CLINICAL PROGRAMS EVALUATION-PHASE 1

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This report contains the qualitative analysis of the Violence Reduction Program, Sex Offender Programming iHeLP and oHeLP, and the Residential Treatment Community.
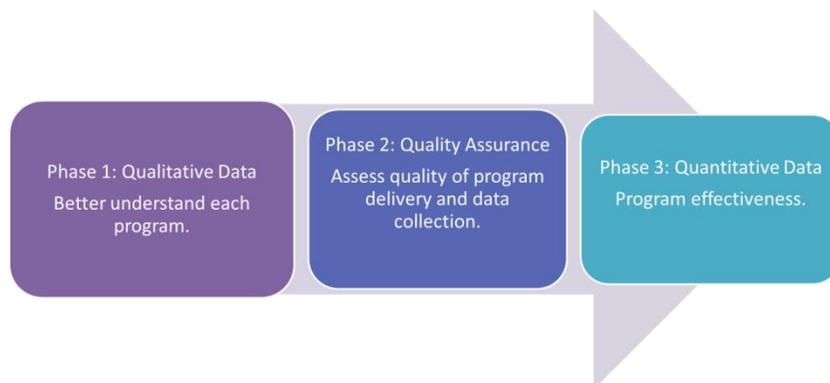
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Executive Summary

I was hired by the Nebraska Department of Correctional Services (NCDS), Research Division, to conduct internal analysis of the programs offered at NDCS. This report uses various research methods to measure the progress and effectiveness of clinical programs offered by NDCS. The process includes three phases. The first consists of evaluating qualitative data. Inmates and staff were interviewed to obtain a holistic perspective of the clinical programs. Phase Two will incorporate quality assurance and data collection. Lastly, Phase Three will be quantitative analyses where I will use statistical modeling to assess effectiveness of clinical programs. Over a six-month period I evaluated the following programs: Violence Reduction Program (VRP), iHeLP (Inpatient Sex Offender Program), oHeLP (Outpatient Sex Offender Program), and Residential Treatment Community (RTC).

Throughout this evaluation process I gathered information about topics such as the housing unit, educational level of inmates, intensity of program, training for staff, progress assessment for inmates, and parole readiness. This report encompasses the voice of inmates, clinical staff, and administration on the current status of the clinical programs and aims to identify why the programs are in their current situation and what their goals are. The key recommendations presented in this report include improving the environment for the inpatient programs, decreasing programming waitlist for screening and entering programs, implement strategies to overcome educational barriers, and addressing communication gaps within the behavioral health team.

Introduction

The purpose of this program evaluation is to provide an objective perspective of the current status of clinical programs and to provide recommendations for improvements of program implementation and data collection. There are three phases to this process. The first phase consisted of interviewing inmates, unit staff, facilitators, supervisors, program managers, and decision-makers to obtain an understanding of the status of each program, data collection methods, learn the strengths and areas in need of improvement, as well as identify the goals for each program. The second phase consists of quality assurance. In this phase I will be using the clinical staff as a resource for knowledge to create an assessment to measure fidelity to the program model. Phase three will be assessing the quantitative data for the programs. I will be conducting analysis and developing reports to see the effects of programs on inmate behavior (Misconduct Reports), recidivism reports, and analyzing the exit surveys. This information herein was gathered during the six months I have been working on phase one in evaluating the Violence Reduction Program (VRP), iHeLP (Inpatient Sex Offender Program), oHeLP (Outpatient Sex Offender Program), and Residential Treatment Community (RTC).

Phase 1: Qualitative Data
Better understand each program.

Phase 2: Quality Assurance
Assess quality of program delivery and data collection.

Phase 3: Quantitative Data
Program effectiveness.

Qualitative Methodology

As a whole I will be using the multi-method approach in evaluating clinical programs. My intent was to start off with quantitative analysis, but in the process I came across various data discrepancies. There are multiple historical records that must be updated, missing start/end dates for programming due to inaccurate data entry, data has been overwritten when updated, and terminations/withdrawals are not consistently tracked on NICaMS. For these reasons I started this project by conducting qualitative analysis to provide me with a rich understanding and context for the later quantitative analysis. Specifically, I used exploratory research to obtain more information for a problem that has not been clearly defined.

In my interview questionnaire I took a grounded theoretical approach, which is an inductive paradigm to research. I used initial guiding questions addressing core concepts, but the questionnaire was not intended to be a static or confining tool. The questionnaire was to guide the research while allowing flexibility to incorporate topics that came up organically during the interview process. The sample size is 98: 48 staff members (unit staff, facilitators, supervisors, program managers, and administration) and 50 inmates. There were five survey instruments used and each instrument was tailored to the specific job classification. Questions were identical within job classification. Participation was voluntary and the opportunity to participate was offered to all Behavioral Health (BH) staff involved in Residential Treatment Community, Violence Reduction Program, and the Sex Offender Programs iHeLP and oHeLP via email.

Inmate interviews were drawn from samples of those who were terminated from a program by staff, those who self-terminated, refusals, completed unsatisfactory, and completed

adequate/satisfactory. In order to obtain this sample the program managers for each program were contacted and asked to provide a random sample of the inmates from the various levels of program. The need to contact staff directly for this list is because refusals and terminations are not tracked on NICaMS.

Once all the data was collected I analyzed the responses for themes and patterns until I reached a saturation point. This means that when going through the interview responses the same information became repetitive and no new information was added. The results of the interviews helped me to determine the goals behavioral health has and also to discover ideas and insights for various issues in programming.

The interview results reported for each program (VRP, iHeLP, oHeLP, RTC) will begin with a description of the clinical review team. Then a description of the program will be followed with the topics pertaining to the program. After that the behavioral health goals will be described and the barriers to achieving those. Lastly, there will be a description of what my role is in working with behavioral health in helping them accomplish their goals.

