relevant texts), (c) review of facilities, and (d) focus groups. The focus group procedures are described below There were two procedures that were domain-specific: (a) ratings of the group facilitation and (b) the administration of the Correctional Institutions Environment Scale (CIES).

THE MINNESOTA CORRECTIONAL FACILITY-RED WING RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

Background Information Re: Residential Substance Abuse Treatment Program

Providing substance abuse treatment services to incarcerated offenders is an important part of a logical national approach to effectively decrease drug use and crime. As noted in the *National Drug Control Strategy,* "Drug treatment in the criminal justice setting can decrease drug use and criminal activity, reduce recidivism, while improving overall health and social conditions." (McCaffrey, *1997).*

Surveys and other research supported the need for this program in the Minnesota Juvenile Correctional System. For example, *The Minnesota Department of Corrections Juvenile Needs Assessment Survey* was conducted in 1997 by the Juvenile Services/Legislative Relations Division and the Office of Planning and Research. This survey included a large cross-section of professionals in the criminal justice system and clearly demonstrated a need for an increase in chemical dependency treatment services in Minnesota State facilities. A study conducted by the Robert F. Kennedy Foundation found that 67.8% (158) of the adolescents placed in the two Minnesota state juvenile facilities had substance abuse problems (*Risk Profile of Minnesota*

Youth, 1996). institutions) were one and one-half times more likely to use alcohol, two times more likely to use opiates, three times more likely to use marijuana and amphetamines, and three and one-half to five times more likely to use other types of drugs" (Harrison, 1996). This information clearly supported the need to increase and enhance the substance abuse treatment services for juvenile offenders being admitted to state correctional facilities. Therefore, the residential substance abuse treatment program (RSAT) was established at MCF-Red Wing to address the needs of the serious and chronic juvenile offenders who were also determined to have significant substance abuse problems.

Overview of the Facility

Constructed in 1889, the Minnesota Correctional Facility-Red Wing (MCF-Red Wing), Red Wing, Minnesota, is a state operated fenced facility for male, juvenile offenders. The campus encompasses 200 acres and is comprised of various administrative and operations buildings, a chapel, 3-two story living units, 5-single floor cottages, and one security cottage. The facility employs a staff of approximately 180. The MCF-Red Wing is designed to provide services to serious and chronic, male juvenile offenders who have been committed to the Commissioner of Corrections as a result of having been determined by the county courts to be inappropriate or unamenable candidates for local corrections programs because of the seriousness of their offense or the chronicity of their offense history.

Programming components include counseling, work programs, recreation and leisure (intramural sports, challenge course, team building, and community service activities), religious services, and volunteer services. Special needs services include substance abuse assessment and treatment, sex offender counseling, psychological and psychiatric evaluation, psychotherapy, abuse victims counseling, grief groups, and effective fathering classes. All residents attend education classes for six hours each day. Students are able to earn a high school diploma or GED certification.

Residential Substance Abuse Treatment Program

In May 1998, the MCF-Red Wing received funds granted by the National Institute of Justice to establish and implement a Residential Substance Abuse Treatment (RSAT) Program within the Prepare Program.

The Prepare Program

The Prepare Program is a longer-term program as compared to the general population of MCF-Red Wing and includes three phases. The first consists of residential programming at the facility during which residents are expected to complete cognitive/ behavioral, academic/vocational, special needs, and aftercare planning goals. The length of stay in the first phase is a minimum of nine months. This is followed by a three-month aftercare/transition program during which the residents remain under the jurisdiction of the facility while participating in structured residential community-based placements. The final phase of the program consists of six months of intensive supervision in the community.

The RSAT program is dedicated to one housing unit-the Princeton Cottage. The RSAT treatment model is an integration of the EQUIP model, the Prepare Program, the Principles of Daily Living and the Recovery Training. These components are implemented through individual, group, and psycho-educational modalities and aim to assist juveniles in developing, implementing, and maintaining pro-social skills and behaviors and recovery from alcohol and other drug abuse. The combination of these components is a unique integration in the field of juvenile corrections.

The RSAT is designed to function from a team approach. The RSAT staff include:

1. Caseworkers assigned to each treatment group. Duties include: treatment planning, group facilitation, individual counseling, and record keeping.
2. Corrections officers assigned to the cottage. Duties include: security, cottage management, and program support.

3. Chemical dependency counselor assigned to RSAT. Duties include: substance abuse assessment, treatment planning, education, group facilitation, and individual counseling.
4. Teacher from general education program. Duties include: facilitating psychoeducation groups.
5. Supervisor of Casemanagers
6. Supervisor of AODA counselor
7. Program Director
8. Consulting psychologist and psychiatrist.

Selection and Assessment of RSAT Program Participants

Participants must be committed to the State Commissioner of Corrections and subsequently placed at MCF-Red Wing. Participants must admission criteria for the Prepare Program. Residents meeting these criteria undergo an assessment that includes assessment of need for substance abuse treatment.

The RSAT Program participants come from diverse counties throughout Minnesota, but the majority of participants are from the Twin Cities metropolitan area. The participants collectively have committed a wide array of crimes as indicated. Although the Minnesota juvenile crime rate is below the national average, the Minnesota rates have increased in recent years (Office of the Legislative Auditor, 1995). In addition, the MCF-Red Wing is the "last stop" for juveniles in Minnesota, thus the MCF-Red Wing clientele tend to be the "difficult to treat" offenders. This must be kept in mind when evaluating treatment effectiveness and comparison to other treatment programs.

RSAT Residents - Assessment

The initial assessment process for program participants includes collecting demographic information, social history (including offense and placement), substance abuse assessment and psychological assessment. RSAT participants tend to have a history of polysubstance abuse and co-occurring psychiatric disorders are not uncommon. These profiles are likely similar to other treatment populations within correctional facilities although little empirical data exist in regard to prevalence of alcohol, drug and mental (ADM) disorders in juvenile justice systems (Linda A. Teplin, Ph.D. Director of Psycho-Legal Studies at Northwestern University Medical School is currently conducting the first large-scale longitudinal study of ADM disorders among juvenile detainees).

Evaluation of Intake and Assessment Procedures

The intake and assessment procedures were viewed to be thorough and appropriate for the clientele. The chemical dependency workers were more satisfied with the measures and procedures as they were more involved and well-versed in the matters as compared to the caseworkers. Both the psychological reports and the AODA assessments were viewed, by the caseworkers, to be disconnected from the rest of the program. That is, either the results were not readily available to the caseworkers or the results of the assessments were not viewed as "user-friendly" and thus were not incorporated into treatment plans or strategies to use with the residents.

Recommendations Regarding Assessment Procedures

The RSAT Program intake utilized the computer-assisted version of the Substance Use Disorder Diagnosis Schedule (SUDDS). The SUDDS is a useful and efficient tool for assisting in diagnosing substance use disorders (Davis, Hoffman Morse & Luehr, 1992; Murphy& Impara, 1996). However, this original version of the SUDDS is targeted at adults and is aimed at the now

outdated Diagnostic and Statistical Manual of Mental Disorders (Third Edition Revised) (American Psychiatric Association, 1987). A new version of the SUDDS is available and is aimed at the diagnostic criteria of The Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) (American Psychiatric Association, 1994).

- The updated version of the SUDDS should be employed. However, The SUDDS has not been normed on adolescents and the availability of reliability and validity studies is limited. Therefore, the interpretation of the SUDDS' results should be made with caution and not in lieu of clinical interview and review of records.

The Recovery Attitude and Treatment Evaluator (RAATE) was developed to assess five key dimensions (resistance to treatment, resistance to continuing care, acuity of biomedical problems, acuity of psychiatric problems, supportiveness of social environment) and can used to assist in treatment planning and determining appropriate level of care and can be effectively employed to monitor progress in treatment (Smith, Hoffman, & Nederhoed, 1992). The RAATE is underutilized by the RSAT in ongoing treatment planning and monitoring residents' progress through treatment.

- The chemical dependency workers need to provide training and consultation to the caseworkers to improve utilization of the RAATE.
- The RAATE should be employed with caution with the RSAT residents as it has not been normed on incarcerated adolescents nor with adolescents in general. This is not to say that the RAATE should not be used, but the limitations need to be realized and the continued use needs to be with close supervision and scrutiny. Reliability and validity studies regarding the RAATE with this population should be undertaken.

The assessment measures associated with the Equip Program (Sociomoral Reasoning Self-Reflection Questionnaire, and the Inventory of Adolescent Problems-Short Form) were administered as a matter of course during the initial phase of this evaluation. However, currently these measures are being administered sporadically.

- Because these measures are vital to any subsequent outcome study allowing for comparison of pre-treatment and post-treatment status the consistent and standard administration of these measures is necessary.
- Per teacher and caseworker report, many of the residents have low-grade reading levels and this impedes residents' progress within the program. Caseworkers and residents would benefit from consultation with the psychologist and teachers regarding residents' reading abilities, cognitive functioning, and learning styles.
- There is a significant amount of co-occurring substance disorders and other psychiatric disorders. Though the RSAT program is not designed to be a mental health unit, by default psychiatric issues other than substance abuse must be addressed. The psychologist needs to directly involved in case supervision and consultation to help the RSAT staff adequately address co-occurring disorders. In general, the program would benefit from regular consultation meetings (ideally at least every other week) between the psychologist, chemical dependency workers, and the caseworkers regarding diagnosis, treatment planning, and intervention strategies. This would provide the forum for connecting the intake information to the main program elements and ongoing case consultation.

RSAT PROGRAM COMPONENTS

Resident Orientation to RSAT Program

Initially, the resident orientation to the RSAT program was viewed as a weakness in the program. The residents perceived the orientation to take place primarily through fellow residents and observing others in group. This was problematic in that there was much confusion around procedures, concepts, and terminology. In October of 1999, a new orientation process was implemented aimed at orienting all residents to the new recovery training model and new residents to the entire RSAT Program. The new orientation process was well received by residents, staff, and administrators.

Therapeutic Community Approach

The RSAT program incorporates elements of Therapeutic Communities. Studies have demonstrated that the therapeutic community (TC) treatment is an effective approach in combating drug abuse for clients who remain in treatment (Melnick, & De Leon, 1999). There are three primary characteristics that contribute to a TC. The first of these components consists of de-emphasizing the distinction between the staff and resident in the treatment setting (Kennard, 1998). The second characteristic of a TC is an emphasis on group sessions (Kennard, 1998). The third crucial characteristic of a TC consists of bringing staff and residents into contact with people from outside the community (Kennard, 1998).

The Equip Program

The Equip program is designed to meet the needs of seriously antisocial youth who typically exhibit cognitive distortions, delayed moral reasoning, and deficiencies in social skills related to their delinquency. The Equip program is employed across the entire facility as well as the RSAT program. The Equip Program has proven to be effective in other locations (Gibbs et al., 1995; Leeman, Gibbs, & Fuller, 1993). The skills learned in Equip sessions are utilized in regularly scheduled mutual help

meetings designed to address the specific cognitive and behavioral problems affecting individual members of the group. The mutual help meetings are delivered by way of a staff-directed peer group counseling process though individual and special needs counseling is also available through the caseworkers.

The Principles of Daily Living

The Principles of Daily Living are utilized throughout the facility and are incorporated into the RSAT program. Residents learn that their interactions in the community are governed by the "Principles for Daily Living" which define what it is to be a contributing member of the community. Residents are taught that a community is a group of people that are interdependent, share a common area, and have common interests that are defined by its laws and standards

The Recovery Training Model

At the outset of the evaluation, the MCF-Red Wing RSAT Program was utilizing a Recovery Training program consisting of the following components: assessment, education, self-help groups, and relapse prevention training. The recovery training is aimed at helping the adolescent develop self-assessment techniques, relapse warning sign identification, and warning sign management techniques based on the *Counselor's Manual for Relapse Prevention for Chemically Dependent Criminal Offenders* (Gorski & Kelley, 1996). The Recovery Training components were intended to be integrated with the cognitive restructuring, psycho-educational, and therapeutic community components of the Equip Program.

However, MCF-Red Wing RSAT Program's Administration and Staff (in consultation with the Marquette University Research Team, the Office of Planning and Research, and the Chemical Dependency Unit of MNDOC) made a decision during the course of the process evaluation to replace the Gorski and Kelley (1996) model with the Strategies for Self-Improvement and Change (SSC) model (Wanberg & Milkman, 1998). MCF-Red Wing reported

that the Gorski and Kelley model did not provide a clear curriculum. Furthermore, it did not focus on the relationship between substance abuse and criminal conduct. In contrast, the SCC model offers a substance abuse treatment model that addresses the reciprocal relationship between substance abuse and criminal behavior. The SSC Model incorporates empirically supported models and approaches to substance abuse treatment, including the Stages of Change (Prochaska, DiClemente, & Norcross, 1992), motivational enhancement approaches (Miller & Rollnick, 1991), and relapse prevention approaches (Marlatt & Collier, 1995; Marlatt & Daley, 1997; and Marlatt & George, 1998).

STAFF ISSUES and SOCIAL CLIMATE

Program Morale

There was fluctuation in morale of over time as morale for staff and administrators was relatively low during the summer in response to larger institutional dynamics and the amount of flux in the RSAT program, but morale did improve in the fall. Most residents suggested that feelings fluctuate between motivation and an apathetic stance toward the RSAT program. Though overall , the residents had a positive view of the RSAT program and related that it was helpful to them.

Reactions from later focus groups and interviews indicated much improvement in morale especially in regard to the RSAT program. Both staff and residents greatly attributed this the stabilization of the program components, training provided to staff, and the new orientation process.

Security versus Treatment

A dichotomy is acknowledged in the institution between a more security driven philosophy and a focus upon rehabilitation and treatment. The RSAT administrators suggested

that their programming had been affected by pressure from those holding a more security driven philosophy.

From the staff perspective, the difficulties related to this institutional dichotomy: Security versus Treatment was a result of the entire institution being in "flux". The staff observed that a lot of tension exists due to the security vs. treatment politics in the institution and that administrators feel immense competing pressures from this.

The intensity of the "Security versus Treatment" issue was at its peak at the time of the 2nd round focus groups. The stress level and negative effects upon morale were very apparent to the research team not just in focus group conversation, but in tone of discussion and body language. During the October and December focus groups, the intensity of this issue had diminished substantially. This is due, in part, to the progress in the development of the program. It was also apparent that the RSAT administrators had made successful attempts to downplay the dichotomy for themselves and for the staff. It should be noted that the residents did not report perceiving the "Corrections versus Treatment" dichotomy within the institution.

Corrections Officers management/supervision

Directly related to the correction versus treatment dichotomy is the issue regarding separate supervision structures for Corrections Officers (COs) and caseworkers. Each group is beholden to a separate group of supervisors and separate philosophy/approach to the job at hand.

- One of the problems in the division between the Correction Officers and Caseworkers is that each reports to different supervisors, there is a lack of CO staff continuity, and there is a lack of empowerment of the CO's to make decisions.

- The assignment of Correction Officers to the cottages is often dictated by seniority and scheduling. Hence, no emphasis is placed upon assigning officers who have a particular knowledge base for working with the particular population serviced by a cottage.
- All staff and administrators interviewed agreed that effective CO-caseworker teamwork is essential to optimal programming.

Staff Turnover

The MCF-Red Wing was reported to have lower staffing levels as compared to county and private juvenile facilities (Office of the Legislative Auditor, 1995). The lower staffing levels places higher demands on staff, increasing stress, decreasing efficiency and ability to meet residents' and program needs. The staffing level has also negatively affected morale and, in turn, has exacerbated the security versus treatment split amongst the Red Wing staff.

In spite of lower staffing levels, The RSAT team has remained generally intact and is working well as a team. There were two instances of staff turnover during the evaluation period: one caseworker (replaced by a caseworker from another cottage and one teacher (Equip facilitator) replaced by a teacher from outside the institution. The integration of the two new staff into the team has gone well.

RSAT Staff Training and Supervision

Overall, the relationship between the RSAT program staff and RSAT administration is viewed as effective and generally helpful. The staff was concerned about some lack of clear communication between staff and administration particularly regarding supervision. Specifically in relation to who was going to provide direct supervision, when the supervision would take place, and the purpose of the supervision (evaluative, or simply to focus on problems?).

Training for all staff (including caseworkers and COs) was seen as a top priority by both staff and administrators. Training needs to focus on all areas programming including chemical dependency (all staff) and advanced group facilitation skills for caseworkers.

Training was conducted with the correction officers for 16 hours. This was held so that the officers in the chemical dependency unit would better understand the program. Specifically, there were 2 eight-hour training units including teambuilding exercises, videos, and the Equip model. The need to familiarize the correction officers with the terminology and rationale of the Equip and Recovery Training models was recognized.

RSAT Staff Role Clarification and Work Demands

There was significant concern about role-definition for the caseworkers and the chemical dependency staff. Caseworkers were unclear as to the extent to which they were expected to participate in the development of the new Recovery Training Component. Both staff and administration stated that the flux in the program contributed greatly to the lack of clarity in role definition and communication. As the transition to the Wanberg and Milkman Recovery Training Model drew nearer to full integration into the RSAT Program the role ambiguity decreased. There are still concerns regarding job roles, competing demands upon time, and insufficient time to complete all job requirements.

Caseworkers are spending much time in class preparation for the new recovery training model although additional preparation time had not been allotted. As facilitators cycle through the classes preparation time will decrease. However, there are 50 classes so the "cycle" will likely take a substantial period of time.

Resident Religious and Cultural Issues

Generally, residents said that they viewed the program as respectful in permitting sweat lodge visits, church, bible study, etc. Three residents suggested that their religious and cultural perspectives/practices were not being respected to the extent that they desired. They expressed that they feel that there are too many limitations on religious exercises, such as sweat lodges. Addressing diversity issues is a vital part of effective programming. Staff understanding of the effects of racial, ethnic, socioeconomic, and cultural dynamics upon the treatment process and outcomes is essential.

The Correctional Institution Environment Scale: Social Climate

The CIES scores indicated a very positive social climate. There is a remarkable level of satisfaction with the current social climate for both residents and staff. This is indicated by the small Real Form-Ideal Form discrepancy scores. The Real form scores indicated that the staff and residents generally agreed that there is currently a positive social climate that incorporates elements of an effective therapeutic community. The Relationship, Personal Growth, and System Maintenance dimensions are all, at least, adequately addressed in the RSAT program.

Staff control was consistently rated the lowest of the subscales (though still "average" as compared to the national norm. This rating indicates that both residents and staff believe that a certain amount of control is necessary (and obvious as the RSAT program is located in a correctional facility), but a climate that is too restrictive can be a hindrance to the overall aims of the program. There can be detrimental effects of too much staff control upon program morale, adaptive behaviors, relationships and personal growth (Moos, 1975; Deschner, 1980). There appears to be an appropriate level of staff control within the RSAT Program. This provides

further proof that the security versus treatment dichotomy which seemed to be at its peak in summer 1999 is being bridged.

Recommendations Regarding Staff and Social Climate

- It is strongly recommended that cottage meetings be continued and that flexibility in scheduling and compensation (i.e., periodic overtime pay) be provided to support all RSAT staff attendance. Continuing the cottage meetings (along with training) will serve to unite the staff regarding RSAT Program policies, procedures, philosophies and approaches.
- Additional and more intensive training for COs and caseworkers in regard to the RSAT program components is likely to increase the sense of efficacy for the staff and thus increase morale.
- Training needs to focus on all areas programming including chemical dependency (all staff) and advanced group facilitation skills for caseworkers.
- Joint trainings involving COs and caseworkers throughout the year will help to solidify the team and treatment approaches.
- Periodic retreats involving caseworkers, COs, and administrators should be held to address RSAT program issues.
- Consistent "clinical supervision" (i.e., supervision pertaining to facilitation of program components) by RSAT supervisors can provide the forum for positive, constructive, and preventive feedback to the caseworkers. The clinical supervision must be supported and valued by upper administration in the forms of flexibility of scheduling, compensation, and inclusion in job expectations. Supervisors should be afforded advanced training in clinical supervision.

