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The Transformation Project: Program Update & Recommendations for the Future - 2019

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Transformation Project



Program Update & Recommendations for the Future – 2019

Prepared by the Nebraska Center for Justice Research



Transformation Project

Program Update & Recommendations for the Future – 2019

Submitted to The Sherwood Foundation ®

by the Nebraska Center for Justice Research

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June 28, 2019

UNIVERSITY OF
Nebraska
Omaha



Executive Summary

The current report outlines the history of the Transformation Project (TP), highlights prior evaluations, and presents a new evaluation. Recommendations for the future of TP conclude the report. TP is a pilot cognitive-behavioral program that targets criminogenic thinking patterns and attitudes in order to promote prosocial outcomes. TP seeks to assist inmates to identify and alter thinking patterns that lead to antisocial behavior. Its ultimate goal is to reduce institutional misconducts and community recidivism, and increase quality of life for inmates and correctional staff.

There are 13 modules completed by each participant. The modules are then collected by staff, commented on by facilitators, returned to participant, and recompleted by the participant. The trained facilitators determine when a participant has completed the necessary cognitive change to advance to the next module. Facilitators are to use Motivational Interviewing techniques that they receive full training on prior to facilitation.

To assess change and program fidelity, there were two evaluation scales administered to participants during programming: the Motivation to Change Scale (MTC) and the Client Evaluation for Motivational Interviewing Scale (CEMI). A pre-post design, the MTC was to be given at the orientation module and upon completion of the 13th module. The CEMI was to be given at modules four, eight, and 12, in order for participants to first get a grasp on the facilitator and reevaluate twice.

In addition to the annotated history of the TP, the current report also provides a new evaluation that examines the TP administered in restrictive housing units in three medium to maximum custody facilities. While prior evaluations have examined TP in the prison general population, the current only examines TP in restrictive housing, which is the only setting in which TP has been running since 2016. The evaluation is limited in its ability to provide a comprehensive process (i.e., formative or implementation) evaluation of program fidelity, but does provide a considerable outcome (i.e., summative) evaluation analysis. Findings suggest that overall, participants (N = 546) had higher motivation to change their anti-social attitudes/behaviors to more pro-social ones at the end, compared to the beginning of programming. However, when considering only the proportion of those completing all 13 modules (N = 91), motivation for change scores did not increase over time. Unfortunately, there was no comparison group available, due to multiple policy changes over the past decade and the program being fully available to all individuals housed in restrictive housing units during the years examined. Essentially, study design and program implementation severely limited the evaluation from estimating a program effect with sufficient power. Further, the proportion of the sample completing all five prescribed scales was less than 2.2 percent, making quantitative analysis of completers fundamentally moot.

Considering the low-fidelity by which the program was administered and data was collected, the current findings should be taken with caution. Generalizations regarding the

TPs potential to affect change within participants and achieve its stated goals should not be made with current or past findings.

However, the report concludes with recommendations to assist future evaluation and implementation. Program fidelity is a central component to the recommendations.

Highlights include:

- Requiring separate agencies to implement and evaluate the program.
- The program coordinator's sole job responsibilities should rest with the TP. The coordinator should be employed by the agency that implements the program.
- Both agencies should be involved in the development of process (formative) and outcome (summative) measures prior to implementation.
- A logic model should be developed and followed to ensure consistency of program delivery.
- The development of metrics and an analysis plan to evaluate the implementation should occur prior to implementation.
- All data should be stored and tracked digitally.
- Extensive follow-up (e.g., 3 years) should be conducted on the outcome measures.
- At least one control group should be developed.
- Control measures should be taken on control and participant groups at multiple points in time, with extensive follow-up.
- Informal buy-in is necessary for all levels of administration.
- Program facilitators should be qualified, trained, and retrained.

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Introduction

The current report presents an overview of the Transformation Project (TP), a novel correctional intervention administered to individuals incarcerated in restrictive housing units, or commonly referred to as solitary confinement, in three facilities in one state. TP is a module-based intervention program for correctional use that integrates the teachings of Malcolm X with cognitive-behavioral techniques designed to initiate change within the participant.

The report consists of five sections. The introduction presents the history of TP and an outline of Malcolm X's life. The second presents prior outcome evaluations, sometimes referred to as summative evaluations. The third section is the current evaluation (2019). The limitations subsection on page 39 is particularly telling of the remaining barriers in implementing TP. Finally, the report concludes with implementation and evaluation recommendations to institutions considering adopting TP. The recommendations reflect the challenges remaining on the individual, institutional, and social levels, including operational, personal, personnel, theoretical, and financial aspects.