Clinical Violence Offender Review Team- CVORT

Clinical Violence Offender Review Team makes decisions for initial recommendations, termination, placing an inmate on probation within the program, inmate progression (whether to go to the next phase), and treatment outcome (satisfactory, adequate, or unsatisfactory). CVORT contains about six members and no CVORT member is a facilitator for VRP. CVORT utilizes the Pre-Sentence Investigation (PSI), class study, occasionally staff input (such as inmate's supervisor for job, unit staff feedback) and the inmate's institutional behavior to make decisions. When there is no PSI available CVORT will delay making a decision until they have tried to get

the most information possible, such as police records. All of these documents must be compiled for each inmate prior to the meeting where CVORT will review them.

The current process of preparing information for CVORT is the program manager for violent offenders collects all information available for the inmates that are next on the list to review. This program manager will then work on reviewing the cases that are clearly identifiable to which program an inmate needs: the so called "black and white" cases. At the meeting only the difficult cases are brought for review. Due to the abundant amount of paperwork, CVORT would benefit from a staff assistant who could help in preparing the paperwork for the CVORT meetings, as well as in screening individuals for the "black and white" cases. This would free up time for a LMHP to do duties where a mental health individual is needed.

There is verbal consensus of the decisions made as well as a signed document showing agreement. CVORT members are allowed to dissent to a recommendation and document that formally. There must be at least three members in agreement for a recommendation to be made. If all six members are present, there must be a majority vote. *See Appendix 1 for the statistics of the current status of CVORT workload and information related to VRP completion.

Violence Reduction Program-VRP

The Violence Reduction Program is a 9-12 month program. It is inpatient and meets twice a week for two hours. Each group contains a maximum of twelve individuals. VRP is divided into three phases. The current training method for the facilitators for VRP is informal. Not all facilitators have gone through formal training from Dr. Wong on the model. Facilitators have cognitive behavioral training and learn on the job to facilitate for VRP with the guidance of facilitators already trained in the model.

There is currently no quality assurance in VRP. Because of staff's high workload, formal quality assurance has not been a priority, exit surveys, however, are conducted to obtain feedback from inmates. The current progress assessment is semi-formal assessment. Staff rely on the notes they take after each group session and observations of how inmates are interacting with their peers and other staff to determine the inmate's level of progression. This is used in conjunction with the treatment plan. The quantifiable aspect of the progress assessment is the Violence Risk Scale [VRS], which is used to inform the treatment plan and should be completed at the beginning and end of treatment. This scale allows for participants to demonstrate increased understanding of risk factors and progression through the stages of change. Scores on the VRS can go down based on the second evaluation and this is the preferred way to document progress.

Entry to the Violence Reduction Program

At intake, if inmates obtain a violence offense score greater than six then they are put on the CVORT screening waitlist. Inmates wait approximately 715 days from admission to program recommendation. There is variance in days waiting caused by an individual's sentence structure in number of days waiting. Currently the list for screening holds 805 individuals. Inmates are screened based on parole eligibility date, tentative release date, and other clinical factors. An average of 50% of inmates starts VRP before their parole eligibility date (PED). An average of 9% of inmates complete the program before parole eligibility date with an adequate or satisfactory completion. There are various contributing factors to why an inmate may not complete before parole eligibility date including inmate behavior, placements in restrictive housing, program length, and granted parole.

Many inmates prefer to jam out because they are not able to start/finish VRP with adequate time before PED. Although there was negative feedback on the wait time to get into

VRP, inmates did admit that after going through the whole program they saw why it took so long and understood more of the frustrations that staff have in having only minimum resources. Facilitators observe resistance from inmates and also notice that they do not have that mentality to change due to motivation for programming being low.

The recommendation for this issue is to reduce the waiting period for programming. A barrier to meeting this need is that there are only three VRP facilitators and two groups running at the time of this report. More facilitators will be trained in October 2016 to obtain more groups and meet inmate needs. In addition, operational changes are being made to ensure that inmates are screened and recommended for programming within 90 days of admission to NDCS. Another barrier is the allocation of space for the group sessions. Parole is a major incentive inmates have in completing VRP. Alternative recommendations include offering a different incentive for programming such as priority on wait list to obtain job skills like construction or a welding certificate.

Dosage of the Violence Reduction Program

Inmates would like to see an increase in intensity of the program because there are too many free days. Inmates indicated that having group sessions three times per week would be most beneficial. In addition, inmates would like more one-on-one meetings with facilitators. Facilitators are challenged however, because they must also provide multiple mental health services/duties such as responding to emergencies, counseling general prison population, segregation among others, along with providing VRP. Currently facilitators are meeting inmates individually at least five times for each major project, at the end of each phase, and then as requested. Each facilitator has a case load of eight participants when two groups are running. The estimated time VRP facilitators spend on one group each week: 4 hours for the group sessions,

1.5 hours for group notes, 3 hours to review projects and assignments, 2 hours to prepare for sessions, and 2-6 hours for paperwork including discharge summaries, creating documents for CVORT referrals, responding to kites, and others. Facilitators spend approximately 14 hours a week, or 56 hours a month, for a single VRP group. When two groups are running VRP facilitators spend about 28 hours per week, or 112 hours a month, on VRP. A recommendation for this issue would be to obtain staff dedicated just for VRP. This would allow for more one-on-one sessions with inmates and to increase intensity of program.