- Ongoing training should be provided to staff regard to developing cultural competencies. As the sociodemographics of the residents change, these trainings need to reflect the cultures represented in the RSAT program.
- The orientation for residents must be continued and strengthened.
- It is recommended that the CIES be administered at regular 6-month intervals at least until completion of an outcome study.

PROCESS FINDINGS

The process findings consisted of information from the ratings of videotaped group sessions; focus groups conducted with the administration, staff and residents; interviews with staff, residents, and corrections officers and two administrations of the Correctional Institution Environment Scale (CIES).

Integration of program components (cottage issues, terminology etc)

The integration of program components was seen to be of the utmost importance. At times, the Equip Model, Prepare Program, Mutual Help, Recovery Training, and general cottage functioning seemed disconcerted. That is, the concepts, skills, etc. from one component were not consistently reinforced in other components. One major reason for this was lack of consistency of terminology across components. There was also concern about RSAT concepts and skills being reinforced outside of "program time" i.e., in the cottage during evenings and weekends.

Recovery Training Model

The staff and administration had concerns regarding the theoretical and research base of the Gorksi & Kelley (1996) model, it was not easily compatible with the Equip program, and it was cumbersome for the staff to implement. The lack of a clear curriculum in the model made it difficult for staff to implement in a consistent and effective manner.

In the fall of 1999, the decision was made to adopt the SSC (Wanberg & Milkman, 1998) model for the Recovery Training component of the RSAT Program.

The implementation of the SSC Model

Changes in programming [i.e., adoption of the SSC Model] were still in the early stages. Transition had been accepted well by caseworkers, administrators, and residents. The smooth transition was due primarily to the fact that all members of the team were involved in the adoption of the program and implementation

Strengths of the SSC Model

Residents suggested that the old recovery training program was not as good because they did the same material repeatedly. In contrast, they said that the new program provides an opportunity to move forward in the material. Residents suggested that the recovery training model presents a way of understanding the cycle of substance abuse more clearly than the Gorski and Kelley model.

Concerns regarding the SSC include:

- SSC was developed for use with adults. Some adaptation to adolescents is likely to be needed.
- SSC was developed for outpatient use. The curriculum will need to be adapted to a residential setting.
- The reading level in the SSC curriculum is reported to be at the 6th grade level. However, after perusal of the curriculum, staff and administrators were concerned that the reading level of the curriculum is actually much higher and the residents will have difficulty reading and comprehending the material. The materials will need to be adapted to lower reading levels.

- Though the concepts in SSC parallel the concepts of Prepare and EQUIP, the terminology is different. There is a need to standardize the terminology across program components to universalize the definitions of terms and to reinforce these universal terms in all components of the program.

Process Discussion

The relationship between staff and residents is seen as paramount by all involved in the RSAT Program. The relationships or "working alliance" between residents and staff is generally very strong and consistent over time as reported by all three groups (residents, staff, and administrators).

Strengths of Facilitators (RATING)

In terms of the implications of the ratings for the Red Wing model, the results demonstrate that the facilitators in the program have demonstrated definite strengths in their adherence to the model in-group sessions as well as good skill level in group facilitation. Specifically, the facilitators have demonstrated (a) the ability to communicate the concepts of the model, (b) the ability to present the model utilizing multiple techniques, and (c) the ability to impart the treatment concepts to the group members. The facilitators have also demonstrated excellent group facilitation characteristics, including: (a) responding to questions, (b) an attentive posture, (c) showing acceptance and support of the group members, (d) summarizing content effectively, (e) refocusing the process of a session, and (f) insightfully interpreting the meaning of group members' comments.

Areas of Concern Regarding Group Facilitation (RATING)

With much of the emphasis of the results indicating positive characteristics of the facilitators, a number of recommendations (based on the rating results) could be utilized to further enhance their treatment delivery. It is recommended that:

- the facilitators provide a clear indication at the outset of each treatment session of the subject matter to be discussed. The rating demonstrated that this clarification became much less prevalent in the October sessions as compared to August sessions.
- it would be beneficial for the facilitators to incorporate some kind of material that explicitly communicates the session's rules and norms prior to each session. The raters indicated that this component was heavily lacking in the sessions that were evaluated. The addition of this discussion of group rules/norms provides group members with a shared understanding of how the group should ideally function.
- Consistent supervision should be provided to the facilitators by the RSAT administrators in regard to group facilitation
- regular "peer supervision" meetings should be scheduled in order that facilitators can review their work and learn from each other.
- purposes of each component and facilitator roles should be clarified amongst staff
- review of group expectations at the beginning of each group should be conducted
- more active facilitation of group process by the group facilitators especially in regard to the Mutual Help Groups.
- additional and ongoing training in regard to group facilitation should be provided.

Process Recommendations

- Consistent and regular cottage meetings attended by all RSAT staff and administrators will help tremendously with role-clarification. Also, consistent and regular supervision sessions for caseworkers will help with role-clarification. Further development and familiarity with the new SSC recovery training model will also help alleviate stress and anxiety regarding adoption of a new model.
- The integration of terminology across treatment components will ease facilitation and clarify concepts for staff and residents. It is recommended that a review of all components be made with the intent of developing a glossary of terms, thesaurus of terms, and that "official" RSAT terminology be identified and utilized across all components.
- The SSC model was developed for use with adults. The RSAT staff have been adapting this model for their juvenile population and the MCF-Red Wing administrators have reported that the authors of the SSC model are currently developing an adolescent version of the SSC model. It is recommended that the RSAT program document the changes made for working with adolescents and begin immediate consultation with the SSC authors.
- The SSC model claims that the reading level of the curriculum materials is at the sixth grade level. However, the RSAT staff suspect that the reading level is much higher. The reading level of the materials should be re-examined and any handouts to the residents should be adjusted to their reading level.
- Though the RSAT Program is well-developed and defined, further articulation of the treatment philosophy and model by the staff and administrators will serve to strengthen the program. Issues pertaining to harm reduction approaches, abstinence based approaches (it

should be noted that harm reduction and abstinence approaches are not mutually exclusive), and group facilitation approaches need to identified and clarified.

OUTCOME EVALUATION

Issues and Concerns

There were numerous concerns regarding an outcome evaluation. Of particular concern was the lack of adequate resources for transition programming, the lack of Red Wing control in type and quality of aftercare, the definition of "success" being limited to abstinence or recidivism only, and the lack of understanding of the residents' severity of substance abuse and criminal history. There is some concern about the adolescents finding adequate social support to bolster their efforts upon leaving the institution.

Administrators expressed the desire to provide more consistent aftercare services. Their preference would be to work with fewer providers of such services and to become more involved with their delivery. Administrators would like to have more control of the type and length of aftercare services

Recommendations:

It is extremely difficult for caseworkers to meet the demands for transition programs. Additional staff needed to be added. A new position of "transition caseworker" was developed. One of the RSAT caseworkers moved into this new position (the resulting RSAT caseworker vacancy was filled in January 2000). Considering that this is new position to the RSAT Program:

- time for position development and training need to be afforded to the transition caseworker.

A major problem is that transition programs are controlled at the county level and not at the state level. This severely hampers the RSAT Program's effectiveness regarding transition and limits continuity of transition programs because counties vary dramatically in services provided.

The new transition caseworker position is a step in the right direction, but there is a tremendous amount of work involved in coordinating transition services.

- Additional resources are likely to be needed to optimally administer the transition services.
- Involving family members and members of the community to which the resident will be returning (i.e., employers, teachers, recovering community, clergy) in the transition process is crucial to developing positive social support networks and ultimately successful outcomes.

There is a growing emphasis in the treatment outcome research literature on the global concept of Quality of Life (Speer, 1998). Quality of life is an umbrella concept that involves multiple dimensions and purports that the effectiveness of interventions or treatments are not adequately measured nor understood if approached from a unidimensional perspective (i.e., abstinence versus non-abstinence).

CONCLUSION

The MCF-Red Wing Residential Substance Abuse Treatment (RSAT) Program is an innovative and well-designed treatment program. There are many strengths of this program noted throughout the report. The staff and administration share a sense of mission and direction in implementing the RSAT program. The design of the RSAT is viewed to be sound, appropriate to the clientele being served, and effective in facilitating positive change within the residents.

There are systemic issues related to staffing and treatment philosophies that need to be addressed if the RSAT program is to function optimally. Also, there are numerous training needs for both correctional officers and caseworkers that need to be met. Funds will need to made available for this training so that the RSAT program can operate at peak performance.

THE HISTORY, GOALS, MANAGEMENT PLAN, MODEL, AND METHODOLOGY OF THE PROCESS EVALUATION

HISTORY OF THE PROCESS EVALUATION

Marquette University, with consultation from the Center for Addictions and Behavioral Health Research (CABHR), in partnership with the Minnesota Correctional Facility at Red Wing (MCF-Red Wing), was awarded funding for a process evaluation of the MCF-Red Wing Residential Substance Abuse Treatment (RSAT) through the *Local Evaluations of the Residential Substance Abuse Treatment for State Prisoners Program (1998)* grant from the National Institute of Justice. Prior to the Process Evaluation award the MCF-Red Wing RSAT program received operating funds granted by the National Institute of Justice. Operating funds continued to be received for this RSAT. This RSAT program provides interventions to incarcerated, male adolescents and lasts 9-12 months. The RSAT program was implemented in May 1998 with the intent of including an evaluation component designed to evaluate the quality of the service delivery systems.

The MCF-Red Wing was responsible for overseeing the entire program as it relates to treatment. Marquette University with consultation from the CABHR served as the lead-collaborating independent evaluator for the MCF-Red Wing RSAT program. Marquette University was responsible for overseeing the treatment process evaluation. Both the MCF-Red Wing and Marquette University were responsible for the training and supervision of their respective staffs.

MANAGEMENT PLAN AND BACKGROUND INFORMATION

Management Plan

Representatives from the Minnesota Department of Corrections, Marquette University and the Center for Addiction and Behavioral Health Research joined together in a collaborative effort to evaluate a unique and very promising residential substance abuse treatment program. The Principal Investigator for the Process Evaluation, Todd C. Campbell, Ph.D., is Assistant Professor/Co-Director of Training – Department of Counseling and Educational Psychology at Marquette University and Center Scientist/Executive Board Member for the Center for Addiction and Behavioral Health Research. Dr. Campbell is also a licensed psychologist (Wisconsin) and a Certified Alcohol and Drug Counselor III (CADC III-Wisconsin). Dr. Campbell was responsible for overall leadership and direction of the project; ensuring that all reports, evaluations, surveys, focus groups and interviews were conducted in a timely manner; overseeing the project budget; and acting as the primary liaison between the Marquette University research team and the MCF-Red Wing administration and staff. Dr. Campbell supervised the recruitment, the training, and the performance of the student raters, interviewers, and focus group facilitators; and supervised the rating process and evaluation. Dr. Campbell was responsible for data analysis, report writing, and dissemination of information.

Marvin Berkowitz, Ph.D. served as the Co-Principal Investigator for this project. Dr. Berkowitz is Sanford N. McDonnell Professor of Character Education University of Missouri-St. Louis. Dr. Berkowitz assisted in the overall planning and implementation of the process evaluation.

The project coordinator was Mr. Lee Hildebrand. Mr. Hildebrand was administratively responsible to the Principal Investigator and assumed responsibility for co-management of the

project, including: collection and entry of the project's data; analysis of the data; coordination of the recruitment, training, and supervision of the raters; development and implementation of the rating scales; assistance in the recruitment, training, and supervision of the focus group facilitators; coordination of the focus groups and interviews; assistance in writing project reports; and assistance with the overall administrative operations of the process evaluation.

The MCF-Red Wing RSAT program cooperated fully with the process evaluation. This cooperation allowed investigators access to staff, residents, and facilities relevant to the process evaluation. The MCF-Red Wing was responsible for the hiring, training and maintenance of treatment team staff. Key MCF-Red Wing RSAT program administrators involved in the project were: John Handy (Program Director), Steve Larson (Substance Abuse Program Coordinator), and Tom Crisp (Caseworker Supervisor). The Juvenile Services Division, Office of Planning and Research and the Chemical Dependency Services Unit staff from the MNDOC Central Office were involved in overall planning and served as advisors for the process evaluation. CABHR Center Scientists, Dr. Allen Zweben and Dr. Ron Cisler, also served as advisors to process evaluation.

Goals and Objectives of the Process Evaluation

(Process Evaluation Mission Statement)

The mission of the process evaluation was to evaluate the integrity of the Minnesota Correctional Facility-Red Wing Residential Substance Abuse Treatment (RSAT) program service delivery system in order to (a) provide feedback designed to enhance the existing strengths of the RSAT program and improve any existing or potential weaknesses and (b) prepare for a subsequent outcome evaluation.

Overview of Process Evaluation Model

The CIPP model of program evaluation (Hadley & Mitchell, 1995) was used as the foundation of the evaluation of the MCF-Red Wing RSAT program. The acronym is drawn from the four types of assessments identified by the model: (a) context, (b) input, (c) process, and (d) product. This conceptual model performed two important functions: First, it offered a structure that brought order to the mass of issues, data, problems, and decisions. Second, the model reduced the likelihood that crucial variables or aspects were overlooked. The CIPP model provided a systematic link between the mission of the evaluation project and the MCF-Red Wing RSAT program.

The greatest challenge in evaluating the MCF-Red Wing RSAT program rested in developing the most accurate measures to examine the context, input, process, and outcome (product) of the services. Accurate assessment of the program components allow for more effective decisions regarding program implementation and assist in identifying and developing measures to be utilized in a subsequent outcome evaluation.

Further, this evaluation sought to provide a reliable and valid evaluation of the program. As a result, not only will the MCF-Red Wing RSAT program staff be guided in their future choices, but the study assists in comparison to other RSAT programs and research findings in the realms of **(a)** the dose (amount and intensity) of treatment, **(b)** adherence to the theoretical model, that is, the integration of the EQUIP counseling model and the substance abuse treatment model. **(c)** the skill level of caseworkers, **(d)** how in-session interactions between and among clients and facilitators change over time, **(e)** measures of quality control, **(f)** staff characteristics relevant to treatment processes and outcomes, and **(g)** a detailed description of the overall implementation of the RSAT

program. The process evaluation offers important insights to others seeking to fine-tune or begin similar programs.

A central problem in performing evaluative research is exactly how to measure and assess the changes that transpire through the treatment process (Hadley & Mitchell, 1995; Lambert & Hill, 1994; Moos, 1975). The treatment process is a complex, multivariate, systemic, and longitudinal phenomenon and the analytic model needs to match these characteristics. Therefore, diverse research methods including objective measures, repeated measures (e.g., institutional atmosphere was assessed over time), session ratings, focus groups, and interviews were employed in this evaluation.

Traditional evaluation of substance abuse treatment programs has focused on quantitative methodology. Many program evaluations incorporate process measures (e.g., program retention, number of sessions attended, number of days in treatment etc.), but not enough include investigation of subjective realities of the primary people involved in the program (i.e., residents, staff, administrators). An essential component of program evaluation is the collection of qualitative data. The utilization of qualitative methods, in this case focus groups, interviews, and review of documents and facilities, allowed a thorough and systematic investigation of several issues regarding programming from several different perspectives (i.e. residents, staff, and administrators).

The following guidelines were used to bolster the accuracy of the evaluation of the MCF-Red Wing RSAT program (Hadley & Mitchell, 1995; Lambert & Hill, 1994): (a) clearly determine, both from a programmatic and research perspective, what is being measured so that replication is possible, (b) measure change from numerous perspectives (i.e., residents, staff, administrators, and objective observers) with several kinds of rating scales and methods, (c) employ system-based measures, and (d) examine the patterns of change over a period of time.

Context Evaluation

In general, context evaluation addressed the following questions: (a) what needs of the institution remain unmet, (b) what is desired relative to certain value expectations, areas of concern, difficulties, and opportunities, in order that goals and objectives may be formulated and (c) in what geographic, physical, and personnel setting does the program operate (Hadley & Mitchell, 1995; Isaac & Michael, 1981)? These questions were primarily addressed through the planning and implementation of the RSAT program. That is, the need for substance abuse treatment in MCF-Red Wing was established, goals for the RSAT were determined, operating funds were secured, and the RSAT was implemented by MCF-Red Wing personnel. However, it was important to continue to evaluate the on-going impact of the context upon the treatment program.

Input Evaluation

The input evaluation aimed to assess the human and material assets available, program design and procedures, and barriers to programming (Hadley & Mitchell, 1995; Isaac & Michael, 1981; Stufflebeam & Shinkfield, 1985). Input variables are present prior to the start of the treatment and are distinct from the process (Hill, 1991). Interviews and focus groups with staff, administration, and residents were used to assess the RSAT program input components. Review of pertinent documentation was conducted.

Chart reviews and interviews with staff and residents were conducted to determine: (a) compliance with stated assessment protocol, (b) proper documentation of assessment results, and (c) that the assessment protocol adequately addresses pertinent resident input variables (previously identified: e.g., criminal behavior, level of sociomoral reasoning severity and

chronicity of AODA etc.). Chart reviews were conducted during three separate time periods. Charts were randomly selected for review. The following input components were considered:

Resident variables:

- Criminal behavior
- Level of sociomoral reasoning
- Severity and chronicity of AODA
- Psychological characteristics
- Presenting problem
- Appropriateness RSAT program in concordance with assessment
- Expectations for treatment
- Educational background
- Family history
- Racial and ethnic background
- Age

- **Staff variables:**

- Type of training
- Education
- Professional experience
- Expectations for treatment
- Motivation for providing treatment
- Demographics (e.g., age, gender, race/ethnicity)

(Treatment) Process Evaluation

The treatment process was reviewed from three perspectives: (a) the residents, (b) the staff/administration, and (c) independent observer(s). From these perspectives, four conceptual domains were investigated (Orlinsky & Howard, 1978; DiClemente, Carroll, Connors, and Rock, 1994):

- ***Dose of treatment*** (the amount and length of sessions that the juveniles attended)
- ***With-in session treatment interventions*** (caseworker adherence and skill-level) (Hill, 1995). The caseworker adherence is a gauge of how well the caseworker adheres to, or follows, the

guidelines of the overarching Treatment Model. The skill level of a caseworker is their competence in facilitating sessions.

- ***The therapeutic relationship*** was broadly conceptualized as the sense of unity or connectedness in a group's member to member relationships and also defined as the formation of positive emotional bonds and sense of moving together toward shared goals between group members and the caseworker(s).The therapeutic relationship was investigated via focus groups and the Correctional Institutions Environment Scale (CIES). The focus groups and the CIES were administered over time and allowed for assessment of the "rupture and repair" cycle that is likely to occur in therapeutic alliances.
- ***Extratherapy events*** (DiClemente et al., 1994; Hill, 1991)(i.e., additional 12-step program involvement and disciplinary actions) were monitored and analyzed because they may enhance or detract from the treatment process. Extratherapy events occur outside of counseling while treatment is ongoing. These events can be both helpful and detrimental to the process. For example, if one of the RSAT clients attends 12-step meetings outside of the session, this is an extratherapy event that may be conducive to the process. However, some clients were excluded from some groups due to disciplinary action; this was an extratherapy event that may have been a detriment to the process.

Product (Outcome) Evaluation

The Process Evaluation was aimed to perform the context, input, and process evaluations as precursors to a future product (outcome) evaluation. The MCF-Red Wing RSAT administration plans to seek external funding to perform a subsequent outcome evaluation of the MCF-Red Wing RSAT program. Because the content, input, and process components investigate variables intimately linked to outcome evaluation, the treatment outcomes can only

be fully understood when considered in relationship to the preliminary components of content, input, and process.