Transformation Project

TP is a prisoner transition and reentry program aimed at promoting positive behavior and developing cognitive change during incarceration. It further prepares participants for transition back into the community upon release from prison. TP was initially developed at the encouragement of a generous donor and Nebraska native who wanted to address community needs, including the needs of persons incarcerated in the Nebraska. TP expands on the philosophy of Malcolm X, who strongly believed in education, commitment to purpose, self-transformation, and personal growth as methods to rise above one's circumstances. TP helps participants explore beliefs, attitudes, and actions that may increase one's odds of successful reentry by using the practices of motivational interviewing and cognitive behavioral therapy. TP relies on the life experiences of Malcolm X to help participants determine their core values and to identify choices that lead to successful community reentry (Malcolm X, 1964).

Our Mission

Transformation Project facilitates prisoners in developing a foundation for learning and motivation to change through a process of self-reflection and goal setting

History of the Transformation Project

TP was originally designed for use in the classroom for inmates housed in the general population. TP was first implemented in 2009 with 175 male inmates from three institutions within the Nebraska Department of Correctional Services (NDCS). The modules combine life stories from individuals who changed their lives for the better with exercises based on cognitive-behavioral therapy (CBT) practices. No one evidence-based CBT is used, rather

general CBT practices are used as a foundation. A second trial of the program in general population began at the Work Ethic Camp (WEC) in McCook, Nebraska, in March 2013.

TP was adapted in 2014 for use in restrictive housing. The modifications allowed inmates to engage in programming in their cell through written communication with the program facilitator. The program facilitator provided inmates with written feedback on modules or designated readings in an effort to encourage further thought of topics or ideas relevant to the program. The program lasts approximately six months and targets issues that may better prepare inmates for reintegration into the general population of the prison. Modules allow participants to determine their own goals and values, which are then used to help offenders identify their behavioral motivations. Once motivations are identified, inmates' desire for change are theoretically expected to increase (Miller & Rollnick, 2002).

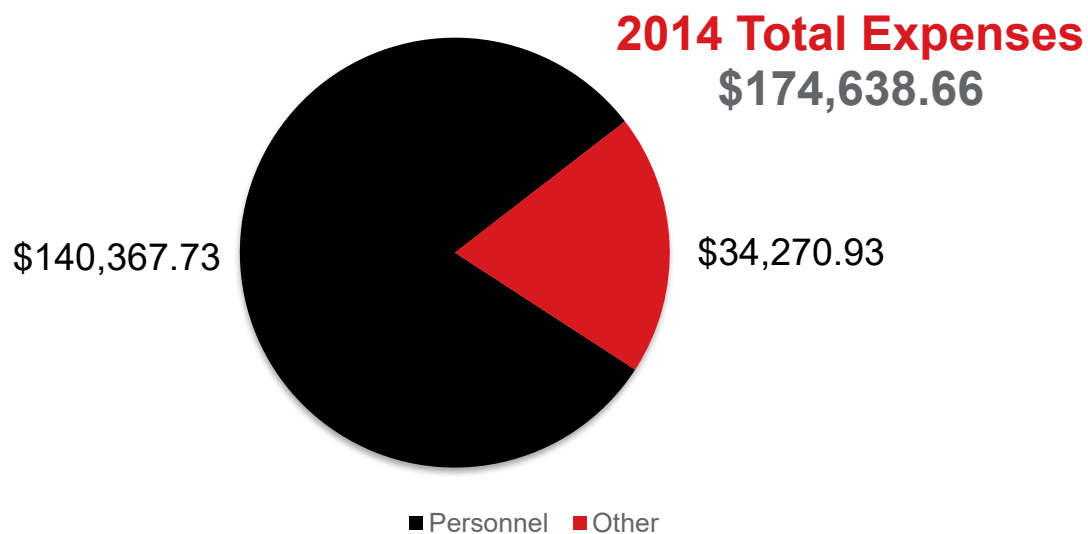


Timeline of Malcom X

May 19, 1925 – Born in Omaha, Nebraska
September 28, 1931 – Malcolm X's father, Earl Little, run over by a street car and died.
January 9, 1939 – Malcolm X's mother, Louise Little, declared legally insane and committed to a mental hospital.
Spring 1939 – Told by teacher that becoming a lawyer is not a "realistic goal for a nigger."
February 1941 – Moved to Boston to live with sister and began involvement with crime.
March 1943 – Moved to New York City. Worked various jobs, hustled and pushed dope.
October 25, 1943 – Avoided military service by pretending to be mentally unfit.
December 1945 – Burglarized Boston homes.
January 12, 1946 – Arrested while reclaiming a stolen watch from a jewelry store.
February 27, 1946 – Began 8-10 year sentence for Grand Larceny at Charlestown, MA.
1948 – Introduced to the Nation of Islam by brother.
March 1948 – Transferred to Norfolk Prison Colony.
August 7 & 8, 1952 – Paroled from Massachusetts State Prison. Travelled to Detroit to live with brother.
1953 – Moved to Chicago to study for the ministry.
June 1953 – Named assistant minister in the Nation of Islam.
1953-1958 – Served as a minister in the Nation of Islam in cities across the U.S.
January 14, 1958 – Married Betty X.
1958-1963 – Travelled and spoke throughout the U.S. and Africa.
February 1963 – Developed tension with prominent members of Nation of Islam.
March 1964 – Reportedly split with Nation of Islam.
April 19, 1964 – Travelled to Mecca.
April 20, 1964 – Wrote letter stating change of opinion regarding race relations in U.S.
June 12, 1964 – Life threatened.
June 28, 1964 – Formed the Organization of Afro-American Unity.
June 1964-February 1965 – Continued speaking engagements. Threats continued.
February 21, 1965 – Shot and killed in New York City.