Duties for one Violence Reduction group	Hours per week
Group sessions	4 hours
Group Notes	1.5 hours
Review of Projects and Assignments	3 hours
Preparation for sessions	2 hours
Paperwork: discharge summaries, creating documents CVORT referrals, responding to kites, and others	2-6 hours
An approximate total spend on VRP per week	14 hours
An approximate total spent on VRP per week with two groups running	28 hours

Housing Unit for the Violence Reduction Program

Inmates perceive the unit staff needs to do more monitoring and provide a better therapeutic environment. The unit staff does obtain information about the program from the VRP facilitators, but they would still like a formal training to deal with volatile inmates. A recommendation for this would be to create a training curriculum about the program for the unit staff. This would allow for the unit staff to be more knowledgeable about the program and to be

aware of the expectations of the program. Also, it would give insight to unit staff on what to monitor for in the unit and how to provide guidance so that inmates can be successful in the program.

There are 20 cells per gallery and 40 inmates per gallery in the VRP unit. When there are two VRP groups running (about 24 inmate's total) inmates are housed with about 16 general population inmates. For the most part, inmates do not like having to move to the VRP unit where they feel more provoked to do violent actions. Inmates perceive that other inmates and staff pick on VRP members since they are usually close to their tentative release date and know they are trying to not misbehave. Also, inmates don't like being demoted to medium/max custody. The inmates would rather just not take VRP just to avoid being in that setting. They note it is not a therapeutic setting and it is a very stressful environment. All inmates interviewed said the worst part of VRP is being in that unit.

Facilitators teach inmates on how to deal with those who are "bullying" and to use skills from VRP to overcome those challenges. Facilitators would like a unit just for VRP members. Unit staff rotates frequently creating inconsistency with treatment of inmates in unit. A recommendation for this issue would be to separate VRP members from inmates in the general population. Also, create permanent unit staff positions that are dedicated to the VRP unit. This would allow for those unit staff members to go through intense training specific to VRP so that knowledge is obtained about the program and its expectations. Trust and rapport can be built with the inmates and the unit staff can be mentors when counselors are not present.

Education Barriers in the Violence Reduction Program

Inmates struggle with reading, writing, and vocabulary needed for VRP and would like a pre-requisite program. When facilitators encounter education barriers they consult with CVORT

to obtain feedback on ways to handle these issues. VRP facilitators conduct verbal tests at the end of phase assessments, when they notice inmates have poor writing skills but appear to comprehend material. Facilitators conduct one-on-one sessions with those that request help in their projects and homework. CVORT will recommend probation when facilitators express concerns of lack of motivation or progress. Probation is an intervention method that is meant to encourage participants. The purpose of it is to provide inmates with an opportunity to meet goals that will address certain areas of concerns. Moral Reconation Therapy is staged to be a pre-requisite program to take before intensive treatment. A recommendation to better meet inmate needs in education would be to collaborate with education to obtain Test of Adult Basic Education [TABE] results prior to VRP. Education can customize their material on vocabulary and enhance writing skills to better prepare inmates prior to entering VRP. The Strong-R can also assist in screening those who have not completed General Educational Development (GED) and require those inmates to be referred to education.

Assessment of Progression in the Violence Reduction Program

Inmates have concerns about their evaluation of progression by CVORT. Inmates would like CVORT to conduct an interview prior to making determinations of program completion. The process for assessment of progression is that facilitators gather information from their notes and the treatment plan of the inmates as well as they go to the VRP unit every Tuesday to check on the inmate behavior and talk with the unit managers. There is a log book where the unit staff can write notes regarding the VRP members whether it be positive or negative. This information is then used in conjunction with the treatment plan. Facilitators make sure they present both positive and negative facts in their document sent to CVORT. Facilitators send a document to CVORT at the end of each phase for their decision on evaluation of progress, including all

available information. Also, when facilitators see inappropriate behavior or lack of motivation from inmates they send a document to CVORT so that they may make their decision of termination/probation/outcome decision.

Facilitators like the format that CVORT makes the final decisions about an inmate's progress because it takes some pressure off from them. Also, facilitators indicated that they have good communication with CVORT. A recommendation would be to create a progress assessment matrix to use in conjunction with the other documents. This would help facilitators in keeping weekly/or monthly progress documented.

Overall Feedback for the Violence Reduction Program

Inmates indicated that after finishing the program successfully they understood why the program was the length it was. Inmates noted that facilitators are able to break down terms in an understandable way. Techniques learned are applicable to relationships and helped better their personal life. Inmates found it very helpful to contemplate on why they committed their crime. Many inmates stated how they already knew the material but didn't know how to apply it and the program provided various ways to do that. Various elements in their life were brought to light and inmates found the facilitators to be good listeners. The inmates reported that the thought process you have to go through is challenging but beneficial. All inmates interviewed said they really benefitted from learning their risk factors of what the triggers are to their personal violence. The take away almost all of them said was "Thinking before you act" and the "Stop & Check". Inmates indicated that they would like a role model to come in and talk to them at the end of treatment to provide motivation for success in program.

Clinical Sex Offender Review Team- CSORT

Clinical Sex Offender Review Team makes decisions for initial recommendations, termination, probation, progress (whether to go to the next phase) and treatment outcome. CSORT contains about five members and includes a representative from each facility where sex offender programming is offered (usually the psychologist). Members of the team recuse themselves when they have facilitated for an inmate in which they are reviewing. CSORT utilizes the Pre-Sentence Investigation (PSI), class study, occasionally staff input (such as inmate's supervisor for job, unit staff feedback) and institutional behavior, to make decisions. When there is no PSI available, decisions are based on information that is available. CSORT will delay making a decision until they have tried to get the most information, such as police records. All of these documents must be put together for each inmate prior to the meeting where CSORT will review them. There is verbal consensus of the decisions made as well as a signed document showing agreement. CSORT members are allowed to dissent to a recommendation and document that formally. There must be a majority vote for a recommendation to be made. *See Appendix 2 for the statistics of the CSORT workload and information on iHeLP and oHeLP completions.