Treatment processes are considered to be primary influences upon outcome results (i.e., treatment effectiveness). Because outcome results can only be fully understood in relation to the actual process of treatment, the process evaluation took into consideration a wide range of variables that have potential influence upon a subsequent outcome evaluation. Hence, the process evaluation will enhance the outcome evaluation because in addition to understanding whether or not the RSAT program met its objectives, it will aid in understanding why the objectives were met or not.

Outcome factors influencing client change expected to be evaluated in a future outcome (product) study will include: (a) criminal behavior, (b) level of alcohol and other drug abuse, (c) relapse prevention skills, (d) sociomoral reasoning, (e) social skills, (f) anger management, (g) decision making, (h) compliance with release conditions, (i) level of participation in the RSAT program, (j) strength of working alliance, (k) family relationships, (l) peer relationships, and (m) educational/vocational progress will be considered.

METHOD

Participants

Residents

Resident-participants in this study were male juvenile offenders incarcerated at the MCF-Red Wing who have been determined to have significant substance abuse problems as an aspect of their delinquency. Referral for participation in the RSAT Program is determined based on the results of the facility's substance abuse screening.

During the course of the Process Evaluation there were approximately 30 residents involved in the RSAT Program at any one time. A total of 69 residents participated in the RSAT Program during the course of evaluation. All RSAT program residents were required to participate in all aspects of the program. All residents who were at the facility at the time of the 4 focus groups participated in the focus groups. The RSAT participants had an average age of 17 years old and have various racial/ethnic backgrounds.

All MCF-Red Wing residents have been committed to the Commissioner of Corrections. Therefore, informed consent to participate in the process evaluation was obtained from the Commissioner of Corrections. Residents were informed of the nature and purpose of the process evaluation. Policies and procedures regarding confidentiality were presented to residents.

Staff

A total of four caseworkers (one resigned mid-way into the evaluation and a new caseworker was hired), one chemical dependency counselor, and two teachers (one resigned mid-way into the evaluation and a new teacher was hired) participated in all aspects of the process evaluation. Two corrections Officers participated in interviews. Ten Corrections Officers participated in the CIES administration.

Administrators

Three administrators (Program Director, Caseworker Supervisor, Substance Abuse Coordinator) participated in focus groups, interviews, and the CIES.

Additional information pertaining to the participants is included in the "input section".

Procedures

The primary investigator supervised all data collection and analyses. A systematic and objective collection of both quantitative and qualitative data was collected on a continuing basis as part of the process evaluation.

Several investigative approaches that were utilized addressed issues across all four domains (i.e., context, input, process, product): (a) individual and group interviews with staff, administrators, and residents, (b) review of documents (i.e., RSAT grant, chart reviews, program manuals, and relevant texts), (c) review of facilities, and (d) focus groups. The focus group procedures are described below There were two procedures that were domain-specific: (a) ratings of the group facilitation and (b) the administration of the Correctional Institutions Environment Scale (CIES). The procedures are described below.

Site Visits

Six site visits were conducted in: May of 1999, June of 1999, August of 1999, October of 1999, December of 1999, and in April of 2000. The first (May) site visit consisted of an orientation to the evaluation with staff and administration and review of facilities. The second (June) site visit included; (a) focus groups, (b) interviews, (c) collaborative discussion, (d) chart reviews, and (e) review of facilities. The third (August) visit included; (a) focus groups, (b) interviews, and (c) a feedback session with staff and administrators. The fourth (October) visit included; (a) focus groups, (b) interviews, (c) chart reviews, and (d) a feedback session with staff and administrators. The fifth (December) visit included; (a) focus groups (b) interviews, (c) chart reviews, (d) review of facilities, and (e) a feedback session with staff and administrators. And, the sixth (April) visit involved the presentation and collaborative feedback with staff and administrators on the findings for the final report.

Review of Facilities

The facilities were toured and reviewed during all site visits.

Review of Documents

The original grant application for implementation of the RSAT Program was reviewed at the onset of the process evaluation and reviewed periodically throughout the process evaluation. Quarterly progress reports to the RSAT funding source (NIJ) were reviewed. Program manuals and related texts were reviewed at the onset of the process evaluation and again during the middle phase of the evaluation as a new Recovery Training Model was considered and then adopted.

Resident charts were randomly selected for review at each site visit. By the end of the process evaluation all charts for RSAT residents that had been in the program during the process evaluation were reviewed.

Interviews

Semi-structured Individual interviews were conducted during the site visits. Interviews with caseworkers were conducted during the second and fourth site visits. Interviews with administrators were conducted during the first, second, fourth, and fifth site visits. Phone interviews with the Program Director were conducted between the site visits (primarily for clarification of program issues and administrative issues related to the evaluation). Brief individual interviews were conducted with 1-2 randomly selected residents during the first, second and third site visits. Phone interviews were conducted with two corrections officers following the fourth site visit.

Focus Groups

A series of four focus groups (June of 1999, August of 1999, October of 1999, and December of 1999) were held to obtain feedback throughout the evaluation. The focus groups

were aimed at obtaining a greater understanding of the staff's, residents' and administrators' expectations, perceptions, and practices regarding the RSAT program. The focus groups were designed to be iterative in that certain issues or questions might not have been originally targeted for discussion by the researchers, but arose out the focus and warranted inclusion in subsequent focus groups.

Focus Group Method

Participants

All residents in programming at the time of a particular focus group were included in the focus groups. Because of intakes and discharges there was some fluctuation in the composition of the groups over time, but the majority of the residents participated in all four focus groups. Focus groups were comprised of residents who have recently entered the RSAT program, those who were in the middle of their programming, and those residents who were exiting the program. The RSAT program is comprised of three groups of residents that stay together for all aspects of the program. The three focus groups comprised of residents were delineated by their program group. Each resident group had approximately 10 residents in each group over all four times.

The staff focus groups were comprised of the caseworkers, one teacher who facilitated the EQUIP component of the program (described in detail in next section) , and the Chemical Dependency Counselor. There were two cases of staff turnover between the second and third focus groups. One caseworker left the institution and was replaced by a caseworker from a different cottage. The teacher that was directly involved in the RSAT program left the institution and was replaced by a new teacher hired from outside the institution.

The administrator focus groups were comprised of the Program Director, Caseworker Supervisor and the Substance Abuse Coordinator. All three administrators participated in all

four focus groups. It needs to be noted that correction officers (COs) were conspicuously absent from the focus group process. In retrospect, this was a mistake in the design of the evaluation especially considering the weight given to the "security versus treatment" dichotomy (explained below). In an attempt to balance this oversight, two phone interviews were conducted to obtain CO perspectives regarding the RSAT Program. These responses were included in the results section.

Focus Group Procedures

Focus group facilitators were graduate students from the Department of Counseling and Educational Psychology at Marquette University. The three facilitators all had group-facilitation training and previous experience in group facilitation. Training regarding focus group facilitation, questions, and strategies were provided by the primary researcher. Facilitators were matched with particular groups and facilitated those groups over all four times. The primary researcher monitored all focus groups, reviewed audiotapes and provided critiques of the facilitators. In addition, debriefing sessions were conducted with all facilitators following each session.

The areas targeted for focus in the groups paralleled the overarching aims of the entire evaluation. That is, the focus areas aimed at Context, Input, Process, and Product (outcome) issues) with particular emphasis given to process and secondarily to Product (Outcome). Originally, areas of focus were determined by the aims of the grant and discussions with staff and administrators, both informally and formally through interviews and during the evaluation's orientation session. Of course, it is the nature and purpose of focus groups to be dynamic and give rise to unexpected issues and determine emphases to address. In this light, after each round of focus groups the research team identified areas to be further addressed in the following focus

group. Feedback sessions were conducted after each round including the staff and administrators (residents were not included in these feedback sessions).

Analysis of Focus Groups

All focus groups were audiotaped. Debriefing sessions including the primary researcher and the facilitators were conducted after each session. Field notes were kept and reviewed for analysis. The first round of focus group audiotapes were transcribed completely. The cost of transcription became too burdensome as the transcriptionists had great trouble in deciphering the slang and program terminology. Because of this, the primary researcher and project coordinator were required to review and retype the transcripts. Therefore it was decided that for rounds 2,3,4, a tape-based analysis including careful review of the tapes and abridged transcripts would be utilized (Krueger, 1998)

All audiotapes were reviewed independently by the primary researcher and the project coordinator. An abridged transcript was made for each group. Each researcher coded themes and issues independently. Following the independent coding, the researchers discussed the issues and themes and reached consensus regarding identification and interpretation. The results were presented to staff, administration, and selected residents for reaction to the accuracy of the results and for clarification of any issues and/or themes.

The focus groups covered a tremendous amount of topics and issues in depth and provided a wealth of information pertaining to the processes and implementation of the RSAT Program. These perceptions and recommendations are incorporated into the appropriate sections of the report.

Ratings of Facilitation of RSAT Groups

An extensive evaluation of group facilitation was undertaken. All groups were videotaped between May 1999 and September 1999. (Groups: EQUIP, Mutual Help, Recovery Training. These treatment components are described in detail in Section II.) These videotapes were shipped to Marquette University for review. All participants in the groups were considered in the rating process. The videotapes were stratified by (a) facilitator, (b) type of group, and (c) time in order to assure a representative sample of videotapes from all the groups recorded. Once the tapes were stratified videos were randomly selected for review and rating. In total, 122 videotapes were reviewed and rated. Two randomly selected raters evaluated each tape on the twenty-two item Red Wing Global Scale (developed for this evaluation). The primary components of the sessions evaluated by the rating scale involved: (a) the adherence of the facilitators to the treatment model, (b) the skill level of the facilitators, and (c) the contribution of the residents to the group processes. An analysis of the rating scale itself is presented in Appendix A.

Selection and Training of the Raters

Marquette graduate and undergraduate students were hired to perform the rating. The selection process for the raters involved a number of steps. First, raters were given a sample task of rating several of the videotapes for practice. This provided an indication of their adequacy to perform the real task and afforded them the opportunity to ask questions concerning the process. By doing so, the raters received a realistic preview of exactly what they would be doing. This did result in some self-selection by potential raters.

Second, raters were favored who gave careful attention to detail, yet were not so detailed that they could not make a decision. Third, raters were favored who asked questions and

provided valuable assistance in clarifying the concepts being used. In other words, raters who thought interactively about the issues but did not try to overturn the entire process were favored candidates. The selection process included careful attention to the following desirable characteristics of a rater: (a) dependability, (b) trustworthiness, and (c) scrupulousness.

Training of the raters was conducted to familiarize them with the model, the measures, and the process of rating videotapes. Training manuals were developed and provided for the raters to ensure a consistent format for training. As a first step in training, raters were assisted in familiarizing themselves with the texts and documents of the treatment model. Once a rater acquired an understanding of the fundamental concepts, gray areas were introduced. Raters were given individualized feedback about the categories that seemed difficult.

Following training, the raters began rating the videotapes in a progression of three rounds (each round consisting of a month). Rounds of rating were conducted in June (1999), August (1999), and October (1999). During a round, the raters would rate a total of approximately sixteen videotapes each.

The Collaborative Evolution of the Rating Scale

A rating system for evaluation of counselor's skills was generated based on an understanding of the model and feedback received from the program's administrator. From the outset of the rating process, the rating scale was viewed as a measure that would be changed and further developed as the evaluation progressed. One of the keys to the evolution of the scale involved receiving feedback from the Red Wing staff and administrators in the development and use of the scale. A feedback session was provided to the Red Wing staff following each round of ratings to both provide evaluator observations about the rating process and to receive staff input. The rationale behind this focus on collaboration was to continue to improve the scale so it would

most accurately measure the facilitator's adherence to the Red Wing model and their skill level. As the developer and user of the Red Wing model, the input of the administration and staff was crucial in providing for the most accurate understanding of exactly what adherence to the model is and what constitutes a skilled facilitator. In addition, the goal of the evaluators from the outset was to develop the rating scale as a tool that the Red Wing program can utilize (and revise) on an ongoing basis as a tool for training and supervision.

The initial version of the Global Scale utilized a Likert-type response scale and consisted of five items. One of these items is found below.

1. To what extent did the facilitator(s) remind the group of the **ground rules** for discussion?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

The rater would indicate on the scale to what extent the characteristic was present. This format was used in the first round of rating in the month of June 1999. However, an unacceptably low percentage of agreement between the raters for various items became evident following the first round. The characteristics involved in the questions were sometimes subtle and involved a complex array of variables. For example, in the above item regarding ground rules, a facilitator might use a series of verbal information and possibly visual aids to communicate this information. Although, the raters could agree on whether or not the ground rules were provided in a group, it was more difficult for them to agree on the extent to which the facilitator reminded the group of the rules. A decision was made to change the questions to measure whether or not a specific characteristic (e.g. reminding the group of the ground rules) was present in the session ("yes" or "no") rather than attempting to measure to what extent a certain characteristic was present. This change improved inter-rater consistency substantially. Furthermore, the alteration made the scale much more viable as a training and supervision tool for the facility. When

training new facilitators, the supervisor can explain to the new person each of the criteria and exactly what they would like to have happen in facilitating treatment groups. When evaluating sessions, a supervisor can use the scale and indicate whether or not the desired criterion for each question is present in the session and discuss the items with facilitators.

Because of the changes to the scale after the first (June) round of ratings and the difficulty of comparing the results from the first round (June) with those in the later two rounds (August and October), the results focus on the August and October rounds of rating.

The results from the rating scale are discussed later in section II regarding RSAT groups and in APPENDIX A. In sum, the analysis of the group videotapes indicated that the group facilitators demonstrated an appropriate adherence to the prescribed model and generally strong group facilitation skills in sessions with a few exception discussed in Section II. The findings also indicated that in group the residents demonstrated a good understanding of the program concepts and utilized these principles when they participated in the group sessions.

The Correctional Institution Environment Scale (CIES)

A treatment program's social climate can be an important factor in treatment outcomes affecting morale, program implementation, compliance, and other issues ultimately impacting treatment effectiveness (Conrad & Roberts-Gray, 1988; Moos & Lemke, 1996). Personal factors (e.g., sociodemographics of residents and staff, preferences for treatment approaches, and history with the program etc.) interact with institutional and programmatic factors (e.g.,policy/procedure guidelines, treatment philosophy, funding issues etc.) to create a social climate. Systematically assessing the social environment of a program can help staff and residents to articulate their concerns and to assist in the development a cognitive framework for understanding the program. The employment of the Correctional Institution Environment Scale (CIES) provides information

about perceptions (both staff and residents) of the program, and it encourages staff to become involved in program planning and design. The CIES is used to in developing descriptions of RSAT program dynamics, to compare resident and staff perceptions, and to assess changes in these perceptions over time.

The Correctional Institution Environment Scale (CIES) was developed to measure the social climate of correctional institutions including both adult and juvenile facilities in the normative samples (Moos, 1987). Moos proposed that three domains comprise the CIES: (a) Relationship, (b) Personal Growth, and (C) System Maintenance. The three domains are comprised of a total of nine subscales: (a) Involvement, (b) Support, (c) Expressiveness, (d) Autonomy, (e) Practical Orientation, (f) Personal Problem Orientation, (g) Order and Organization, (h) Clarity, and (i) Staff Control.

The Relationship domain subscales are: (a) Involvement, (b) Support, and (c) Expressiveness. The Involvement subscale examines the extent to which residents participate in the day-to-day functioning of the unit. The Support subscale measures to what extent the residents are encouraged to support one another and how supportive the staff is toward residents. The Expressiveness subscale measures the extent to which open expression of feelings by residents and staff is encouraged in the program.

The Personal Growth subscales are: (a) Autonomy, (b) Practical Orientation, and (c) Personal Problem Orientation. The Personal Growth dimension addresses the unit's treatment orientation (i.e., program emphases). The Autonomy subscale measures the extent of encouragement given to residents to take initiative in planning unit activities and in unit leadership. Practical Orientation and Personal Problem Orientation mirror two important treatment orientations used in correctional institutions. The Practical Orientation subscale

measures the extent to which resident's are taught practical skills and prepared for release. The Personal Problem Orientation subscale measures the degree to which Residents are encouraged to address personal issues.

The System Maintenance Dimension addresses the organizational functioning of the correctional institution. The Maintenance subscales are: (a) Order and Organization, (b) Clarity, and (c) Staff Control. The Order and Organization subscale measures the level of importance given to order and organization within the institution. The Clarity subscale measures the degree to which residents know the day-to-day expectations and explicitness of program rules and procedures. The Staff Control subscale measures the degree to which staff use measures to control residents.

There are four forms of the CIES: (a) The Real Form (Form R), (b) the Short form (Form S), (c) the Ideal Form (Form I), and (d) the Expectations Form (Form E). Form R and Form I were employed in this study.

Form R is the standard form of the CIES (all other forms are adaptations of Form R). Form R measures resident and staff perceptions of the current or "actual" climate of the program. Form I is worded to allow residents and staff to answer questions in terms of the program that they would ideally be involved with. Both forms are comprised of 90 true-false statements.

The psychometric properties of the CIES have been published by Moos (1987) and indicate adequate reliability statistics. The subscale internal consistencies (KR-20) ranged from moderate to substantial (.54-.75; mean = .66). The item-to-subscale correlations for the juvenile sample ranged from .38 (Clarity subscale-residents) to .56 (Order and Organization subscale-staff). The test-retest reliability coefficients for the subscales were all within the acceptable range

(range = .65-.80). The overall CIES profile stability was .96 for two one-month intervals and .91 for two-year interval.

The CIES is not without criticism. The factor structure of the scale has been called into question. For example, Chin (1981) identified a two-factor structure: (a) a treatment oriented factor, and (b) a control-authority factor (as reported in Moos, 1987). Also, Wright and Boudouris (1982) found the subscales to be highly inter-correlated and produced a three-factor model. However, we agree with Moos (1987) that "Factor-analytic solutions are determined both by conceptual considerations and by aspects of the sample, statistical procedures, and criteria employed" (p. 22). Indeed, the psychometric properties inure to the data and not the test itself (Thompson 1994). Considering the history of the CIES yielding reliable and valid data and that the normative samples adequately compared to the Red Wing sample, it is reasonable and informative to utilize the CIES in this study.

Subjects

Time 1 September 1999

Participants in this administration of the CIES were 28 residents of the Princeton Cottage (The cottage which housed the RSAT participants) and 12 staff (administrators, caseworkers, correction officers).

Time 2 December 1999

Participants in this administration were 25 residents of the Princeton Cottage and 10 staff (administrators, caseworkers, correction officers).

Procedure

The CIES was administered on two occasions. The first administration was conducted in September of 1999 and the second one was conducted in December of 1999. A Red Wing staff

member was appointed to administer the CIES following the guidelines described in the Correctional Institutions Environment Scale Manual: A Social Climate Scale (2nd Ed.) (Moos, 1987). The only deviation from the standard administration described in the manual was that participants were instructed not to include their names on the cover sheet in order to protect anonymity. The surveys were collected and sent to the Marquette University investigators for scoring and interpretation.

CIES Results

For Form R, the unit raw mean scores, standard deviations, and standard scores for each subscale are presented for residents and staff in Table 1 (administration time 1) and Table 2 (administration time 2). The standard scores (mean = 50, standard deviation = 10) are calculated from the raw mean scores of the normative sample. In order to allow direct comparison of the resident and staff perceptions, both the resident standard scores and the staff standard scores were calculated on the basis of the resident normative sample. A standard score of 50 indicates average social climate as compared to the national norms. Though it has been proposed that a standard score exceeding 50 indicates a relatively positive social climate and a standard score below 50 indicates a relatively negative social climate (Houston, Gibbons, & Jones, 1988), the scales must be interpreted relative to the mission of the unit. For example, it is reasonable to state that a primary goal of any correctional institution is to "control" the residents; however, some studies indicate that as staff control increases morale and adaptive behaviors decrease and as emphasis on relationships and treatment increases, morale and reports of opportunities for personal growth, self-revelation, and social contact increase (Moos, 1975; Deschner, 1980). Therefore, a relatively low score on the control subscale can be interpreted as being in

congruence (i.e., "positive") with the mission of a particular program—as is the case with the Red Wing RSAT program.

Given the small sample sizes and the fact that participants were not randomly selected (though all the residents in the Princeton cottage were selected to participate not all staff participated in the survey) there are no statistical analyses that can justifiably be employed to determine statistically significant differences between residents' and staff 's scores. Nevertheless, there does not appear to be a sampling bias as we sampled all of the cottage residents and we have a proportionate mixture of administrators, casemanagers, and correctional officers within the sample. "Statistical significance" should not be viewed as synonymous with "importance" as statistical significance is primarily driven by sample size and fraught with other pitfalls (see Cohen, 1994; Thompson 1994). Therefore, we adopted the arbitrary, but reasonable approach that differences of 10 points (one standard deviation) or more constituted important or "significant" differences between the residents and staff and over time and those differences less than 10 points were considered "not significant"(Houston, Gibbons, & Jones, 1988).

Form R Administration Time 1

The Form R profiles for the first administration at Red Wing are shown in Figure 1. Residents and staff perceived all of the domains to be above average (i.e. standard score greater than 50) except for the staff control subscale which was perceived to be of average level (resident SS = 48; staff SS = 43) relative to the normative sample.

On the Relationship dimension, both residents and staff reported above average support and expressiveness. Both residents and staff indicated well-above average involvement with the staff reporting even more resident involvement in the day to day activities of the unit.

On the Personal Growth dimensions, residents and staff reported equivalent above-average levels of autonomy (both residents and staff had a standard score of 61) and equivalent high levels of practical orientation (both residents and staff had a standard score of 71). The staff reported high levels on the personal problem orientation, while the residents reported above-average levels.

On the System Maintenance dimensions, the two groups closely agreed in rating order and organization at a high level and staff control at a low level. Both residents and staff reported the clarity (i.e., routine, rules, procedures) to be at least above average with the staff reporting very high clarity in the program routine, rules, and procedures.

Table 1. The Real Form (Form R) Results (Administration Time 1).

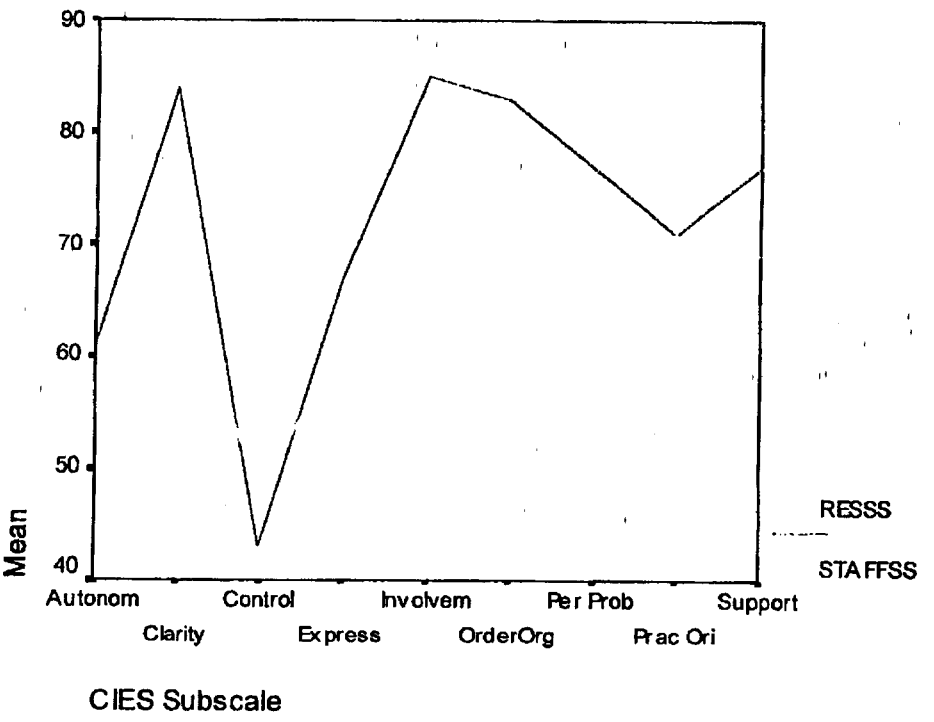
Residents N = 28 Staff N = 12

Subscales	Mean Residents	SD Residents	Std Score Residents	Std Score Staff	Mean Staff	SD Staff
Involvement (10)	7.64	2.13	**73***	**85***	9.00	1.21
Support (10)	7.39	2.28	69	77	8.58	1.31
Expressiveness (9)	5.18	1.85	61	67	5.42	1.78
Autonomy (9)	5.68	1.12	61	61	5.50	1.31
Practical Orientation (10)	8.11	1.20	71	71	8.08	1.51
Personal Problem Orientation (9)	5.75	1.92	**66***	**77***	6.83	1.03
Order & Organization (10)	8.18	1.85	79	83	8.67	1.50
Clarity (10)	7.18	1.85	**69***	**84***	8.33	1.15
Staff Control (9)	5.71	1.18	48	43	5.33	1.83

Note. Bolded * indicates standard score difference between residents and staff equal to or greater than 10.

Figure 1. Real Form (Form R) Standard Scores (Administration Time 1).

(Residents N=28, Staff N=12)



Administration Time 2 (Form R)

The results from the second administration of Form R closely parallel the results from the first administration with a few exceptions. The results are shown in Table 2 and Figure 1. In the second administration, residents and staff reported all of the domains to be above average (i.e. standard score greater than 50) except for the staff control subscale which was perceived to be of average level (resident SS = 48; staff SS = 43) relative to the normative sample.

On the Relationship dimension, both residents and staff reported above average expressiveness. Both residents and staff indicated well-above average support and involvement. Although, unlike the first administration, residents reported a higher score on the involvement subscale than did staff. On the Personal Growth dimensions, residents and staff differed in their perceptions of autonomy in the unit with staff reporting average levels and residents reporting above average levels. Residents and staff agreed that Practical Orientation and Personal Problem Orientation were, at least, above average.

On the System Maintenance dimensions, the two groups agreed in rating the Order and Organization subscale and the Clarity subscale at high levels. The staff and residents were consistent relative to the first administration in scoring the Staff Control subscale as average.

Table 2. The Real Form (Form R) Results (Administration Time 2).

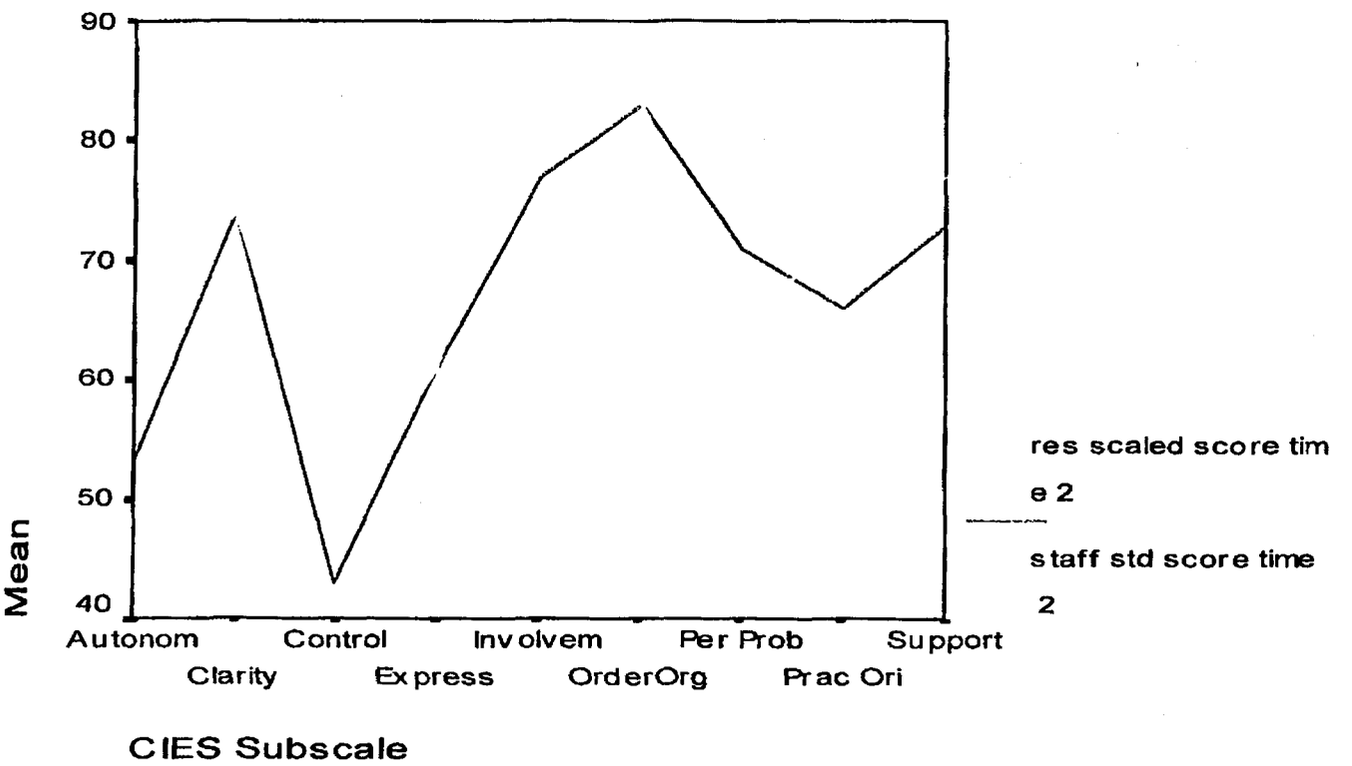
Residents N = 25 Staff N = 10

Subscales	Mean (Resident)	SD (Residents)	Std Score Residents	Std Score Staff	Mean (Staff)	SD (Staff)
Involvement (10)	9.04	1.06	85	77	7.90	1.79
Support (10)	8.56	1.36	77	73	7.90	2.02
Expressiveness (9)	5.16	1.60	61	61	4.80	1.14
Autonomy (9)	5.84	1.40	**65***	**53***	4.70	1.49
Practical Orientation (10)	7.92	1.08	71	66	7.30	2.00
Personal Problem Orientation (9)	5.76	1.30	66	71	6.70	1.95
Order & Organization (10)	8.32	1.57	83	83	8.60	1.35
Clarity (10)	7.52	1.58	74	74	7.30	1.42
Staff Control (9)	5.96	1.46	48	43	5.50	1.84

Note. Bolded * indicates standard score difference between residents and staff equal to or greater than 10.

Figure 2. Real Form (Form R) Standard Scores (Administration Time 2).

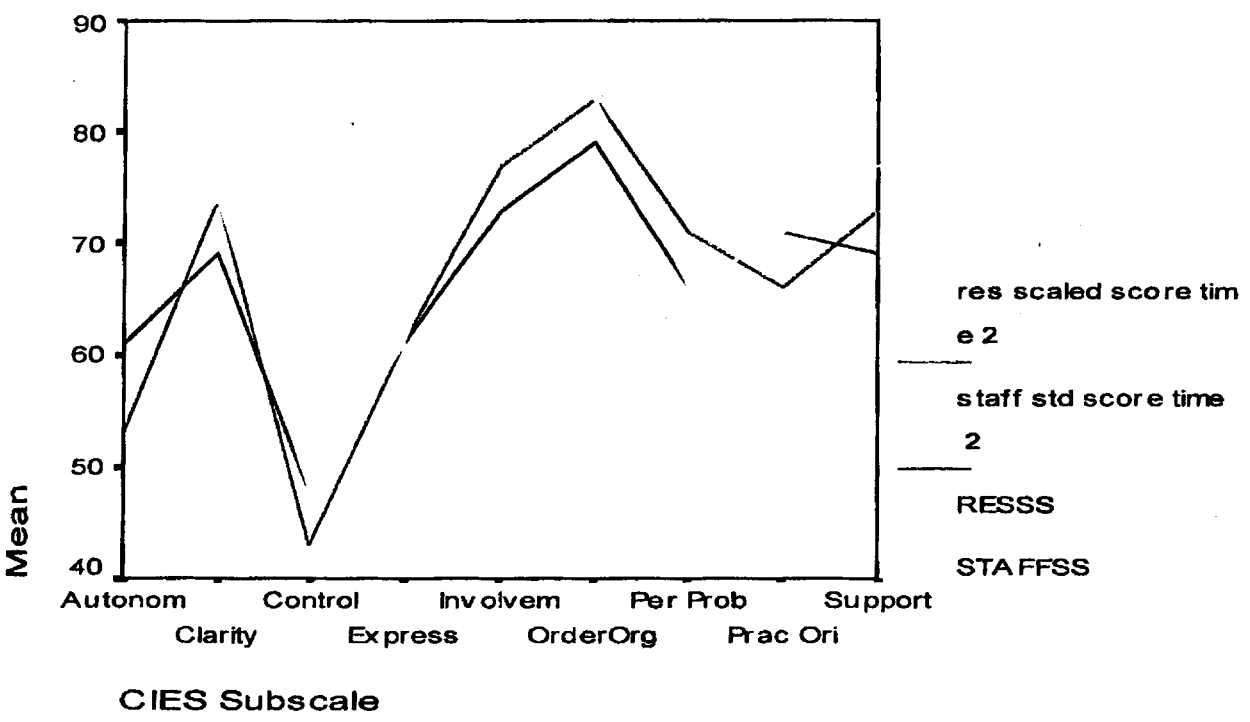
(Residents N=25, Staff N=10)



Form R (Administration Times 1 and 2)

The scores for the residents and staff were remarkably consistent over the administration times (see Figure 3). However there were some differences over time. In the first administration, residents and staff differed most in their assessment of involvement, personal problem orientation and clarity. Staff rated these three subscales higher by over ten points as compared to residents. At administration time 2 these three subscales were basically rated equivalent by residents and staff. Also in the first administration, the two groups agreed precisely on autonomy and practical orientation. However, in the second administration, the resident and staff scores differed most in autonomy (the residents scored 12 points higher than staff) and basically agrees on the ratings of the other subscales.

Figure 3. Real Form (Form R) Standard Scores (Administration Time 1 and Time 2).



Ideal Form

The Ideal Form (Form I) profiles for the first administration and second administration are presented in Tables 3 and 4. Mean raw scores are reported in both tables. Respondents answer Form I in terms of the "ideal program". These responses can then be compared to the Real Form responses to assess the congruence between the "real' program and the "ideal' program.

In general, the staff placed more emphasis on all CIES domains as compared to the residents with the exception of the "Expressiveness", Autonomy", and "Staff Control" subscales where staff and residents were congruent in their responses (i.e., differences between mean scores less than one). Staff place more emphasis on involvement, support, practical orientation, personal problem orientation, order and organization, and clarity than did the residents. However, both residents and staff appear to value all the domains (as indicated by the relatively high raw mean scores across all subscales) with "staff control" being given the least weight relative to the other scales.

The mean scores of the staff and the residents in the second administration were even more closely related as staff and residents generally agreed on the emphases across all subscales except for the "Personal Problem Orientation" subscale. The staff desired a greater emphasis on Personal Problem Orientation as compared to the residents. Again, there is general agreement across the subscales including agreement in relatively moderate level of "staff control".

Table 3. The Ideal Form (Form I) results (Administration Time 1).

Residents N = 28 Staff N = 12

Subscales	Mean (Resident)	SD (Residents)	Mean (Staff)	SD (Staff)
Involvement (10)	8.67	1.88	9.64	.67
Support (10)	7.38	2.10	9.55	.691
Expressiveness (9)	6.00	2.48	6.82	1.78
Autonomy (9)	6.04	1.49	6.73	1.01
Practical Orientation (10)	7.71	1.81	9.18	.60
Personal Problem Orientation (9)	5.83	2.01	7.64	1.21
Order & Organization (10)	7.87	2.25	9.36	.920
Clarity (10)	7.17	1.99	8.73	1.42
Staff Control (9)	4.79	1.96	5.00	2.00

Table 4. The Ideal Form (Form I) Results (Administration Time 2).

Residents N = 25 Staff N = 10

Subscales	Mean (Resident)	SD (Residents)	Mean (Staff)	SD (Staff)
Involvement (10)	8.92	1.47	9.33	.87
Support (10)	8.62	1.55	9.11	1.96
Expressiveness (9)	6.15	1.89	6.33	1.22
Autonomy (9)	6.42	1.50	6.65	1.67
Practical Orientation (10)	8.23	1.39	8.44	1.33
Personal Problem Orientation (9)	5.92	1.90	7.67	1.41
Order & Organization (10)	8.50	2.00	8.44	2.65
Clarity (10)	8.12	1.56	8.00	1.32
Staff Control (9)	5.77	1.75	4.89	1.69

Real Form-Ideal Form Discrepancies

The Real Form-Ideal Form discrepancies indicate changes residents and staff at Red Wing would make to improve the current program. The amount of change desired is calculated by subtracting the mean score on Form R from the mean score on Form I for each subscale. When the ideal score is higher than the real score, a positive number is obtained, indicating that respondents would like to see an increase in that area. A negative number indicates that respondents would like to see less emphasis in that area. If the ideal score is the same as the real score, the difference is 0, indicating that no change is desired. We deemed it reasonable to adopt the arbitrary rule that discrepancies of less than plus or minus one point are considered to be zero difference.

In the first administration there is remarkable satisfaction with the current program as indicated by the small discrepancy scores. Staff did indicate a desire to see moderate increases in emphasis in expressiveness, autonomy, and practical orientation.

In the second administration there was, again, a high level of satisfaction with the current program as indicated by the small discrepancy scores. As in time 1, the staff desired increased emphasis in expressiveness and practical orientation. However, there was some difference in staff desired emphases as compared to time 1 as staff desired improvements in involvement and support, but appeared satisfied with the level of autonomy as compared to time 1. Residents appear to be very satisfied with the program in terms of the CIES subscales as indicated by near-zero discrepancy scores across all the subscales. Tables 5 and 6 depict the Real Form-Ideal Form discrepancies for administration times 1 and 2 respectively.

Table 5. Real-Ideal Program Discrepancies as Perceived by Residents and Staff (Administration Time 1).

Discrepancies	Residents (N=28)	Staff (N=12)
Involvement (10)	-0.12	0.64
Support (10)	-0.30	0.97
Expressiveness (9)	0.99	1.40
Autonomy (9)	0.58	1.23
Practical Orientation (10)	0.31	1.10
Personal Problem Orientation (9)	0.16	0.81
Order & Organization (10)	0.18	0.69
Clarity (10)	0.60	0.40
Staff Control (9)	-0.19	-0.33

Table 6. Real-Ideal Program Discrepancies as Perceived by Residents and Staff (Administration Time 2).

Discrepancies	Residents (N=25)	Staff (N=10)
Involvement (10)	-0.12	1.43
Support (10)	-0.30	1.21
Expressiveness (9)	0.99	1.53
Autonomy (9)	0.58	0.58
Practical Orientation (10)	0.31	1.14
Personal Problem Orientation (9)	0.16	0.97
Order & Organization (10)	0.18	-0.16
Clarity (10)	0.60	0.70
Staff Control (9)	-0.19	-0.61

Overall, the CIES scores indicated a very positive social climate. The Real form scores of both the residents and staff show a strong congruence between perceptions of the program and the elements of an effective therapeutic community (Melnick, & De Leon, 1999). That is, all the subscale scores were at least above average or greater except for the staff control subscale, which was rated as average. There was remarkable consistency between staff and residents and over time on regard to all the CIES subscales. There is impressive consistency between the Real Forms and the Ideal forms of the CIES indicating strong support for the current program. Implications and conclusions are discussed further in Section II.