Sex Offender Programs-iHeLP & oHeLP

The oHeLP program is outpatient and is a 12-15 month program that has two phases and meets once a week for about two hours. The iHeLP program is inpatient and is a 2-3 year program that has two phases. Phase 1 consists of the Healthy Lives group once every three weeks for two hours, peer support twice a week for one hour, once a month community meeting for one hour, and meeting with therapist is once every three weeks at minimum. Phase 2 consists of core groups once a week for two hours, 3RT groups once a week for two hours, once a month community meeting for one hour, and meeting with therapist once every two weeks minimum.

Phase 1	• Once every three weeks Healthy Lives Group • Peer support twice a week for an hour • Once a month community meeting for an hour • Meeting with therapist occurs once every three weeks minimum
Phase 2	• Core groups meet once a week for two hours • 3RT groups once a week for two hours • Once a month community meeting for an hour • Meeting with therapist occurs once every two weeks minimum

Current staff training method for these programs is semi-formal. Two staff members for sex offender programming are Certified Trainers for the Static-99R, Stable-2007, and Acute-2007. These two staff members provide training several times a year as needed based on the addition of new staff. The training is also offered to Probation and Parole for their staff members who work with sexual offenders as well as outside community mental health staff are invited to attend. This training has been provided since late spring of 2012. Normally an average of 3 trainings a year and lasts 2.5 days each. In addition to this training, new staff is given the packet of materials to read and an experienced facilitator will go over materials and answer any questions. New staff are paired with an experienced facilitator and act as a co-facilitator until they are comfortable being a leader.

Because behavioral health is short staffed, leaders have stepped in to facilitate for programs and have not been able to do much quality assurance, such as making sure oHeLP in both Omaha Correctional Center and Nebraska State Penitentiary are delivering the program in the same way. Currently exit surveys are not being done but have been implemented in the past. The current progress assessment for iHeLP is formal. There is a rating sheet which is filled out by facilitators as well as inmates to determine progress on the various areas such as homework,

attendance, and quality of feedback during group. The current progress assessment for oHeLP is informal. Staff rely on the notes they take after each group session and observations of how inmates are interacting with their peers and other staff to determine the level of progression. This is used in conjunction with each inmate's treatment plan.

Entry to Program iHeLP & oHeLP

At intake, if inmates come in on a sexual offense then they are put on the CSORT screening waitlist. Inmates wait approximately 1,094 days from admission to program recommendation. There is variance in days waiting caused by an individual's sentence structure in number of days waiting. Currently the list for screening holds 550 individuals. Inmates are screened based on PED, TRD, and other clinical factors. An average of 50% of inmates start iHeLP before their parole eligibility. An average of 31% of inmates start oHeLP before their PED. An average of no iHeLP participants complete the program before their parole eligibility date with an adequate or satisfactory completion. An average of 1% of oHeLP participants complete the program before their PED with an adequate or satisfactory completion. There are various contributing factors to why an inmate may not complete before their PED including inmate behavior, placements in restrictive housing, program length, and granted parole.

Inmates prefer to jam out because they are not able to start or finish iHeLP/oHeLP with adequate amount of time before PED. Facilitators note resistance from inmates and that they do not have that mentality to change due to motivation for programming being low. The recommendation for this issue is to reduce the waiting period for programming. A barrier to meeting this need is the capacity limitation for the iHeLP program due to bed availability. A recommendation for this would be to develop a method to improve efficiency in completing psychological evaluations so that transition process is more efficient.

Projects for iHeLP & oHeLP

There are two in-depth projects where inmates talk about crime. The disclosure project in which inmates are asked to write a detailed description of their crime and then staff makes sure it aligns with the information that they have (such as the PSI). The alternate disclosure project is where inmates write a detailed description of their version of what happened. Inmates feel criticized for their crime and indicated that staff needs to have a better understanding of their crime. The recommendation for this issue is to emphasize that the purpose is not to analyze the crime committed. Due to lack of information, plea bargain, and other factors it is hard to determine the accuracy of details of a crime. Staff is understanding of this and focuses more on whether the inmate takes steps toward changing their behaviors/lifestyle.

Education Barriers in iHeLP & oHeLP

Programs are very writing intensive and inmates would like staff to be more patient with those with learning disabilities. The iHeLP staff would like inmates to have access to computers in education. Facilitators consult with CSORT to obtain guidance when encountering education barriers. CSORT makes recommendations such as working more frequently with participant and have participant paraphrase concepts back to therapists, request specialized intelligence testing, pair inmates with a peer to assist in writing, and collaborate with education for specific learning deficits. The recommendation is to assess the benefits and the risks in giving inmates in the iHeLP program computer access. The second recommendation is to obtain the educational pre-requisite such as the TABE prior to entering sex offender programming. The progress on this issue is that iHeLP staff created a group for those with developmental needs where materials are presented in alternate formats.

Social Stigma in Sex Offender Programming

Inmates feel stigmatized and isolated by other inmates and unit staff. Staffs provide inmates with skills on dealing with this stigma, but staff themselves feel stigmatized by the team. This stigma stems from unit staff in the facilities as well as mental health staff. The recommendation is to model inclusive behavior to enhance NDCS culture. Progress on this issue is that recently participants in the oHeLP program were given a study room for concentration on major projects. The intent for this study room is to provide oHeLP participants with more opportunity to collaborate with peers on their projects, given that many indicate that due to the social stigma in the yard they don't like to associate with others from the sex offender program.