SECTION II

THE MINNESOTA CORRECTIONAL FACILITY-RED WING RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

Background Information Re: Residential Substance Abuse Treatment Program

Providing substance abuse treatment services to incarcerated offenders is an important part of a logical national approach to effectively decrease drug use and crime. As noted in the *National Drug Control Strategy,* "Drug treatment in the criminal justice setting can decrease drug use and criminal activity, reduce recidivism, while improving overall health and social conditions." (McCaffrey, *1997).* Adolescent increase in drug use prolongs involvement in delinquent behavior. The Office of Juvenile Justice and Delinquency Prevention reported in the *Juvenile Offenders and Victims: A National Report* that, "Generally the more serious a youth's involvement in delinquency, the more serious his or her involvement is with drugs. Changes in drug use have been shown to produce large changes in delinquent behavior ... increases in substance abuse may lead to increases in delinquent behavior" (Snyder 1995).

Surveys and other research supported the need for this program in Minnesota. For example, *The Minnesota Department of Corrections Juvenile Needs Assessment Survey* was conducted in 1997 by the Juvenile Services/Legislative Relations Division and the Office of Planning and Research. This survey included a large cross-section of professionals in the criminal justice system and clearly demonstrated a need for an increase in chemical dependency treatment services in Minnesota State facilities. A study conducted by the Robert F. Kennedy Foundation found that 67.8% (158) of the adolescents placed in the two Minnesota state juvenile facilities had substance abuse problems (*Risk Profile of Minnesota Youth*, 1996). The *1995 Minnesota Student Survey - Juvenile Correctional Facilities* compared adolescents in the state correctional institutions to students in regular public schools throughout the state. This study revealed that the families of adolescents in state correctional facilities were three times more likely to experience substance abuse problems than the families of children from public schools. In addition, the survey found that, "They (adolescents in correctional institutions) were one and one-half times more likely to use alcohol, two times more likely to use opiates, three times more likely to use marijuana and amphetamines, and three and one-half to five times more likely to use other types of drugs" (Harrison, 1996). This information clearly supported the need to increase and enhance the substance abuse treatment services for juvenile offenders being admitted to state correctional facilities. Therefore, the residential substance abuse treatment program (RSAT) was established at MCF-Red Wing to address the needs of the serious and chronic juvenile offenders who were also determined to have significant substance abuse problems.

Overview of the Facility

Constructed in 1889, the Minnesota Correctional Facility-Red Wing (MCF-Red Wing), Red Wing, Minnesota, is a state operated fenced facility for male, juvenile offenders. The campus

encompasses 200 acres and is comprised of various administrative and operations buildings, a chapel, 3-two story living units, 5-single floor cottages, and one security cottage. The facility employs a staff of approximately 180.

The MCF-Red Wing is designed to provide services to serious and chronic, male juvenile offenders who have been committed to the Commissioner of Corrections as a result of having been determined by the county courts to be inappropriate or unamenable candidates for local corrections programs because of the seriousness of their offense or the chronicity of their offense history. The serious offenders are identified as those who have committed offenses which if committed as an adult would result in a sentence of imprisonment. The chronic offenders are identified as those offenders who have at least two prior felonies and have experienced a previous residential correctional program placement of at least ninety days.

Programming components include counseling, work programs, recreation and leisure (intramural sports, challenge course, team building, and community service activities), religious services, and volunteer services. Special needs services include substance abuse assessment and treatment, sex offender counseling, psychological and psychiatric evaluation, psychotherapy, abuse victims counseling, grief groups, and effective fathering classes. All residents attend education classes for six hours each day. Students are able to earn a high school diploma or GED certification.

Residents are assigned to four general population housing units with a capacity of 26 residents per unit. Residents are assigned to peer groups within each unit. These peer groups consist of approximately 9 members. While there are common living areas, residents attend school and participate in counseling, recreation, and work activities only with members of their assigned peer group.

The average daily population of the facility is 113 juveniles. The average age of the residents of the facility is approximately seventeen years old and includes juveniles from various racial/ethnic backgrounds.

Residential Substance Abuse Treatment Program

In May 1998, the MCF-Red Wing received funds granted by the National Institute of Justice to establish and implement a Residential Substance Abuse Treatment (RSAT) Program within the Prepare Program.

The Prepare Program

In 1997, the facility designated two of the general population living units as the housing units for the most serious and chronic juvenile offenders. A program designated as the Prepare Program was designed and implemented to meet the needs of these residents. Residents assigned to the Prepare Program participate in a school-to-work academic/vocational program designed to provide them with academic and work-related skills. Prepare emphasizes enhanced vocational training offered in printing, food service, graphic arts, and building trades. Additional activities include career exploration, independent living skills, and work skill preparation.

The Prepare Program is a longer-term program as compared to the general population of MCF-Red Wing and includes three phases. The first consists of residential programming at the facility during which residents are expected to complete cognitive/ behavioral, academic/vocational, special needs, and aftercare planning goals. The length of stay in the first phase is a minimum of nine months. This is followed by a three-month aftercare/transition program during which the residents remain under the jurisdiction of the facility while participating in structured residential community-based placements. The final phase of the program consists of six months of intensive supervision in the community.

The RSAT program is dedicated to one housing unit-the Princeton Cottage. The RSAT treatment model is an integration of the EQUIP model, the Prepare Program, the Principles of Daily Living and the Recovery Training. These program components are described in more detail below. These components are implemented through individual, group, and psycho-educational modalities

and aim to assist juveniles in developing, implementing, and maintaining pro-social skills and behaviors and recovery from alcohol and other drug abuse. The combination of these components is a unique integration in the field of juvenile corrections.

The RSAT is designed to function from a team approach. The RSAT staff include:

1. Caseworkers assigned to each treatment group. Duties include: treatment planning, group facilitation, individual counseling, and record keeping.
2. Corrections officers assigned to the cottage. Duties include: security, cottage management, and program support.
3. Chemical dependency counselor assigned to RSAT. Duties include: substance abuse assessment, treatment planning, education, group facilitation, and individual counseling.
4. Teacher from general education program. Duties include: facilitating psychoeducation groups.
5. Supervisor of Casemanagers
6. Supervisor of AODA counselor
7. Program Director
8. Consulting psychologist and psychiatrist.

The following table (Table 7) provides the job position title, date that employment began at Red Wing, and the educational background of the program staff (as of March 30, 2000).

Table 7. RSAT Staff

NAME	TITLE	DATE OF EMPLOYMENT	EDUCATION/DEGRE MAJORS
Anderson, Thomas	Corrections Officer 2	7-1-97	BS in Youth Work Cert. Prof. Peace Offic
Berry, Juan	Corrections Officer 2	3-29-96	2 yrs. Post Secondary Hum.Relat./Criminolo
Baker, Darnell	Corrections Therapist 1 AODA Counselor	3-18-98	2 yrs. Post Secondary Chemical Dependency
Crisp, Thomas	Corrections Lieutenant Caseworker Supervisor	9-22-93	BS in Sociology AA Corrections
Courtier, David	Corrections Officer 2	12-18-86	BS in Social Studies
Davis, Tim	Corrections Officer 2	9-11-98	1 yr. Post Secondary Liberal Arts
Hall, Joette	Corrections Security Caseworker	9-16-98	2 yrs Secondary CD Counseling and Corrections Sociology
Handy, John	Correction Juvenile Program Director	2-15-70	MA Sociology/Corrections
Johnston, Genevieve	Corrections Security Caseworker	1-19-2000 (RW) 5-9-91 (State of MN)	BS in Human Services Minor/CD Counseling
Larson, Steven	Corrections Program Therapist 2 (AODA)	11-13-96	Cert. of Chemical Dep. Family Treatment and MN Dept. Health License – 2 yrs + Post Secondary Education
Maclin, Pen	Corrections Officer 3	8-19-98	6 yrs. Post Secondary Ed. - Speech Communications, Sociology and Law Enforcement
Poliachik, Michael	Corrections Security Caseworker	10-15-97	BS in Criminal Justice plus 2 yrs. Post Secondary Education
Sperl, Brian	Corrections Officer 2	11-10-95	BA in Corrections Working on MA
Velander, Sarah	Corrections Officer 2	2-19-99	BA in Psychology Minor in Biology
Vikdal, Monty	Corrections Security Caseworker	9-16-98	BA in Criminal Sociology AA General Studies

Selection and Assessment of RSAT Program Participants

Participants must be committed to the State Commissioner of Corrections and subsequently placed at MCF-Red Wing. Participants must meet admission criteria for the Prepare Program. Residents meeting these criteria undergo an assessment that includes assessment of need for substance abuse treatment.

The RSAT Program participants come from diverse counties throughout Minnesota, but the majority of participants are from the Twin Cities metropolitan area. The participants collectively have committed a wide array of crimes as indicated in Table 1. Although the Minnesota juvenile crime rate is below the national average, the Minnesota rates have increased in recent years (Office of the Legislative Auditor, 1995). In addition, the MCF-Red Wing is the "last stop" for juveniles in Minnesota, thus the MCF-Red Wing clientele tend to be the "difficult to treat" offenders. This must be kept in mind when evaluating treatment effectiveness and comparison to other treatment programs. Table 8 provides information regarding RSAT participant's county of commitment, aftercare placement and criminal offense (information as of March 30, 2000).

Table 8. RSAT Resident County of Commitment, Aftercare Placement, Offense

Resident	County of Commit	Placement/Aftercare	Offense
A	Stearns	Discharged to Adult Authorities (no placement)	Unauthorized Use of a Motor Vehicle
B	Ramsey	Woodward Academy – Woodward, Iowa	Criminal Sexual Conduct 3rd Degree
C	St. Louis	Discharged to Adult Authorities (no placement)	

D	Douglas	Vanderhouse – Moorhead, MN	Burglary 2nd Degree
E	Isanti	Discharged to Adult Authorities (no placement)	Unauthorized Use of a Motor Vehicle, Assault 4th Degree, Tampering
F	Mille Lacs	Aurora Four Winds Lodge – Brainerd, MN	Assault 2nd Degree
G	LeSueur	Discharged to Adult Authorities (no placement)	Theft of a Motor Vehicle, Burglary 3rd Degree
H	Dakota	R-Home – Cottage Grove, MN	Aggravated Robbery, Burglary 2nd Degree
I	Hubbard	TNT House – Grand Rapids, MN	Aggravated Robbery
J	Scott	Mother - Belle Plaine, MN	Burglary 3rd Degree, Escape from Custody
K	Hennepin	S.T.E.P. – Victoria, MN	Theft
L	Chisago	Mother - Chisago City, MN	Unauthorized Use of a Motor Vehicle (2 counts)
M	Beltrami	Independent Living – Bemidji, MN	Felony Incest
N	Hennepin	Hearthstone – Eagan, MN	Aggravated Robbery
O	Clay	Vanderhouse – Moorhead, MN	3rd Degree Assault
P	Itasca	Foster Home – Stacey, MN	2nd Degree Murder
Q	Dakota	Second Chance Ranch- Ham Lake, MN	2nd Degree Assault
R	Hennepin	Father – Las Vegas, NV	Possession of Pistol
S	Hennepin	Independent Living – St. Paul, MN	Aggravated Robbery
T	Faribault	Mother – Austin, MN	1st Degree Burglary
U	Hennepin	S.T.E.P. – Victoria, MN	3rd Degree Assault
V	Martin	Mother – Fairmont, MN	Criminal Sexual Conduct
W	Hennepin	Currently at MCF-RW	1st Degree Burglary
X	Cass	Port Group Home – Brainerd, MN	Unauthorized Use of a Motor Vehicle
Y	Mahnomen	Mother – Naytahwaush, MN	Possession of Explosives

Z	Hennepin	Currently at MCF-RW	Felony Property Damage
A2	Wright	Foster home – Rice, MN	1st Degree Burglary
B2	Hennepin	S.T.E.P. – Victoria, MN	3rd Degree Assault
C2	Federal	Currently at MCF-RW	
D2	Meeker	Father – Atwater, MN	2nd Degree Burglary
E2	Clay	Mother – Moorhead, MN	2nd Degree Assault with a knife
F2	Benton	Foster home – Swan River, MN	1st Degree Burglary
G2	Hennepin	After Today Group Home – Minneapolis, MN	Control Substance 3rd Degree
H2	Ramsey	Bob Lawrence Group Home – St. Paul, MN	Terroristic Threats
I2	Ramsey	Aunt – Cumberland, WI	Unauthorized Use of a Motor Vehicle
J2	Le Sueur	Mom – Kilkenny, MN	Unauthorized Use of a Motor Vehicle
K2	Hennepin	Currently at MCF-RW	2nd Degree Assault
L2	Hennepin	Mother – Minneapolis, MN	Aggravated Robbery
M2	Redwood	House of Hope – Mankato, MN	Simple Robbery
N2	Pennington	Foster home – Bovey, MN	3rd Degree Robbery
O2	Federal	Currently at MCF-RW	
P2	Hennepin/ Ramsey	Jerry Root Group Home – St. Paul, MN	Possession of Pistol
Q2	Scott	R-Home – Cottage Grove, MN	Aggravated Robbery 1st Degree
R2	Hennepin	Currently at MCF-RW	
S2	Chisago	Currently at MCF-RW	Possession of Stolen Property
T2	Hennepin	Currently at MCF-RW	Simple Robbery
U2	Clay	Currently at MCF-RW	Stolen Property
V2	Hennepin	Mother – Minneapolis, MN	Possession of Controlled Substance
W2	Hennepin	Currently at MCF-RW	Probation Violation

X2	Hennepin	Currently at MCF-RW	Escape from Custody
Y2	Hennepin	Currently at MCF-RW	Escape (fleeing an officer)
Z2	Hennepin	Currently at MCF-RW	2nd Degree Burglary
A3	Hennepin	Currently at Goodhue County Court	Theft (over $500)
B3	Benton	Currently at MCF-RW	Theft of Motor Vehicle
C3	Nicollet	Currently at MCF-RW	2nd Degree Assault
D3	Olmsted	Currently at MCF-RW	Possession of Stolen Property
E3	Federal	Currently at MCF-RW	
F3	Hennepin	Currently at MCF-RW	Escape from Peace Officer
G3	Federal	Currently at MCF-RW	
H3	Wright	Currently at MCF-RW	3rd Degree Burglary
I3	Blue Earth	Currently at MCF-RW	Theft of Motor Vehicle
J3	Hennepin	Discharged by Expiration (no placement)	5th Degree Assault, Aggravated Robbery
K3	Hennepin	Aunt – Brooklyn Park, MN	Unauthorized Use of a Motor Vehicle
L3	Hennepin	Mother- Minneapolis, MN	False Name to Police, Burglary 1st Degree
M3	Ramsey	Discharged to Adult Authorities (no placement)	Assault 3rd Degree, Assault 4th Degree
N3	Ramsey	Discharged by Expiration (no placement)	Possession of Pistol
O3	Federal	Discharged to Other Authority: Intermountain Youth Center – Santa Fe, NM	
P3	Cass	Evergreen House – Bemidji, MN	1st Degree Arson, Theft of a Motor Vehicle
Q3	Hennepin	Grandmother – Minneapolis, MN	Sale of a Controlled Substance

RSAT Residents - Assessment

The initial assessment process for program participants includes collecting demographic information and social history (including offense and placement). In addition the following tests are administered and evaluated: the Substance Use Screening; the Substance Use Disorders Diagnostic Schedule (SUDDS), the Drug and Alcohol Abuse Normative Evaluation System (DAANES); and the Recovery Attitude and Treatment Evaluator (RAATE). A psychological evaluation utilizing the Minnesota Multi-Phasic Personality Inventory-Adolescent (MMPI-A), the Shipley-Hartford Scale, and the Sentence Completion Test are also completed.

RSAT participants tend to have a history of polysubstance abuse and co-occurring psychiatric disorders are not uncommon. These profiles are likely similar to other treatment populations within correctional facilities although little empirical data exist in regard to prevalence of alcohol, drug and mental (ADM) disorders in juvenile justice systems (Linda A. Teplin, Ph.D. Director of Psycho-Legal Studies at Northwestern University Medical School is currently conducting the first large-scale longitudinal study of ADM disorders among juvenile detainees). Table 9 provides the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) (DSM-IV) (American Psychiatric Association, 1994) diagnoses for the residents in the program or who are on extended furlough in spring 2000.

Table 9. RSAT Residents - DSM IV Diagnoses.

RESIDENT	DSM-IV (Substance Abuse Diagnosis)	DSM-IV (Other Diagnosis)
1	Psychoactive Substance Use Disorder, Cannabis Dependence	
2	Adolescent Onset Type-Severe Alcohol Abuse by history, Cannabis Abuse by history	Conduct Disorder, Major Depressive Disorder-Single Episode by history
3	Alcohol Abuse	Major Depressive Disorder- recurrent, mild,

		Attention Deficit/Hyperactivity Disorder, combined type by history
4	Psychoactive Substance Use Disorder, Alcohol Abuse, Cannabis Abuse	
5	Alcohol Dependence, Cannabis Dependence	
6	Psychoactive Substance Use Disorder, Cannabis Abuse	
7	Psychoactive Substance Use Disorder, Alcohol Abuse, Cannabis Abuse	
8	Alcohol Abuse, Cannabis Abuse	Alcohol Abuse, Cannabis Abuse
9	Cannabis Dependence	Cannabis Dependence
10	Rule Out Cannabis Abuse, Rule Out Alcohol Abuse	Attention Deficit/Hyperactivity Disorder by history, Conduct Disorder
11	Substance Abuse by history, Rule Out Polysubstance Disorder, Rule Out Substance –Induced Persisting Dementia	Dysthymia, Conduct Disorder, Rule Out Dementia Due to Head Trauma
12	Cannabis Abuse, Rule Out Cannabis Dependence, Alcohol Abuse, Rule Out Alcohol Abuse,	Impulse Control Disorder, NOS, Rule Out Dysthymia
13	Polysubstance Abuse-Provisional	Conduct Disorder, Rule Out Attention Deficit/Hyperactivity Disorder, Learning Disability NOS
14	Psychological Evaluation has not been completed at this time.	Psychological Evaluation has not been completed at this time.
15	Psychoactive Substance Abuse Disorder, Alcohol Abuse, Cannabis Abuse	
16	Psychological Evaluation has not been completed at this time.	Psychological Evaluation has not been completed at this time.
17	Cannabis Dependence, Alcohol Abuse	Bipolar Disorder, Mixed-Currently More Depressed, Post Traumatic Stress Disorder, Conduct Disorder, Childhood Onset-Severe,
18	Cannabis Abuse, Inhalant Abuse, Rule Out Substance Dependence	Conduct Disorder, Parent/Child Relational Problem,
19		Conduct Disorder, Adolescent Onset Type-Severe, Attention Deficit/Hyperactivity Disorder-

		Provisional, Encropresis
20	Cannabis Abuse, Alcohol Abuse	Major Depressive Disorder-In Partial Remission, Disruptive Behavior Disorder NOS
21	Psychoactive Substance Use Disorder, Alcohol Abuse-In Possible Remission, Cannabis Abuse	
22	Alcohol and Cannabis Abuse-In Full Remission	Post-Traumatic Stress Disorder, Conduct Disorder, Depressive Disorder Not Otherwise Specified, History of Schizoaffective Disorder
23	Alcohol Dependence, Mixed Substance Abuse	
24	Psychoactive Substance Use Disorder, Alcohol Dependence, Cannabis Dependence, Polysubstance Dependence	
25	Psychoactive Substance Use Disorder, Alcohol Dependence, Cannabis Dependence	
26	Psychoactive Substance Use Disorder, Alcohol Abuse (Rule out dependence), Cannabis Abuse (Rule out dependence)	

Evaluation of Intake and Assessment Procedures

The intake and assessment procedures were viewed to be thorough and appropriate for the clientele. The chemical dependency workers were more satisfied with the measures and procedures as they were more involved and well-versed in the matters as compared to the caseworkers. Both the psychological reports and the AODA assessments were viewed, by the caseworkers, to be disconnected from the rest of the program. That is, either the results were not readily available to the caseworkers or the results of the assessments were not viewed as "user-friendly" and thus were not incorporated into treatment plans or strategies to use with the residents.

Focus Group Responses regarding Intake and Assessment:

- "Residents often don't grasp why they are in Red Wing—especially acceptance of substance abuse problems. Assessment information has the potential to be used educatively and therapeutically with residents."
- Caseworkers tend to be disconnected from the intake information. Brief narratives of assessments may be useful to caseworkers.
- "Some assessments strike me as a statement of the obvious. They do not provide a solution to the best way to respond to the psychopathology".
- The lack of a full time psychologist and psychiatrist (cited as barrier to optimal programming by facilitators)
- "One of the ways to enhance the LSI is to make sure you have good collateral information. We are looking at other assessments that will make us more accurate in our level of services inventory estimates. I think that will help."

Recommendations Regarding Assessment Procedures

The RSAT Program intake utilized the computer-assisted version of the Substance Use Disorder Diagnosis Schedule (SUDDS). The SUDDS is a useful and efficient tool for assisting in diagnosing substance use disorders (Davis, Hoffman Morse & Luehr, 1992; Murphy& Impara, 1996). However, this original version of the SUDDS is targeted at adults and is aimed at the now outdated Diagnostic and Statistical Manual of Mental Disorders (Third Edition Revised) (American Psychiatric Association, 1987). A new version of the SUDDS is available and is aimed at the diagnostic criteria of The Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) (American Psychiatric Association, 1994).

- The updated version of the SUDDS should be employed. However, The SUDDS has not been normed on adolescents and the availability of reliability and validity studies is limited. Therefore, the interpretation of the SUDDS' results should be made with caution and not in lieu of clinical interview and review of records.

The Recovery Attitude and Treatment Evaluator (RAATE) was developed to assess five key dimensions (resistance to treatment, resistance to continuing care, acuity of biomedical problems, acuity of psychiatric problems, supportiveness of social environment) and can used to assist in treatment planning and determining appropriate level of care and can be effectively employed to monitor progress in treatment (Smith, Hoffman, & Nederhoed, 1992). The RAATE is underutilized by the RSAT in ongoing treatment planning and monitoring residents' progress through treatment.

- The chemical dependency workers need to provide training and consultation to the caseworkers to improve utilization of the RAATE.
- The RAATE should be employed with caution with the RSAT residents as it has not been normed on incarcerated adolescents nor with adolescents in general. This is not to say that the RAATE should not be used, but the limitations need to be realized and the continued use needs to be with close supervision and scrutiny. Reliability and validity studies regarding the RAATE with this population should be undertaken.

The assessment measures associated with the Equip Program (Sociomoral Reasoning Self-Reflection Questionnaire, and the Inventory of Adolescent Problems-Short Form) were administered as a matter of course during the initial phase of this evaluation. However, currently these measures are being administered sporadically.

- Because these measures are vital to any subsequent outcome study allowing for comparison of pre-treatment and post-treatment status the consistent and standard administration of these measures is necessary.
- Per teacher and caseworker report, many of the residents have low-grade reading levels and this impedes residents' progress within the program. Caseworkers and residents would benefit from consultation with the psychologist and teachers regarding residents' reading abilities, cognitive functioning, and learning styles.

As can be seen in Table 9 there is a significant amount of co-occurring substance disorders and other psychiatric disorders. Though the RSAT program is not designed to be a mental health unit, by default psychiatric issues other than substance abuse must be addressed.

- The psychologist needs to directly involved in case supervision and consultation to help the RSAT staff adequately address co-occurring disorders. In general, the program would benefit from regular consultation meetings (ideally at least every other week) between the psychologist, chemical dependency workers, and the caseworkers regarding diagnosis, treatment planning, and intervention strategies. This would provide the forum for connecting the intake information to the main program elements and ongoing case consultation.

RSAT PROGRAM COMPONENTS

Resident Orientation to RSAT Program

Initially, the resident orientation to the RSAT program was viewed as a weakness in the program. The residents perceived the orientation to take place primarily through fellow residents and observing others in group. This was problematic in that there was much confusion around procedures, concepts, and terminology.

In October of 1999, a new orientation process was implemented aimed at orienting all residents to the new recovery training model and new residents to the entire RSAT Program. Initially there was a heavy caseload in the orientation as "older'" residents needed to be oriented to the new components. It was projected that the number of residents participating in orientation at any given time would diminish as current residents no longer needed the orientation. The orientation is given very early upon a resident's admission to the RSAT Program and is aimed at introducing program concepts and procedures and answering resident questions and concerns. The new orientation process was well received by residents, staff, and administrators.

Therapeutic Community Approach

The RSAT program incorporates elements of Therapeutic Communities. Studies have demonstrated that the therapeutic community (TC) treatment is an effective approach in combating drug abuse for clients who remain in treatment (Melnick, & De Leon, 1999). The Therapeutic Communities of America (TCA) utilize six extensive domains to outline the characteristics of a TC (Melnick, & De Leon, 1999). Grouping these criteria in larger categories results in three primary characteristics that contribute to a TC. The first of these components consists of de-emphasizing the distinction between the staff and resident in the treatment setting (Kennard, 1998). This involves delegating to the residents some of the responsibility of making decisions and helping one another in the treatment process, as reflected in the philosophy of the positive peer culture (Vorrath & Bendtro, 1974).

The second characteristic of a TC is an emphasis on group sessions (Kennard, 1998). In the group context, residents can use these meetings to apply the principles of the treatment program in the context of a group. They also have the opportunity to develop an alliance and

practice leadership in the group with their peers, as well as learn how to apply program principles outside of the group setting.

The third crucial characteristic of a TC consists of bringing staff and residents into contact with people from outside the community (Kennard, 1998). In a correction facility, this exposure is limited due to the nature of facility. However, there are opportunities for residents to meet with family, job recruiters, twelve-step members, and religious groups who have interactions with the residents.

The Equip Program

The Equip program is designed to meet the needs of seriously antisocial youth who typically exhibit cognitive distortions, delayed moral reasoning, and deficiencies in social skills related to their delinquency. The Equip program is employed across the entire facility as well as the RSAT program. The Equip Program has proven to be effective in other locations (Gibbs et al., 1995; Leeman, Gibbs, & Fuller, 1993).

All juvenile residents participate in the facility's Equip Program which is designed to teach residents to think and act responsibly. Residents at the facility attend regularly scheduled Equip sessions designed to enhance their skills, abilities, and knowledge in the areas of principles for daily living, cognitive restructuring, problem solving, anger management, moral reasoning, and social skill development. The skills learned in theses sessions are utilized in regularly scheduled mutual help meetings designed to address the specific cognitive and behavioral problems affecting individual members of the group. The mutual help meetings are delivered by way of a staff-directed peer group counseling process though individual and special needs counseling is also available through the caseworkers.

In the Equip model (Gibbs, Potter, & Goldstein, 1995), juveniles become motivated and equipped to assist one another with the three domains mentioned above (cognitive distortions,

delayed moral reasoning, and deficiencies in social skills related to their delinquency). There are two types of meetings in the Equip model, the *equipment meetings* and the *mutual help meetings.* The *equipment meetings* (approximately two per week), assist juveniles in correcting cognitive distortions, improving social skills and anger management and improving sociomoral reasoning. While working on these personal enhancements, juveniles can exercise their development in the above areas in the mutually supportive problem solving exercises performed in the *mutual help meetings.* The *mutual help meetings* (approximately three per week), lasting from 1 to 11/2 hours, consist of a five phase format: (a) introduction, (b) problem reporting, (c) awarding a meeting, (d) problem solving, and (e) summary.

At the introduction, the group leader (or coach) begins the meetings with commentary from the previous meeting, assessment of the group's progress, and encouraging comments and challenges to the group. The introduction should take no longer than five minutes. In the problem-reporting phase, each member in the group reports on problems that he or she has had since the prior meeting. Problem reporting takes approximately fifteen minutes. In the awarding the meeting phase, the group decides who in the group most needs help in the given session. Once the group agrees on the individual with the most dire need, the meeting is awarded to that person. This takes approximately five minutes. In the problem-solving phase, the group members actively engage in an attempt to understand the problem of the member and provide a solution to the problem. The group member awarded the meeting will be assisted in committing to a plan for implementing the proposed solution, including a time line of accountability for reporting the progress of implementation. The problem-solving phase may last up to an hour. The summary phase consists of the leader summarizing achievements in the meeting and

suggests improvements to make subsequent meetings more effective. The summary takes approximately ten minutes (Gibbs, Potter, & Goldstein, 1995).

In the above manner, the components of the Equip model (Gibbs, Potter, & Goldstein, 1995), *equipment meetings* and *mutual help meetings*, work in unison to both improve the cognitive functioning, social skills, anger management skills, and sociomoral reasoning of juveniles. It also provides them with a supportive problem-solving format to practice new skills in the crucible of daily problems.

The authors of the Equip program (Gibbs, Potter, & Goldstein, 1995) contend that because antisocial behavioral problems so often entail concomitant substance abuse problems the Equip Program can be merged with and supplement substance abuse programs.

The Principles of Daily Living

The Principles of Daily Living are utilized throughout the facility and are incorporated into the RSAT program. Residents learn that their interactions in the community are governed by the "Principles for Daily Living" which define what it is to be a contributing member of the community. Residents are taught that a community is a group of people that are interdependent, share a common area, and have common interests that are defined by its laws and standards. The residents are taught that they are members of a community and that in order for the community to function that they must abide by the rules and laws and actively contribute to the welfare of the community. Below is a list of the eight principles used in the program, (Handy, 1997):

MCF-RW Principles For Daily Living

1.	Respect:	To recognize and value the inherent worth of each person.
2.	Integrity:	To act consistently with honesty and trustworthiness.
3.	Courage:	To commit to what you believe is right.
4.	Care:	To consider and attend to the well-being of self, others, and

the environment.

5. Inquiry: To seek knowledge and understanding.

6. Excellence: To work to the highest level of your ability.

7. Citizenship: To make, to follow, and to protect the laws, rights and freedoms of our society.

8. Responsibility: To assume personal ownership to know and do your part for the common good.

The program teaches the residents the advantages and disadvantages of living by the program principles. In evaluating the progress in the program, the staff utilize the "Principles of Daily Living" to determine each resident's preparation to return to the outside community (Handy, 1997).

The Recovery Training Model

At the outset of the evaluation, the MCF-Red Wing RSAT Program was utilizing a Recovery Training program consisting of the following components: assessment, education, self-help groups, and relapse prevention training. The recovery training is aimed at helping the adolescent develop self-assessment techniques, relapse warning sign identification, and warning sign management techniques based on the *Counselor's Manual for Relapse Prevention for Chemically Dependent Criminal Offenders* (Gorski & Kelley, 1996). The Recovery Training components were intended to be integrated with the cognitive restructuring, psycho-educational, and therapeutic community components of the Equip Program.

However, MCF-Red Wing RSAT Program's Administration and Staff (in consultation with the Marquette University Research Team, the Office of Planning and Research, and the Chemical Dependency Unit of MNDOC) made a decision during the course of the process evaluation to replace the Gorski and Kelley (1996) model with the Strategies for Self-

Improvement and Change (SSC) model (Wanberg & Milkman, 1998). MCF-Red Wing reported that the Gorski and Kelley model did not provide a clear curriculum. Furthermore, it did not focus on the relationship between substance abuse and criminal conduct. In contrast, the SCC model offers a substance abuse treatment model that addresses the reciprocal relationship between substance abuse and criminal behavior. The SSC Model incorporates empirically supported models and approaches to substance abuse treatment, including the Stages of Change (Prochaska, DiClemente, & Norcross, 1992), motivational enhancement approaches (Miller & Rollnick, 1991), and relapse prevention approaches (Marlatt & Collier, 1995; Marlatt & Daley, 1997; and Marlatt & George, 1998).

The SSC model utilizes a combination of cognitive-behavioral strategies (Samenow, 1989; Samenow, 1984) and other substance abuse treatment principles. The program contains three primary phases of the curriculum: (a) Challenge to Change, (b) Commitment to Change, and (c) Taking Ownership of Change. The program consists of approximately fifty group sessions to complete the three-phase curriculum (Wanberg & Milkman, 1998).

In the first phase, trust and rapport is established with residents in order to build the groundwork of the treatment. Following this, the focus moves to building a desire and motivation to change. This includes psycho-education to provide a knowledge base to support change, including the role of feeling and thinking in change, the role of behavior in self-change, the nature of drugs, understanding addiction, and understanding criminal conduct and the influence of drugs. The next step in this phase one is to build and encourage pathways to self-disclosure and self-awareness. After this, a relapse prevention plan is developed and more attention is given to how people change (Wanberg & Milkman, 1998).

In the second phase, residents focus on increasing their commitment to change. This includes and in-depth assessment of each resident's readiness to change, involvement of social support in change, and developing a plan for desired life changes (most notably in the areas of substance abuse and criminal conduct). This phase also provides extensive guidance on specific actions that resident's can take to further their own personal change process (Wanberg & Milkman, 1998).

In the final phase of the curriculum, residents learn to take ownership of the change that has been initiated. Relapse and recidivism prevention skills are revisited by residents. In addition, resident's are taught the art of critical reasoning and decision making, not only for avoiding substance abuse and criminal conduct, but to develop good decision making skills that are applicable to all areas of life. Lastly, the curriculum focuses on the maintenance of the self-improvement and change that has been made. Resident's are taught how to develop and maintain healthy leisure activities, productive work habits, and how to model change to others (Wanberg & Milkman, 1998).

STAFF ISSUES and SOCIAL CLIMATE

Program Morale

There was fluctuation in morale of over time as morale for staff and administrators was relatively low during the summer in response to larger institutional dynamics and the amount of flux in the RSAT program, but morale did improve in the fall. The following is a question from the focus groups to further illuminate this:

"If you had to rate your morale, in terms of your job, how would you rate it?"

- "As the development of the program progresses, predictability increases thus increasing comfort levels for staff and residents."
- "I'd rate it an 8 (scale of 10) because I love the kids."
- "It has been difficult for me to watch programming deteriorate." (This statement was in relation to the overall institution)
- "We keep our kids together more than anywhere else. But, around grounds kids are working independently and caseworkers speak about how meetings are a joke, the group isn't a group anymore, the staff isn't involved anymore etc."

Most residents suggested that feelings fluctuate between motivation and an apathetic stance toward the RSAT program. Though overall , the residents had a positive view of the RSAT program and related that it was helpful to them.

Reactions from later focus groups and interviews indicated much improvement in morale especially in regard to the RSAT program. Both staff and residents greatly attributed this the stabilization of the program components, training provided to staff, and the new orientation process.

Security versus Treatment

A dichotomy is acknowledged in the institution between a more security driven philosophy and a focus upon rehabilitation and treatment. The RSAT administrators suggested that their programming had been affected by pressure from those holding a more security driven philosophy.

From the staff perspective, the difficulties related to this institutional dichotomy: Security versus Treatment was a result of the entire institution being in "flux". The staff observed that a

lot of tension exists due to the security vs. treatment politics in the institution and that administrators feel immense competing pressures from this.

Focus Group Response:

- "I think it adds a lot of stress to my supervisors. I think Mr. * is under constant stress. Do you hear it (looking at **)".

The intensity of the "Security versus Treatment" issue was at its peak at the time of the 2nd round focus groups. The stress level and negative effects upon morale were very apparent to the research team not just in focus group conversation, but in tone of discussion and body language. During the October and December focus groups, the intensity of this issue had diminished substantially. Both staff and administrators stated that the issue had "cooled off" at least in relation to the Princeton Cottage if not the entire institution. This is due, in part, to the progress in the development of the program, "As the development of the program progresses, predictability increases thus increasing comfort levels for staff and residents." It was also apparent that the RSAT administrators had made successful attempts to downplay the dichotomy for themselves and for the staff. It should be noted that the residents did not report perceiving the "Corrections versus Treatment" dichotomy within the institution.

Corrections Officers management/supervision

Directly related to the correction versus treatment dichotomy is the issue regarding separate supervision structures for Corrections Officers (COs) and caseworkers. Each group is beholden to a separate group of supervisors and separate philosophy/approach to the job at hand.

- One of the problems in the division between the Correction Officers and Caseworkers is that each reports to different supervisors, there is a lack of CO staff continuity, and there is a lack of empowerment of the CO's to make decisions.

- The assignment of Correction Officers to the cottages is often dictated by seniority and scheduling. Hence, no emphasis is placed upon assigning officers who have a particular knowledge base for working with the particular population serviced by a cottage.
- All staff and administrators interviewed agreed that effective CO-caseworker teamwork is essential to optimal programming.

Staff Turnover

The MCF-Red Wing was reported to have lower staffing levels as compared to county and private juvenile facilities (Office of the Legislative Auditor, 1995). The lower staffing levels places higher demands on staff, increasing stress, decreasing efficiency and ability to meet residents' and program needs. The staffing level has also negatively affected morale and, in turn, has exacerbated the security versus treatment split amongst the Red Wing staff.

In spite of lower staffing levels, The RSAT team has remained generally intact and is working well as a team. There were two instances of staff turnover during the evaluation period: one caseworker (replaced by a caseworker from another cottage and one teacher (Equip facilitator) replaced by a teacher from outside the institution. The integration of the two new staff into the team has gone well.

Though there has been some turnover in teaching staff this is seen as temporary. The majority of institutional staff turnover is with the correction officers. This is seen as problematic as it is disruptive to the functioning of the cottage because COs are not familiar with the RSAT Program. There was some concern regarding some staff commitment to working with adolescents. Starting to work with adolescents can be an entryway into the MNDOC system and some workers are not truly interested in working with adolescents. Rather, they simply see the opportunity as an entry to other MNDOC job positions.

Focus Group Responses Regarding Staff Turnover:

- "At this time, I think the majority of turnover has occurred with the Corrections staff. It used to be that corrections staff would either be focused upon kids or adults. Now, we have staff from adult corrections working with kids. When working with adults, your posture must be more removed. To the contrary, with kids a more relational approach is taken. I think this can present problems."
- Casework in this setting is a much different type than in the adult setting. Some things have occurred that have helped. They used to work most holidays and some weekend days. This is no longer true and not helped. The workload is not equitable in a juvenile facility when compared with that of similar staff of adult facilities. (Administrator)
- When you look at the daily mode, even though caseloads are smaller in juvenile corrections, the work and relationships are more intensive. It is not even fair to compare the two. Some in juvenile corrections say, "you are making the same money as I am and you seem more relaxed to me."
- Caseworkers will often take a casework job to get into the system and then seek a job elsewhere due to a lack of commitment to working with kids.

RSAT Staff Training and Supervision

Overall, the relationship between the RSAT program staff and RSAT administration is viewed as effective and generally helpful. The staff was concerned about some lack of clear communication between staff and administration particularly regarding supervision. Specifically in relation to who was going to provide direct supervision, when the supervision would take place, and the purpose of the supervision (evaluative, or simply to focus on problems?).

Focus Group Responses on Training and Supervision

- It was suggested that administrators might not have seen enough of their sessions to have a good feel for what is actually happening in the meetings.
- It was indicated that there have been misunderstandings between the administrators and facilitators about expectations, program changes, and what facilitators are doing in meetings.
- Facilitators stated that meetings were often held to solve specific problems. They thought preventative and routine meetings would be more effective. (It may be helpful to put in place regularly scheduled supervision meetings to open up the lines of communication with facilitators). A "clinical supervision" model was thought to be a good idea, but that it would be difficult to implement due to limited resources and time constraints.

Training for all staff (including caseworkers and COs) was seen as a top priority by both staff and administrators. Training needs to focus on all areas programming including chemical dependency (all staff) and advanced group facilitation skills for caseworkers.