CSORT and the iHeLP & oHeLP Programs

Inmates see that there is a lack of communication and that CSORT needs to have more personal contact with facilitators. Facilitators feel decisions are communicated by CSORT just not always in a timely manner. The progress on this issue is that CSORT is working with staff to have draft letters with the decisions made by CSORT to increase communication with facilitators. Also, facilitators indicated that they would like to learn more about the CSORT process. The first recommendation is to create a rotating position in CSORT. The second recommendation is for CSORT to work on consistency and efficiency in communicating decisions.

Program Curriculum-iHeLP

Inmates would like more groups in Phase 1. Specifically inmates indicated they would like the 3RT groups to be in Phase 1 and Phase 2. Staffing issues are a barrier to providing more treatment sessions and more one-on-one sessions. Administration is working on obtaining competitive wages to attract and maintain program facilitators. In addition, one LMHP position has been added to the iHeLP staff.

Environment-iHeLP

Inmates would like an improved method in changing cells. iHeLP inpatient unit contains 26 cells and has a bed availability of 52 participants (26 upper bunks and 26 lower bunks). At the time of this report, 22 iHeLP participants hold a bottom bunk pass. There are issues with room placements due to the medical bunk passes that inmates hold. Staff are aware that the medical bunk passes limits compatibility of pairing inmates in the unit. An additional issue arises due to iHeLP staff conducting PREA reviews in deciding room placements. Staff need to monitor and keep perpetrators and potential victims separate. Having those bunk passes limits the ability for staff to accomplish their role in keeping that separation. Staff have voiced their concerns that medical is not responsive to efforts to have the bottom bunk passes checked and that medical responds aggressively to staff members when they suggest that a particular inmate does not need a bottom bunk pass. Staff note that medical at Lincoln Correctional Center seems to be resistant to revoking bottom bunk passes. Currently, there is no process for referral of participants back to medical to have the passes checked or revoked for participants who do not truly need them. Also, inmates admit that it is easy to get a bottom bunk pass. In addition, due to data inaccuracies on NICaMS, medical bunk passes are sometimes not entered or not removed. The recommendation for all data entry into NICaMS is to make sure that it is regularly updated when needed and that it is current.

Unit staff would like iHeLP staff to communicate to inmates they are moving. Unit staff realizes they are placed in a bind when they are the ones to communicate to inmates that they are moving without knowing the reason why. A recommendation for this is to work on a strategy to best communicate to inmates they are transferring. In addition, unit staff would like the list of inmates getting closer to finishing the program to be emailed sooner so that the process can be

initiated earlier for a smoother transition. Unit managers indicated that having a list of clinical programs with a detailed description and the mental health contact person would be helpful. Progress on this issue is the Health Services Plan which contains information about each program and will be coming available soon.

Assessment of Progression-oHeLP

Inmates realize their behavior in the unit is not accurately assessed. oHeLP is an outpatient program therefore inmates are in various housing units. Staffs acknowledge that they can improve on contacting the designated unit staff to incorporate this in assessment. The first recommendation is for oHeLP staff to improve communication with unit staff. The second recommendation is for staff to consider creating a progress assessment tool. This progress tool will assist in keeping daily/monthly tracking of progress and also accountability that all resources were taken into account in the evaluation process.

Inmates also indicated that they would like one-on-one sessions to be part of the program. oHeLP staff conduct various other programs such as Anger Management and Domestic Violence. Due to time allocation, one-on-one meetings with inmates in oHeLP program is not offered as part of the program but does happen when requested by inmates. oHeLP staff indicated contact with inmates outside of group does not happen often.

Program Length oHeLP

Inmates indicate that the length of the program is good but they would like transparency in program description. Inmates indicate that oHeLP is usually taking more than a year. Facilitators are aware that the program runs long sometimes but is because it depends on the pace of the group. Each group is different and learns at a different pace. A recommendation would be

to ensure a balance in group check-in's and adjust the program description so that it is more accurate.

Language Barriers-oHeLP

Inmates indicate that they struggle with a language barrier, specifically Spanish speaking participants. Facilitators have accommodated these inmates by creating handouts and manuals in Spanish. The recommendation for this is to use the Strong-R to see if there is a great need in the NDCS population for an oHeLP program to be in Spanish. CSORT utilizes interpreters as well as pairing inmates with mentors to assist them in the projects and homework.

General Feedback from Inmates-iHeLP

Inmates would like one male & one female facilitator. They recognize that this would balance out the group more and that they would feel more comfortable when discussing certain topics. Inmates also indicated that the facilitators blend positive and negative feedback and this confuses them on where they are in their progress. Inmates note that the groups cannot relate to gang issues and staff does not know how to help deal with that in the programs at NDCS.

Inmates indicated that staff is professional and provide tough feedback, but it is beneficial. Unit staff contributes to a therapeutic environment. Those who complete successfully indicate that the length of the program is perfect. Inmates find it helpful that the material is repetitive. Inmates are very proud of their projects. Many inmates keep their projects and assignments to remind themselves of the material after completing the program. These projects are a reminder of the goals that they have and how they can accomplish them.

General Feedback from Inmates-oHeLP

Inmates thought at first it was a weakness to take this program, but after completing it they realized it was good to ask for help. Inmates indicated that this program helps in their self-

esteem building and to have a more positive outlook on life. The program helped inmates to communicate with family and others, find hobbies, and recognize triggers and methods for asking for help. Inmates found it helpful to have a victim come in a group session to present. Inmates appreciate the articles brought in that relate to the topics being discussed and it makes group more interesting.

Clinical Substance Abuse Review Team-CSART

Clinical Substance Abuse Review Team makes decisions for appeals to the initial recommendation and interview requests. CSART meets once a week and consists of all supervisor staff for substance abuse. The Clinical Program Manager and the Assistant Administrator for Substance Abuse are the two core members that are always at the meeting. *Please see Appendix 3 for the statistics of CSART workload and RTC completions.