Training was conducted with the correction officers for 16 hours. This was held so that the officers in the chemical dependency unit would better understand the program. Specifically, there were 2 eight-hour training units including teambuilding exercises, videos, and the Equip model. The need to familiarize the correction officers with the terminology and rationale of the Equip and Recovery Training models was recognized.

The following is in regard to a focus group question addressing training of COs. Focus question: "Is it possible to further train staff members (COs) in the models? If so, how would you go about doing this?"

- I think we have answered this. I think the training that we put on during a regular basis needs to involve the correction officers as much as possible.

- The training we have presented is for the whole facility. Anybody who is interested is welcome to attend.
- There was interest expressed in having more materials to work from in terms of programming guides, reading materials, etc.
- The facilitators are credited with providing important input and contributions to the program and have done well considering the number of changes in programming that have occurred.
- There is a desire to increase the knowledge and experience of facilitators in understanding and reading group dynamics. In terms of the challenge of adequate training for the facilitators, it is not seen as a limitation in intelligence or commitment, but rather as a matter of lacking the long-term experience working with the program model.

RSAT Staff Role Clarification and Work Demands

There was significant concern about role-definition for the caseworkers and the chemical dependency staff. Caseworkers were unclear as to the extent to which they were expected to participate in the development of the new Recovery Training Component. Both staff and administration stated that the flux in the program contributed greatly to the lack of clarity in role definition and communication. As the transition to the Wanberg and Milkman Recovery Training Model drew nearer to full integration into the RSAT Program the role ambiguity decreased. There are still concerns regarding job roles, competing demands upon time, and insufficient time to complete all job requirements.

Focus Group Responses to Role Clarification and Work Demands:

- At times, it is confusing to define one's role, including components as a caseworker, therapist, and teacher.
- It was felt that the role of the caseworker needed to be clarified.

- Clarifying responsibility for the recovery training model (i.e., Mr. Larson's) helped to alleviate confusion and stress regarding the transition to the new recovery model.
- The Program Director's increased involvement in the RSAT programming provided welcomed guidance and leadership

Caseworkers are spending much time in class preparation for the new recovery training model although additional preparation time had not been allotted. As facilitators cycle through the classes preparation time will decrease. However, there are 50 classes so the "cycle" will likely take a substantial period of time.

Resident Religious and Cultural Issues

Generally, residents said that they viewed the program as respectful in permitting sweat lodge visits, church, bible study, etc. Three residents suggested that their religious and cultural perspectives/practices were not being respected to the extent that they desired. They expressed that they feel that there are too many limitations on religious exercises, such as sweat lodges. Some residents expressed that some people smudge and sweat (Native American rituals) simply to evade class responsibilities. Residents said that some people who are religious may get teased somewhat. However, for the most part, it was indicated that religious beliefs are respected. Residents indicated that some group residents have accused other of racism. Most group residents do not think it was a legitimate complaint.

Addressing diversity issues is a vital part of effective programming. Staff understanding of the effects of racial, ethnic, socioeconomic, and cultural dynamics upon the treatment process and outcomes is essential.

The Correctional Institution Environment Scale: Social Climate

The CIES scores indicated a very positive social climate. The Real form scores indicated that the staff and residents generally agreed that there is currently a positive social climate that incorporates elements of an effective therapeutic community. The Relationship, Personal Growth, and System Maintenance dimensions are all, at least, adequately addressed in the RSAT program.

Staff control was consistently rated the lowest of the subscales (though still "average" as compared to the national norm. This rating indicates that both residents and staff believe that a certain amount of control is necessary (and obvious as the RSAT program is located in a correctional facility), but a climate that is too restrictive can be a hindrance to the overall aims of the program. As mentioned previously, there can be detrimental effects of too much staff control upon program morale, adaptive behaviors, relationships and personal growth (Moos, 1975; Deschner, 1980). There appears to be an appropriate level of staff control within the RSAT Program. This provides further proof that the security versus treatment dichotomy which seemed to be at its peak in summer 1999 is being bridged.

There is a remarkable level of satisfaction with the current social climate for both residents and staff. This is indicated by the small Real Form-Ideal Form discrepancy scores. In fact, the residents are very satisfied with the social climate as there is essentially no difference in the Real Form-Ideal Form Discrepancy scores for both times of administration. At time 1, the staff indicated a desire to have more emphasis in expressiveness, autonomy, and practical orientation. At time 2 the staff desired a stronger emphasis on the Relationship Dimension (Involvement, Support, Expressiveness). At time 2 the staff were satisfied with the level of autonomy in the program.

The differences in the desired changes at time 1 and 2 are probably due in part to the changes in the Recovery Training Component of the RSAT Program and time demands on the staff. Staff indicated in the focus groups and interviews that the implementation of the new recovery-training model absorbed a significant amount of staff time in addition to the current work requirements. Staff consistently indicated in the focus groups that the relationships with the residents were extremely important, but that other job demands often got in the way of relationship development.

The desire for increased emphasis on practical orientation is likely related to the staff concern regarding the residents' abilities to implement their recovery plans upon release. These concerns are heightened in light of the varying types and quality of aftercare opportunities.

The orientation process for the residents is an integral component for continuing the positive social climate of the RSAT Program. An effective orientation informs the residents and reinforces the staff in regard to the goals, norms, and expectations of the program. A strong emphasis on the orientation process should be continued.

The positive social climate of the RSAT Program is a strength of the program and will likely have positive effects upon treatment outcome. Because of the potential effects of social climate upon treatment outcomes, attention to the social climate should be sustained.

Recommendations Regarding Staff and Social Climate

Some of the issues regarding staff turnover are beyond the control of RSAT staff and administrators. For example, Union rules pertaining to Corrections Officers do not provide incentive for COs to remain in the RSAT cottage (successful bidding for "better hours" usually requires COs to change cottages). The issue of security versus treatment needs to be addressed further as continuing to rectify this split is vital to the effectiveness of the program. All staff need

to be consistent in their philosophy and approach to treatment. The continuity of the treatment across all staff is an extremely important factor in treatment effectiveness. The residents can be confused by contradictory or mixed-messages from staff thus impeding their progress in treatment. Residents may undermine program objectives by capitalizing on "team-splitting". Though the issue of security versus treatment has subsided somewhat, it is likely to resurface.

- It is strongly recommended that cottage meetings be continued and that flexibility in scheduling and compensation (i.e., periodic overtime pay) be provided to support all RSAT staff attendance. Continuing the cottage meetings (along with training) will serve to unite the staff regarding RSAT Program policies, procedures, philosophies and approaches.
- Additional and more intensive training for COs and caseworkers in regard to the RSAT program components is likely to increase the sense of efficacy for the staff and thus increase morale.
- Training needs to focus on all areas programming including chemical dependency (all staff) and advanced group facilitation skills for caseworkers.
- Joint trainings involving COs and caseworkers throughout the year will help to solidify the team and treatment approaches.
- Periodic retreats involving caseworkers, COs, and administrators should be held to address RSAT program issues.
- Consistent "clinical supervision" (i.e., supervision pertaining to facilitation of program components) by RSAT supervisors can provide the forum for positive, constructive, and preventive feedback to the caseworkers. The clinical supervision must be supported and valued by upper administration in the forms of flexibility of scheduling, compensation, and

inclusion in job expectations. Supervisors should be afforded advanced training in clinical supervision.

- Ongoing training should be provided to staff regard to developing cultural competencies. As the sociodemographics of the residents change, these trainings need to reflect the cultures represented in the RSAT program.
- The orientation for residents must be continued and strengthened.
- It is recommended that the CIES be administered at regular 6-month intervals at least until completion of an outcome study.

PROCESS FINDINGS

The process findings consisted of information from the ratings of videotaped group sessions; focus groups conducted with the administration, staff and residents; interviews with staff, residents, and corrections officers and two administrations of the Correctional Institution Environment Scale (CIES).

Integration of program components (cottage issues, terminology etc)

The integration of program components was seen to be of the utmost importance. At times, the Equip Model, Prepare Program, Mutual Help, Recovery Training, and general cottage functioning seemed disconcerted. That is, the concepts, skills, etc. from one component were not consistently reinforced in other components. One major reason for this was lack of consistency of terminology across components. For example, some concepts that are identical in meaning are referred to in the Equip model with different terms than used to refer to the same concept in the SSC model. There was also concern about RSAT concepts and skills being reinforced outside of "program time" i.e., in the cottage during evenings and weekends. Part of this is attributed to lack

of CO training and understanding of the RSAT program, the security versus treatment dichotomy, and different supervision structures for COs and caseworkers.

As indicated in the previous section, all staff and administrators involved in the focus groups indicated that they would like to see more CO involvement in the RSAT program. In fact, CO involvement was seen as critical for the success of the program. Because COs have so much contact with the residents, if motivated and properly trained, the COs can provide much needed reinforcement of program concepts and skills.

The reinstatement of cottage committee meetings was initially met with mixed reviews. Most perceive the meetings to be essential to optimal functioning of the cottage in that the meetings can improve cottage communication and serve as a forum to improve integration of program components and services. However, some viewed the cottage committee meetings as a waste of time because "most of the time is spent trying to get COs and caseworkers on the same page." It was pointed out that this was not necessarily problematic in that this was one of the purposes of the meetings

Recovery Training Model

The Gorski and Kelley (1996) Recovery Training was deemed to not be a good "fit" with the overall program. The staff and administration had concerns regarding the theoretical and research base of the Gorksi & Kelley (1996) model, it was not easily compatible with the Equip program, and it was cumbersome for the staff to implement. The lack of a clear curriculum in the model made it difficult for staff to implement in a consistent and effective manner.

In the fall of 1999, the decision was made to adopt the SSC (Wanberg & Milkman, 1998) model for the Recovery Training component of the RSAT Program. The administrators indicated

that they felt the SSC model provided an excellent curriculum for the recovery training portion of the program.

The implementation of the SSC Model

Changes in programming [i.e., adoption of the SSC Model] were still in the early stages. Transition had been accepted well by caseworkers, administrators, and residents. The smooth transition was due primarily to the fact that all members of the team were involved in the adoption of the program and implementation. All team members were "on board". Initial training provided for the SSC Model was helpful, but truly just an introduction. As caseworkers become more familiar with the SSC, it will be essential to provide advanced training opportunities.

Residents were adjusting well to the new program (reported by residents, caseworkers, and administrators). Residents expressed, on the whole, that they viewed the change to the SSC model as a positive change. Assurances and explanations by administrator and caseworkers helped alleviate residents' anxiety about the transition. More interaction with staff, that is — staff teaching more as opposed to residents engaged in independent study, helped the residents with the transition. Residents seem to be grasping more in the new model. Residents already had the basic framework so the concepts were not foreign to them. The SSC Model incorporates the Samenow model of criminal thinking (Samenow, 1984). However, the RSAT program uses the Equip model which is deemed to be simpler and easier for the residents to grasp—therefore more effective.

Strengths of the SSC Model

Residents suggested that the old recovery training program was not as good because they did the same material repeatedly. In contrast, they said that the new program provides an opportunity to move forward in the material. Residents suggested that the recovery training

model presents a way of understanding the cycle of substance abuse more clearly than the Gorski and Kelley model.

Focus Group Responses on the Strengths of the SSC Model

- "The SSC model is extremely clear. Therefore, it will be clear in how to implement it, including rating scales, curriculum, etc."
- "The SSC model gives us the structure that we are seeking. There was too much material left undecided in the Gorski curriculum and it failed to adequately recognize the cognitive portion of the Equip model. It simply didn't fit very well with the Equip model. However, the SSC model works much better with what we have."
- " I think the new model is essentially based on cognitive restructuring and social skills development and is designed to address the delinquent element of substance abuse."
- "It makes sense because the SSC model addresses the cognitive-behavioral issues just like the Equip model."
- "The SSC is designed with people who are in trouble with the law. Hence, it blends together well with what we are doing."
- "From our experience, we don't have anything that we can evaluate it with. The SSC text, however, provides research support for the model. In the instructor's guide, they cited the research done in terms of the delivery system of the model."
- "As far as group counseling, the SSC model has clear guidelines so that staff will not have to decipher things as much with these skills. They will be more like teachers and facilitators.

Concerns regarding the SSC include:

- SSC was developed for use with adults. Some adaptation to adolescents is likely to be needed.

- SSC was developed for outpatient use. The curriculum will need to be adapted to a residential setting.
- The reading level in the SSC curriculum is reported to be at the 6th grade level. However, after perusal of the curriculum, staff and administrators were concerned that the reading level of the curriculum is actually much higher and the residents will have difficulty reading and comprehending the material. The materials will need to be adapted to lower reading levels.
- Though the concepts in SSC parallel the concepts of Prepare and EQUIP, the terminology is different. There is a need to standardize the terminology across program components to universalize the definitions of terms and to reinforce these universal terms in all components of the program.

Process Discussion

The relationship between staff and residents is seen as paramount by all involved in the RSAT Program. The relationships or "working alliance" between residents and staff is generally very strong and consistent over time as reported by all three groups (residents, staff, and administrators). In terms of motivation for working in their positions, all of the facilitators put great emphasis on their relationship and rapport with the residents. Administrators reported that they were very pleased with the facilitator's interaction with clients. The vast majority of residents were pleased with their relationships with caseworkers. Residents consistently reported that they believed the caseworkers genuinely cared about their well being.

Residents report that the staff often go beyond the call of the duty and this reinforces the residents' sense of being cared for. For example, a resident reported that one staff member took a day off to go with him and visit his family. This resident indicated that he greatly appreciated this.

Residents perceive the staff to be helpful by taking time to listen to their personal concerns or problems and by offering feedback and advice to handle problems that arise. Residents report that they generally trust the staff. For example,

Resident: "(My caseworker) is pretty cool. I can trust 'em. (S/He) don't be telling all my stuff you know if nobody's getting hurt or nothing".

There were a few negative comments made by residents in regard to relationship with staff. However, these negative comments were very few and far between. Residents indicated that "some staff care and others seem to be working simply to get a paycheck". Residents indicated that one of the staff told one of them, "I know I will always have a job with people like you in the world." Residents indicated that the staff could make more of an effort to assist those who are not doing well and are struggling to improve. They said that staff focus much more on those who are doing well and want the help.

Strengths of Facilitators (RATING)

In terms of the implications of the ratings for the Red Wing model, the results demonstrate that the facilitators in the program have demonstrated definite strengths in their adherence to the model in-group sessions as well as good skill level in group facilitation. Specifically, the facilitators have demonstrated (a) the ability to communicate the concepts of the model, (b) the ability to present the model utilizing multiple techniques, and (c) the ability to impart the treatment concepts to the group members. The facilitators have also demonstrated excellent group facilitation characteristics, including: (a) responding to questions, (b) an attentive posture, (c) showing acceptance and support of the group members, (d) summarizing content effectively, (e) refocusing the process of a session, and (f) insightfully interpreting the meaning of group members' comments.

Another indicator of the facilitator's effectiveness lies in the realm of the group members and attitudes and interactions within the group. Group members demonstrated in a variety of areas that they are cooperating with the treatment model and facilitation, including: (a) demonstrating prosocial interactions during the sessions, (b) identifying and challenging anti-social attitudes in the group, (c) demonstrating an ability to discuss and understand the subject matter of the sessions, and (d) fostering an environment of basic respect and cooperation.

Areas of Concern Regarding Group Facilitation (RATING)

With much of the emphasis of the results indicating positive characteristics of the facilitators, a number of recommendations (based on the rating results) could be utilized to further enhance their treatment delivery. It is recommended that:

- the facilitators provide a clear indication at the outset of each treatment session of the subject matter to be discussed. The rating demonstrated that this clarification became much less prevalent in the October sessions as compared to August sessions.
- it would be beneficial for the facilitators to incorporate some kind of material that explicitly communicates the session's rules and norms prior to each session. The raters indicated that this component was heavily lacking in the sessions that were evaluated. The addition of this discussion of group rules/norms provides group members with a shared understanding of how the group should ideally function.
- Consistent supervision should be provided to the facilitators by the RSAT administrators in regard to group facilitation
- regular "peer supervision" meetings should be scheduled in order that facilitators can review their work and learn from each other.
- purposes of each component and facilitator roles should be clarified amongst staff

- review of group expectations at the beginning of each group should be conducted
- more active facilitation of group process by the group facilitators especially in regard to the Mutual Help Groups.
- additional and ongoing training in regard to group facilitation should be provided.

Process Recommendations

- Consistent and regular cottage meetings attended by all RSAT staff and administrators will help tremendously with role-clarification. Also, consistent and regular supervision sessions for caseworkers will help with role-clarification. Further development and familiarity with the new SSC recovery training model will also help alleviate stress and anxiety regarding adoption of a new model.
- The integration of terminology across treatment components will ease facilitation and clarify concepts for staff and residents. It is recommended that a review of all components be made with the intent of developing a glossary of terms, thesaurus of terms, and that "official" RSAT terminology be identified and utilized across all components.
- The SSC model was developed for use with adults. The RSAT staff have been adapting this model for their juvenile population and the MCF-Red Wing administrators have reported that the authors of the SSC model are currently developing an adolescent version of the SSC model. It is recommended that the RSAT program document the changes made for working with adolescents and begin immediate consultation with the SSC authors.
- The SSC model claims that the reading level of the curriculum materials is at the sixth grade level. However, the RSAT staff suspect that the reading level is much higher. The reading level of the materials should be re-examined and any handouts to the residents should be adjusted to their reading level.

- Though the RSAT Program is well-developed and defined, further articulation of the treatment philosophy and model by the staff and administrators will serve to strengthen the program. Issues pertaining to harm reduction approaches, abstinence based approaches (it should be noted that harm reduction and abstinence approaches are <u>not</u> mutually exclusive), and group facilitation approaches need to identified and clarified.

OUTCOME EVALUATION

Issues and Concerns

The staff, administrators, and residents were all very supportive of an outcome evaluation of the RSAT Program. All stated that they would cooperate fully with any evaluation as they view the outcomes of the RSAT program as the most critical aspect. Outcomes are not only of concern for the program, they are a campus-wide concern. Residents, staff, and administrators all identify aftercare as one of the most important factor to success-Particularly a seamless transition of support (e.g., one resident stated, "I got away with a lot after my release partly because my PO didn't know me").

There were numerous concerns regarding an outcome evaluation. Of particular concern was the lack of adequate resources for transition programming, the lack of Red Wing control in type and quality of aftercare, the definition of "success" being limited to abstinence or recidivism only, and the lack of understanding of the residents' severity of substance abuse and criminal history. This last point is seen as critical in fully understanding RSAT Program outcomes as Red Wing is the "last stop for these kids" –they have "failed" at other institutions and therefore success of the program must be interpreted in light of this fact.

In terms of preparing the adolescents for life outside of Red Wing, it is felt that the adolescents receive some valuable tools that can be practiced in the program setting. However, it is recognized that the reality of their home communities cannot be recreated in an artificial setting.

There is some concern about the adolescents finding adequate social support to bolster their efforts upon leaving the institution. It is suggested that the tools are available for adolescents to continue to practice positive behavior once leaving the facility. However, it seems up to the individual adolescent whether or not he will choose to continue utilizing them.

In terms of social support following release, most residents indicated that their families would be their greatest source of support. A number of residents also indicated that God is important to them as a source of support. Relatively few residents stated that they would regularly attend 12 step meetings following release from Red Wing.

Administrators expressed the desire to provide more consistent aftercare services. Their preference would be to work with fewer providers of such services and to become more involved with their delivery. Administrators would like to have more control of the type and length of aftercare services

Recommendations:

It is extremely difficult for caseworkers to meet the demands for transition programs. Additional staff needed to be added. A new position of "transition caseworker" was developed. One of the RSAT caseworkers moved into this new position (the resulting RSAT caseworker vacancy was filled in January 2000). Considering that this is new position to the RSAT Program:

- time for position development and training need to be afforded to the transition caseworker.

A major problem is that transition programs are controlled at the county level and not at the state level. This severely hampers the RSAT Program's effectiveness regarding transition and limits continuity of transition programs because counties vary dramatically in services provided. The new transition caseworker position is a step in the right direction, but there is a tremendous amount of work involved in coordinating transition services.

- Additional resources are likely to be needed to optimally administer the transition services.

In considering leaving Red Wing, residents often expressed a desire to be closer to their families and to avoid contact with the negative influences of peer groups. Residents also expressed concerns about future job prospects, education, living situations, substance use temptations, and the negative influence of former peer groups.

- Involving family members and members of the community to which the resident will be returning (i.e., employers, teachers, recovering community, clergy) in the transition process is crucial to developing positive social support networks and ultimately successful outcomes.
- Resources aimed at fostering family support for residents are needed. The resources should include family sessions during programming and transition, family education regarding substance abuse and recovery, and social service assistance for families to locate resources.

There is a growing emphasis in the treatment outcome research literature on the global concept of Quality of Life (Speer, 1998). Quality of life is an umbrella concept that involves multiple dimensions and purports that the effectiveness of interventions or treatments are not adequately measured nor understood if approached from a unidimensional perspective. For example, abstinence versus non-abstinence has long been used as the benchmark for determining the effectiveness of alcohol or other drug abuse (AODA) treatment. However, most researchers today realize that this dichotomy is inadequate (e.g., reduction in harmful use can be viewed as

one positive outcome of treatment) and other dimensions (e.g., work performance, family functioning etc.) must also be assessed to fully evaluate the effectiveness of treatment. This is especially apparent when assessing AODA treatment with criminal offenders. It is not enough that the offenders stop abusing drugs, but other behaviors, such as criminal acts and other delinquent behaviors must be remediated.

CONCLUSION

The residents, staff, and administrators have been very receptive to the process evaluation. They consider the evaluation itself to be helpful, that is, simply being evaluated tends to optimize programming. In addition, all participants have been cooperative to requests from the research team and fully engaged in the research activities. This full engagement occurred despite some minimal reservations as to the utility of the evaluation and the feedback received.

The MCF-Red Wing Residential Substance Abuse Treatment (RSAT) Program is an innovative and well-designed treatment program. There are many strengths of this program noted throughout the report. Administrators and staff are committed to providing quality service. Administrators are confident in the abilities of the RSAT staff to implement the program although both administrators and staff acknowledge room for improvement in various areas.

The staff and administration share a sense of mission and direction in implementing the RSAT program. The design of the RSAT is viewed to be sound, appropriate to the clientele being served, and effective in facilitating positive change within the residents. There is intellectual and programmatic flexibility as evidenced by the decision to change a major component of the RSAT program (the Recovery Training component) as the new component

was deemed to be much more compatible with the other aspects of the program and better grounded in theory and research.

RSAT staff believe that the administrators are supportive of their efforts and generally fair in feedback and evaluation. There is a strong team concept particularly amongst the caseworkers. Both staff and administrators are open to additional training in the various components of the RSAT program, counseling and facilitation skills, and clinical supervision.

The residents generally report that the RSAT program is implemented well and is meaningful to them. The residents view the RSAT program as helpful in developing coping skills that are applicable both within the institution and after release.

There are systemic issues related to staffing and treatment philosophies that need to be addressed if the RSAT program is to function optimally. Also, there are numerous training needs for both correctional officers and caseworkers that need to be met. Funds will need to made available for this training so that the RSAT program can operate at peak performance.

The concept of "continuity of care" was the overarching theme throughout the evaluation. Though this term was never mentioned during any of the groups or meetings, it captures the goals and desires of the staff and administration to unite the components within the RSAT program, synergistically link the program components to those of the institution, and seamlessly transition to the aftercare programs. The "ideal" RSAT Program can not be achieved without continuity in the care/services provided. If the current efforts and recommendations for improvement are implemented the MCF-Red Wing Residential Substance Abuse Treatment (RSAT) Program will be ready to implement an outcome evaluation.

Overall, the RSAT Program is functioning very well and is providing excellent services to the residents. Providing effective residential substance abuse services to incarcerated juveniles can be a daunting task. A quote from one of the residents captures this poignantly:

"It didn't happen over night so it ain't going to change over night."

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APPENDIX A

Analysis of Ratings of Group Facilitation

As described in Section I, all groups were videotaped, then stratified by facilitator, type of group, and time. Videotapes were then randomly selected to be reviewed by two raters in regard to 22 questions (See Table 10). Raters responded "yes" or "no" if certain criteria were present or not.

The Chi-square statistical test was used in the analysis of the ratings. This statistical test is designed to compare the observed frequencies (how often raters actually agree on whether or not a certain characteristic is present in a group session) with the expected frequencies for each category resulting from chance alone (Note, the expected frequencies are the frequencies that would be liable to occur based only on random chance). When analyzing the raters' responses, the Chi-square is used to statistically determine whether or not the responses [(a) both raters choosing "yes," (b) both raters choosing "no," or (c) one rater choosing "yes" and one rater choosing "no"] indicate a result that exceeds the expected frequencies. If the result exceeds the expected frequencies and is statistically significant, according to the Chi-square, then one can conclude that the rater's responses indicate a pattern that cannot occur simply by chance alone. Hence, the rater's responses demonstrate that a factor (the characteristic being observed) other than chance is responsible for the results.

The percent of agreement between the raters demonstrates a measure of the consistency of ratings within pairs of raters for particular items. Raters were consistent (or, in other words, reliable) if they agreed to either "yes" or "no" for an item. The percentage of agreement between the raters for each item was determined by adding together the percentage of "agreed responses"

albeit "yes" or "no". This agreement between raters can be viewed as a type of rater reliability in that it is an indicator of inter-rater consistency.

In the second (August) round, six of the chi-squares were statistically significant. In the third (October) round, ten of the chi-squares were statistically significant. This indicated that the facilitators did not consistently clarified the nature of the subject matter in August (13.98, p=.0001) and October (9.95, p=.002), consistently did not clarify/discuss group rules and norms in August (6.01, p=.014) and October (9.95, p=.002), consistently incorporated examples related to the subject matter in August (7.77, p=.005) and October (18.25, p=.0001), consistently used visual aids, role playing, or other techniques in the presentation of the subject matter in August (39.00, p=.0001) and October (33.39, p=.0001), consistently identified and challenged anti-social behavior in October (16.81,p=.0001), consistently did not relate the subject matter to other program components in October (9.47, p=.002), consistently used the technique of "reflection of feeling" in October (5.70,p=.02), consistently used the technique of "reflection of meaning" in October (4.45,p=.04), consistently used summarization effectively in the sessions in August (4.11,p=.04) and in October (20.03, p=.0001), and consistently summarized the subject matter at the conclusion of the sessions in August (5.11, p=.02) and in October (10.13, p=.001). Please see "Rater Agreement and Item Analysis" for more detailed information on the above findings.

The percentage of agreement between the raters for item 11 is particularly low. A possible explanation for this is due to the difficulty of the raters in identifying exactly what content in a certain session directly relates to other components of the program. This item needs further clarification and explanation.

The rater percentage of agreement between the raters is particularly low for item 21. This may be due to the fact that it is not clear, based on the question, how to rate instances where self-

disclosure is not used at all. In some sessions, this could be interpreted as appropriate since it was not necessary. In others, it may have not been used but deemed necessary by the rater. So, for the some behavioral scenario (no use of disclosure) a rater could possibly put either answer. This language problem needs to be clarified and the term "appropriate disclosure" needs to be well-defined.

TABLE 10. **Rater Agreement and Item Analysis of Group Facilitation Rating**

AUG. Question 1: Facilitator Clarify nature of subject?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	**19 (51%)***	5 (14%)	81%	9.950 / .0001	1
Rater 2 = no	2 (5%)	11 (30%)			
Oct. Question 1: Facilitator Clarify nature of subject?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	**13.3 (33%)***	4 (14%)	76%	9.950 / .002	1
Rater 2 = no	6 (5%)	**17 (43%)***			
AUG. Question 2: Facilitator Clarify/discuss group rules?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	6(16%)	5 (14%)	76%	6.01 / .014	1
Rater 2 = no	4 (11%)	**22 (60%)***			
Oct. Question 2: Facilitator Clarify/discuss group rules?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	**4 (10%)***	4 (10%)	86%	9.951 / .002	1
Rater 2 = no	2 (5%)	**31 (76%)***			
AUG. Question 3: Facilitator Incorporate examples?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df

Rater 2 = yes	23 (59%)*	4 (10%)	77%	7.77 .005	1
Rater 2 = no	5 (13%)	7 (18%)			
Oct. Question 3: Facilitator Incorporate examples?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	25 (61%)*	4 (10%)	85%	9.951 .002	1
Rater 2 = no	2 (5%)	10 (24%)			
AUG. Question 4: Facilitator Incorporate techniques to assist presentation?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	30 (77%)*	0 (0%)	100%	39.00 .0001	1
Rater 2 = no	0 (0%)	79(23%)			
Oct. Question 4: Facilitator Incorporate techniques to assist presentation?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	24 (59%)*	0 (0%)	96%	33.394 .001	1
Rater 2 = no	2 (5%)	15 (37%)			
AUG. Question 5: Facilitator Promote prosocial interaction	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	38 (97%)	0 (0%)	97%	No var ns	1
Rater 2 = no	1 (3%)	0 (0%)			
Oct. Question 5: Facilitator Promote prosocial interaction	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	40 (98%)	1 (2%)	97%	No var ns	1
Rater 2 = no	0 (0%)	0 (0%)			
AUG. Question 6: Group Promote prosocial interaction	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	39 (100%)	0 (0%)	100%	No var ns	1

Rater 2 = no	0 (0%)	0 (0%)			
Oct. Question 6: Group Promote prosocial interaction	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	40 (98%)	1 (2%)	98%	No var / ns	1
Rater 2 = no	0 (0%)	0 (0%)			
AUG. Question 7: Facilitator ID and challenge anti-social behavior?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	32 (82%)	2 (5%)	82%	ns	1
Rater 2 = no	5 (13%)	0 (0%)			
Oct. Question 7: Facilitator ID and challenge anti-social behavior?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	**37 (82%)***	1 (2%)	87%	16.812 / .0001	1
Rater 2 = no	1 (2%)	**2 (5%)**			
AUG. Question 8: Group ID and challenge anti-social behavior?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	30 (77%)	2 (5%)	82%	ns	1
Rater 2 = no	7 (18%)	2 (5%)			
Oct. Question 8: Group ID and challenge anti-social behavior?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	37 (90%)	3 (7%)	90%	16.812 / .0001	1
Rater 2 = no	1 (2%)	0 (0%)			
AUG. Question 9: Facilitator Respond to questions or concerns?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	28 (72%)	3 (8%)	77%	ns	1
Rater 2 = no	6 (15%)	2 (5%)			

Oct. Question 9: Facilitator Respond to questions or concerns?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	26 (63%)	6 (15%)	73%	ns	1
Rater 2 = no	5 (12%)	4 (10%)			
AUG. Question10: Facilitator Relate subject to other program components?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	14 (36%)	11 (28%)	51%	ns	1
Rater 2 = no	8 (21%)	6 (15%)			
Oct. Question 10: Facilitator Relate subject to other program components?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	13 (32%)	8 (20%)	74%	9.471 / .002	1
Rater 2 = no	3 (7%)	17 (42%)			
AUG. Question11: Group Relate subject to other program components?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	12 (31%)	10 (26%)	57%	ns	1
Rater 2 = no	7 (18%)	10 (26%)			
Oct. Question 11: Group Relate subject to other program components?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	12 (32%)	10 (27%)	59%	ns	1
Rater 2 = no	5 (14%)	10 (27%)			
AUG. Question12: Group Able to talk about and understand subject matter?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	39 (100%)	0 (0%)	100%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
Oct. Question 12: Group Able to talk about and understand subject matter?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq.	df

				P value	
Rater 2 = yes	41(100%)	0 (0%)	100%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
AUG. Question13: Group Demonstrate respect and cooperation?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	39 (100%)	0 (0%)	100%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
Oct. Question 12: Group Demonstrate respect and cooperation?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	41(100%)	0 (0%)	100%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
AUG. Question14: Facilitator Demonstrate an attentive posture to the group?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	39 (100%)	0 (0%)	100%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
Oct. Question 14: Facilitator Demonstrate an attentive posture to the group?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	39(95%)	1 (2%)	95%	ns	1
Rater 2 = no	1 (2%)	0 (0%)			
AUG. Question15: Facilitator Display acceptance of group members?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	39 (100%)	0 (0%)	100%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
Oct. Question 15: Facilitator Display acceptance of group members?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df

Rater 2 = yes	40(98%)	1 (2%)	98%	ns	1
Rater 2 = no	0 (0%)	0 (0%)			
AUG. Question16: Facilitator Use reflection of feeling?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	2 (5%)	10 (26%)	44%	ns	1
Rater 2 = no	12 (31%)	15 (39%)			
Oct. Question 16: Facilitator Use reflection of feeling?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	**9(22%)**	7 (17%)	71%	5.701 .02	1
Rater 2 = no	5 (12%)	**20 (49%)***			
AUG. Question17: Facilitator Use reflection of meaning?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	13 (33%)	11 (28%)	51%	ns	1
Rater 2 = no	8 (21%)	7 (18%)			
Oct. Question 17: Facilitator Use reflection of meaning?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	**14 (34%)***	5 (12%)	66%	4.447 .04	1
Rater 2 = no	9 (22%)	**13 (32%)**			
AUG. Question18: Facilitator Used summarization effectively?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	**26 (67%)***	5 (13%)	77%	4.11 .04	1
Rater 2 = no	4 (10%)	4 (10%)			
Oct. Question 18: Facilitator Used summarization effectively?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. P value	df
Rater 2 = yes	**31 (76%)***	1 (2%)	91%	20.032 .0001	1

Rater 2 = no	3 (7%)	6 (15%)			
AUG. Question19: Facilitator Refocus the session when necessary?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	29 (74%)	5 (13%)	77%	ns	1
Rater 2 = no	4 (10%)	1 (3%)			
Oct. Question 19: Facilitator Refocus the session when necessary?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	32 (78%)	2 (5%)	83%	ns	1
Rater 2 = no	5 (12%)	2 (5%)			
AUG. Question20: Facilitator Used interpretation appropriately?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	34 (87%)	1 (3%)	90%	ns	1
Rater 2 = no	3 (8%)	1 (3%)			
Oct. Question 20: Facilitator Used interpretation appropriately?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	36 (88%)	1 (2%)	90%	ns	1
Rater 2 = no	3 (7%)	1 (2%)			
AUG. Question21: Facilitator Demonstrated appropriate self-disclosure?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	23 (59%)	4 (10%)	67%	ns	1
Rater 2 = no	4 (10%)	4 (10%)			
Oct. Question 21: Facilitator Demonstrated appropriate self-disclosure?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	df
Rater 2 = yes	22 (54%)	5 (12%)	59%	ns	1
Rater 2 = no	12 (29%)	2 (5%)			

AUG. Question22: Facilitator Summarized at conclusion?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	DF
Rater 2 = yes	26 (68%)*	4 (10.5%)	79%	5.109 / .02	1
Rater 2 = no	4 (10.5%)	4 (10.5%)			
Oct. Question 22: Facilitator Summarized at conclusion?	Rater 1 = yes	Rater 1 = no	Rater agreement (sum of agreed responses)	Chi Sq. / P value	DF
Rater 2 = yes	29 (71%)*	5 (12%)	83%	10.128 / .001	1
Rater 2 = no	2 (5%)	5 (12%)			

Items Showing Consistent Agreement

A number of the items analyzed in both rounds did not yield a chi-square. This resulted from items not producing enough variance in the responses. Due to the nature of chi-square statistic, some variance must be present for the statistic to work. For example, on a number of the items raters unanimously selected a "yes" response making variance completely non-existent. In these cases, even though the chi-square statistic is not useful, the frequency of agreed upon responses indicates that the percentage of agreement between the raters between the raters was perfect and that the criteria in the item is clearly present in the sessions.

However, even without the chi-square result, the frequency of the responses demonstrated by the chi-square table provides valuable information. The analysis indicated that for both second (August) and third (October) rounds, on 13 of the 22 items on the scale, raters agreed that over sixty percent of sessions demonstrated that a criterion being measured was present. Sixty percent was chosen as the level to be included in the list of items that demonstrated agreement that a certain criteria was present in sessions for the following reason: sixty percent seems reasonable in showing a remarkable amount of agreement (on over half of

the sessions the raters both agreed that the quality was present) between the raters. Table 11 displays the items in which raters strongly agreed that the characteristic in question was evident in the sessions.

Table 11: Raters agreement that at least sixty percent of the sessions demonstrated the quality being measured in videotaped sessions.

SCALE ITEMS	# and percent of sessions that raters both indicated "yes"	
	October (N=41)	August (N=39)
5. Did the facilitator(s) (explicitly or implicitly) promote **prosocial interactions** during the session?	40 (97%)	38 (97%)
6. Did the group (explicitly or implicitly) promote **prosocial interactions** during the session?	40 (98%)	39 (%100)
7. Did the facilitator(s) (explicitly or implicitly) **identify and challenge anti-social attitudes** and behaviors?	37 (82%)	32 (82%)
8. Did the group (explicitly or implicitly) **identify and challenge anti-social attitudes** and behaviors?	37 (90%)	30 (77%)
9. Did the facilitator(s) **respond to questions** or concerns expressed by group participants?	26 (63%)	38 (72%)
12. Did the group demonstrate an **ability to talk about and understand the subject matter** of the meeting?	41 (100%)	39 (100%)
13. Did the group demonstrate a basic **respect and cooperation** with one another?	41 (100%)	39 (100%)
14. Did the facilitator(s) demonstrate an **attentive posture** to the group members?	39 (95%)	39 (100%)
15. Did the facilitator(s) display **acceptance** of the group members?	40 (98%)	39 (100%)
18. Did the facilitator(s) use **summarization** effectively in the session?	31 (76%)	26 (67%)

19. Did the facilitator(s) **refocus** the session when necessary?	32 (78%)	29 (74%)
20. Did the facilitator(s) use **interpretation** appropriately in the session?	36 (88%)	34 (87%)
22. Did the facilitator(s) **summarize the subject matter** at the conclusion of the session?	29 (71%)	26 (68%)

Table 12 indicates the percentage of agreement between the raters of each of the items for each of the rounds of rating. Of the 22 items, 10 of the items had percentage of agreement between the raters above .80 for both of the August and October rounds. Of the remaining items, only one item ("Did the facilitator use reflection of feeling?") had percentage of agreement between the raters under .50.

Table 12: Percentage of agreement between the raters of Items for both the August and October Rounds of Rating

ITEM #	OCTOBER	AUGUST
1	76	81
2	86	76
3	85	77
4	96	100
5	97	97
6	98	100
7	87	82
8	90	82
9	73	77
10	74	51
11	57	57
12	100	100
13	100	100
14	95	100
15	98	100
16	71	44
17	66	51
18	91	77
19	83	77
20	90	90
21	59	67
22	83	79

Discussion and Implications

Percentage of agreement between the raters of the Ratings

The percentage of agreement between the raters for the ratings is strong and robust for many of the items. On the items that did not demonstrate adequate percentage of agreement between the raters, several factors are implicated to account for this. First, the raters may not have been adequately trained on the items. Their understanding of the meaning of the central concepts of items may not have been clear. Second, the items themselves may have been worded poorly. Or, third, some of the items may have been difficult to recognize when viewing the sessions due to their intangible or abstract nature.

In the future development of this scale, the items with questionable percentage of agreement between the raters either need to be analyzed within the theoretical context of the model to determine whether or not they should be removed, or reconceived and clarified with those using the scale. The scale can be used as an effective resource for the training and supervision of those facilitating the Red Wing Model. It can also be utilized by those who are implementing this RSAT model in other facilities.