Residential Treatment Community –RTC

Residential Treatment Community is a six month program that consists of three phases. There are process groups that meet four times per week for an hour. The core class meets four times per week for an hour. GED is a requirement for completion of program. If GED is needed, inmates spend eight hours on this per week. Individual sessions are one hour per week. The current quality assurance is inconsistent. On occasion supervisors will sit in on groups and make sure the group is being run according to the curriculum. There are exit surveys conducted to obtain feedback from inmates. The current progress assessment is ongoing. Because facilitators are able to meet with inmates on a weekly basis they are able to update them on their progress verbally. The current training method is semi-formal. There is a yearly training for substance abuse. New staff are given the materials to study and are guided by a supervisor.

RTC	• Process Groups four times per week for an hour • Core class four times per week for an hour • If GED is needed, eight hours per week • Individual sessions one hour per week

Entry to RTC

At intake all inmates, with exception of parole violators and refusals, are screened for drug and alcohol use when entering the Diagnostic and Evaluation center. Inmates are screened again at the assigned facility by a Licensed Alcohol & Drug Counselor. Inmates can send an application for programming at any time after the recommendation has been made. The waitlist for RTC currently has 137 individuals. Inmates are screened based on PED, TRD, and other clinical factors. An average of 73.3% of inmates start RTC before their PED. An average of 52.4% of RTC participants complete the program before PED with an adequate or satisfactory completion. There are various contributing factors to why an inmate may not complete before PED including inmate behavior, placements in restrictive housing, program length, and prior parole revocations. Sometimes inmates will need to be transferred and they are taken out from the program in their facility without completion. In this case, inmates are put on the waitlist for the program in the facility they go to because of bed availability. The suggestion that arose in entry to RTC from inmates is that in transfers inmates would like to start in a program where they left off as soon as they get to the assigned facility, instead of going back on a waitlist. Staff is working on standardizing programs to best meet inmate needs.

Environment at RTC

Inmates do not feel support from unit staff. Inmates observe that the staff provoke them to get in trouble. The unit staff see the stress inmates go through in having different staff all the

time. Unit staff see other unit staff act with inappropriate behavior towards RTC participants. For example unit staff noted verbal and aggressive demeanor towards inmates. The recommendation for this is to hire permanent unit staff who can obtain in-depth training on RTC. Unit staff needs to obtain more training on the purpose and expectations of the program. Progress on this issue is that two permanent corporal positions have been added to RTC.

The inmates in the groups that are not in the program wholeheartedly or do not want to change destroy the environment for the rest of the group. Inmates would like to see more monitoring so that those misbehaving are dealt with appropriately. Also, inmates want someone who can help them stay accountable. Unit staff would like to do more monitoring, such as random urinalysis (UA), but it is very difficult due to the physical layout and lack of staff. The recommendation for this is to obtain Behavioral Specialists that can do more intense monitoring in the unit.

Materials for RTC

Inmates would like more personalization in the material. Inmates recognize that most of the material is directed towards alcoholics. Facilitators indicate that some of the material is outdated and that the intensity of the program should increase. Staff indicated that the DVD's presented need to be updated. Staff would like inmates to keep their workbooks when they finish the program. Also, staff would like to see consistency in the quality of program deliverance. The recommendation for personalization is to provide this through the one-on-one sessions. In order to be effective there must be intense counselor training.

Privacy at RTC

Inmates struggle with confidentiality. Facilitators are aware that there is a lack of privacy in cubicles. While facilitators conduct the one-on-one sessions, other facilitators may be doing

the same and the inmates can potentially hear each other's confidentiality issues. The recommendation is to strategize a plan to increase privacy for the one-on-one sessions.

General Feedback-RTC

Inmates indicated that staff is very responsive to questions and provides good feedback on progress throughout program. Some facilitators have gone through a substance abuse problem and inmates note that it is easier to relate to those facilitators who know their struggles. Inmates appreciate the videos presented. Inmates really like having their own unit and being surrounded by people with the same struggles. Inmates indicated that staff challenges them at times for the better and although they fail staff sometimes, staff don not fail the inmates, and for that inmates admire their attitude. Inmates said the facilitators and counselors are special; they are in a good mood even on the worst days.

Overall Behavioral Health Goals

Overall, behavioral health has many goals they would like to achieve in the next couple of years. One of the goals is that behavioral health is working towards being fully staffed. Currently there are 34 vacancies that need to be filled. BH wants to better assess the true needs of the population, using the Strong-R. A programming goal BH is working towards is meeting offender needs before PED. The goal is to set the standard for the appropriate treatment dosage and caseload for staff. Behavioral health wants to achieve a formal quality assurance process. Administration is working towards increasing training for staff and providing yearly refreshers. Another goal for BH is staff retention. The reasons staff indicated for why they chose the Department of Correctional services is because of job security, the challenging environment, and because they are passionate about their job. Facilitators indicated that the most rewarding aspect of a program is to see the progress from beginning to the end of the group demeanor and

dynamic. Staff would like value given to clinical programming and recognition of progress. Overall behavioral health would like to obtain support from all of their stakeholders and work effectively as a team.

During the interview process several issues arose that are barriers to meeting the goals that behavioral health wants to achieve. Overall, the analysis of responses revealed a lack of communication and a high degree of contention between the behavioral health staff who provide programs and the behavioral health decision-makers. Behavioral health leaders are essential in executing goals and setting the tone for staff. It is very important to work as a team to achieve all of these goals.

Communication

Communication gaps create difficulties between behavioral health staff and behavioral health decision-makers. Behavioral health staff recognize there are sometimes contradictory messages in addressing issues. For example, staff may be given a specific directive from their immediate supervisor and then be given a differing set of expectations from someone higher in the chain of command. This creates difficulty for staff in knowing what their role is and how to carry out their job functions. Staff perceive they have a lack of access to NDCS Executive leadership because the behavioral health leaders have set that tone. Specifically, some behavioral health staff stated in their interviews that they were told not to bring issues to the attention of the NDCS Director and Deputy Directors.

Decision-makers acknowledge that communication could improve amongst the whole team, but note that they have many demands and advise on multiple issues. This requires them to either rely on their subordinates to communicate decisions, or to communicate with line-level staff directly, rather than going through the full chain-of-command. Differing expectations for

proper communication between BH staff and decision-makers however, creates confusion among staff.

In order to address these gaps in communication, it is important to use the chain of command so that information predictably flows in both directions. This can be achieved through methods as simple as carbon copying people in e-mails. In addition, clear and consistent documentation should be used to communicate important information or changes to behavioral health practices so that directives are clearly understood by all involved. In addition to developing a method for effective communication, staff at all levels of behavioral health need to be receptive to feedback. Feedback should be delivered and interpreted as constructive criticism. Approaching communication with respect for each other's professionalism will allow room for growth in behavioral health treatment.

Organization

The discrepancies between the structural and functional organization of the behavioral health staff also creates difficulties in communication. Staff and their supervisors are at times located in different facilities, or in some cases, different cities. Furthermore, the behavioral health organizational chart does not account for the flow of communication of area expertise. For example, some staff has supervisors in different facilities but have an experienced staff member in their own facility. In these cases of staff members in need of ad hoc advice, immediate peer-to-peer communication with an experienced staff member is preferred to the unknown timeliness of supervisory contact.

Program Background

Behavioral health staff would like decision-makers to be educated in each program. They believe that oftentimes decision-makers have assumptions about how programs operate, or how

they should operate, without first talking to staff or observing programs. As a result, misinformation is delivered to internal and external stakeholders about program operations by people who do not fully understand the programs.

The administration often feels undermined by behavioral health staff who question their level of knowledge about treatment programs. Administrators stated that they are working hard to get to all NDCS stakeholders to get a better understanding of the programs and how they operate. In addition, decision-makers noted that they are knowledgeable of the programs and materials that are offered but do not believe they should have to sit in on program sessions in order to obtain details about program delivery. Rather, they believe that information is being communicated to them by the behavioral health staff. Therefore, they use the information they are given (or not given) by behavioral health staff to educate stakeholders about what is or is not happening with regard to inmate treatment.

It is important to ensure that the messages delivered to stakeholders are accurate, consistent, and free of error. One recommendation for working on this is to pair up providers and administration to work as a team to deliver quality messages. This will ensure that relevant treatment and programming staff have all of the necessary information about program delivery, and that these details are communicated appropriately to stakeholders in and outside of the agency.

Decision Making

Because information is not specifically sought out regarding the provision of behavioral health treatment, staff recognize that their expertise is not being utilized as a resource in making decisions. In addition, some staff also noted that they are forced to go against their ethical standards because of threats against their jobs or professional licensures. For example, staff

raised significant concerns during the Justice Program Assessment (JPA) process, in which

contracted evaluators were given permission to observe clinical treatment sessions. When they

contacted behavioral health decision-makers to ask why they were not given more advanced

notice and noted concerns they had regarding inmate confidentiality, multiple staff were directed

to allow the JPA employees into their sessions and raise no further questions or else they would

they would face disciplinary action for insubordination. Behavioral health staff indicated that a

culture of retaliation is not a new phenomenon within behavioral health and has existed for years,

but that culture has significantly increased recently, most notably from the behavioral health

decision-makers and external stakeholders.

Unlike previous NDCS administrations, the current administration is much more

involved in voicing opinions and directing program delivery, which is a hard change for some

staff. Decision-makers note they have pressure to be responsive to outside stakeholders and

perceive resistance to change when their decisions are presented to front-line staff. As for the

example above, the upper-level behavioral health decision-makers were only notified one day

prior to the event with no explanation, but they understand that sometimes these things happen,

and they had to act quickly in order to accommodate JPA. Decision-makers perceive staff as

resistant and unwilling to change because of a belief that the current practices are the correct way

of doing things and there is no reason to change.

Because of the lack of communication in behavioral health, messages may often be

misinterpreted and harsh responses made. Due to the lack of rapport and trust between BH staff

and decision-makers, questions from staff are interpreted as questioning their authority and being

non-compliant. In turn, their responses provide directives for staff action rather than a direct

answer to the question that was asked. Decision-makers feel a lack of trust from staff, not only

in terms of decisions that are made, but in the partnerships that develop them. For example, staff indicate that there need to be boundaries set between those within behavioral health and those who do not have formal backgrounds in clinical treatment, while administrators value the team approach to program decision-making.

This further erodes the line of communication within the chain of command and destroys morale from both sides. While certain situations require quick responses and participation from all staff, decision-makers should allow for a dialogue on controversial topics and resolve the issue with respect, even if that resolution is an agreement to disagree and enforce their original decision. They should also ensure that a context is provided for all decisions so that staff are aware of the reasons for the change being made and understand their importance in the process.

Staff Recognition

Behavioral health staff feels a lack of appreciation. While some staff appreciate decision-makers and supervisors verbal acknowledgment for the work they do, they do not see that appreciation in their actions. When decision-makers attempt to formally recognize staff, it is often for work that is considered to be above and beyond the normal course of their job duties. Staff would feel more appreciation by decision-makers recognizing the work they do on a daily basis with the limited resources available to them.

Decision-makers noted that they believe they often express their gratitude to staff for the work they do and noted that some of their efforts to formally recognize staff have gone unappreciated. They are also working to address staff concerns by working to increase wages, provide additional training, and inform the media on significant behavioral health accomplishments.

While an "us versus them" perspective has been noted within the agency, as a whole, it is also apparent within behavioral health, specifically. This may stem largely from the communication gaps and lack of respect for others within the chain of command. Once this issue is addressed, increased communication will naturally create greater opportunities for administrators to recognize staff accomplishments and for staff to be more receptive to positive feedback and changes from administration.

A strategic plan with targeted goals should be created for each program in behavioral health. The plan will promote consensus among staff and decision-makers in the future direction of programming, and empower staff to regularly monitor their progress and hold themselves accountable for providing treatment. In order to ensure consistency and accountability among programs, an annual event could be created to educate others on the progress being made in each program and to recognize each program for its accomplishments in the past year.

Continual Quality Improvement

My role in working with the behavioral health team to accomplish their goals is to assist in updating historical records, track progress on goals, create an assessment tool to ensure fidelity to models, ensure accuracy of data in NICaMS, and to create documents to measure progress. I will work on conducting recidivism reports, document the effect of programs on misconduct reports, analyze exit surveys of programs, begin to track refusals in NICaMS, and ensure there is the appropriate treatment outcome measure.

Conclusion

In this report I discussed the interview results for each program (VRP, iHeLP, oHeLP, RTC). There was a description of the clinical review team for each program and the topics

pertaining to each program. The behavioral health goals were described and the barriers to achieving those. Lastly, I provided a summary of what my role is in working with behavioral health in helping them accomplish their goals.

Although there is room for improvements, behavioral health is already working on many changes and continues their duties within the programs with the resources available. Overall, clinical programs are understaffed, there are procedural issues that can be fixed, data quality and methods needs to be improved, and there is animosity between decision-makers and staff in communication. In phase two of my project I will be working with behavioral health to ensure the accuracy of the data in NICaMS as well as aid them in developing a tool to assess quality assurance in their programs. By phase three the data collection processes will be solidified and I will have confidence that the programs are being delivered consistently. At this point I will begin conducting complex quantitative analyses to determine the effectiveness of each program.

Current Status of Program

Clinical Violence Offender Review Team [CVORT]

Intake: an average of 404 inmates per year come in on a violence offense [offense score of >=6]	CVORT makes an average of 374 recommendations per year	CVORT meets 2x a month and reviews an average of 25 inmates per meeting	From Admission to program recommendation inmates wait around 715 days	Current Waitlist for CVORT screening has 805 individuals	Length of time between program recommendation & start date: VRP average: 539 days	The average % of inmates who start programming before PED: VRP: 50 %	The average % of inmates who complete programming before PED: VRP: 9 %

Notes: (1) Data reflects years 2014 & 2015 average (2) Data does not include Continuing Care (3) Data reflects the CVORT tab in NiCAMS (4) There is a variance based on an individual's sentence structure in number of days waiting (5) Individuals with short sentences are screened sooner (6) The amount of inmates CVORT reviews includes new reviews, treatment outcomes, and outside referrals (7) Inmates are screened based on PED, TRD, and other clinical factors (8) The % of completion before PED is only adequate and satisfactory completions. (9) % of completion before PED must consider contributing factors such as inmate behavior, placements in restrictive housing, program length, prior parole revocations, and granted parole

Current Status of Programs

Clinical Sex Offender Review Team [CSORT]

Intake: an average of 245 inmates per year come in with a sexual offense	CSORT makes an average of 276 recommendations per year	CSORT meets 2x a month and has reviewed approximately 121 new cases so far in 2016	From Admission to program recommendation inmates wait around 1,094 days	Current Waitlist for CSORT screening has 550 individuals	Length of time between program recommendation & start date: iHeLP average: 576 days oHeLP average: 792 days	The average % of inmates who start programming before PED: iHeLP: 50% oHeLP: 31%	The average % of inmates who complete programming before PED: iHeLP: 0% oHeLP: 1%

Notes: (1) Data reflects years 2014 & 2015 average (2) Data does not include Continuing Care (3) Data reflects the CSORT tab in NICaMS (4) There is a variance based on an individual's sentence structure in number of days waiting (5) PED is the primary factor when screening therefore individuals with short sentences are screened sooner than those with lengthy time before PED (6) The amount of inmates CSORT reviews includes only new cases (7) CSORT has a total of 276 reviews including treatment outcomes, and outside referrals for 2016 (8) Inmates are screened based on PED, TRD, and other clinical factors (9) The % of completion before PED is only adequate and satisfactory completions. (10) % of completion before PED must consider contributing factors such as inmate behavior, placements in restrictive housing, program length, prior parole revocations, and granted parole

Current Status of Program

Clinical Substance Abuse Review Team

Intake: All inmates, with exeption of parole violators and refusals are screened when entering D&E for drug and alcohol use	An average of 1,837 inmates per year come in with a substance abuse diagnosis	Inmates are screened again at the assigned facility by a Licensed Alcohol & Drug Counselor [Inmates can send an application for programming at any time after recommendation.]	CSART meets once a week and reviews only the appeals to recommendations	Waitlist for RTC has 137 individuals	The average % of RTC inmates who start programming before PED: 73.3%	The average % of RTC inmates who complete programming before PED: 52.4%

Notes: (1) Data reflects from years 2014 & 2015 average (2) These numbers reflect data from the SATP tab on NICaMS
(3) Completion before PED is the % of inmates who complete favorably (4) Inmates are screened based on PED, TRD, and other clinical factors
(5) % of completion before PED must consider contributing factors such as inmate behavior, placements in restrictive housing , program length, prior parole revocations, and granted parole