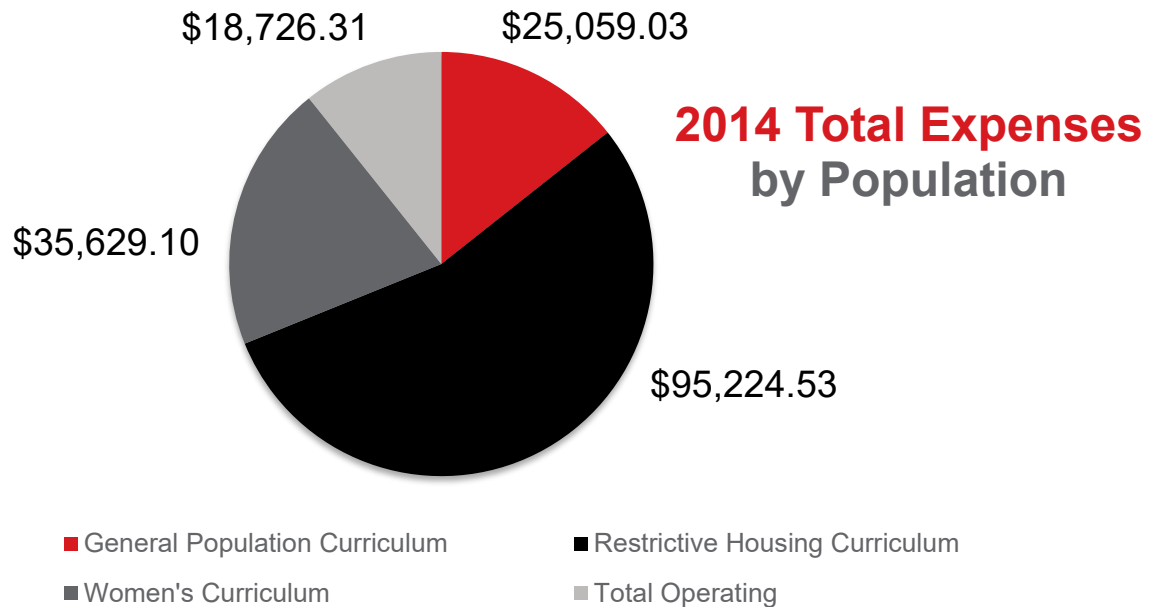
Transformation Project Initial Evaluation 2012 – 2014

A logic model was designed for Transformation Project for use in restrictive housing around 2012. However, there is little mention of the model in records kept by NCJR and NDCS. Therefore, program fidelity as determined by the agreed-upon logic model was not able to be assessed in any evaluation. In early 2015, NCJR conducted an evaluation on a sample of inmates who participated in TP from 2012 through 2014. Participants included 459 housed in restrictive housing, 32 in general population, and 5 in general population in a youth facility.



Restrictive Housing

Restrictive housing is often used to separate inmates from the general population that threaten institutional order and security (Mears, 2013). Restrictive housing isolates inmates in single-bed cells with few opportunities to socialize or engage in prison programming (Riveland, 1999). For instance, inmates in restrictive housing are typically confined to a cell for 23 hours a day with one hour of recreation and exercise. Approximately 1-2 percent of all inmates in the United States are confined in long-term administrative segregation (King, 1999).



TP participants had lower misconduct rates, compared to non-TP for inmates in restrictive housing at the Tecumseh State Correctional Institution (TSCI) and the Nebraska State Penitentiary (NSP), but not at the Lincoln Correctional Center (LCC). TP participation did not appear to increase the number of visits participants receive; however, this may be due to administrative regulations that restrict visits for inmates in restrictive housing at LCC, TSCI, and NSP as well as the geographical distance that makes visits to WEC difficult.

These findings suggest that TP may reduce misconduct, but the relationship may be contingent on the time inmates serve in restrictive housing during the follow-up period. The individual's decision to change their behavioral modalities prior to TP also cannot be determined and considerably dilutes the meaningfulness of the findings. Better control variables and a better evaluation design would have allowed this evaluation to examine the program effects better.

TP Curriculum

Transformation Project's restrictive housing curriculum consists of 13 self-study modules (one orientation and 12 substantive modules), which are based on the transformative prison experience of Malcolm X. Modules utilize real-life examples of change from Malcolm X by relying on excerpts from his autobiography. Each module is linked with an excerpt and focuses on a variety of topics. While the content of each module is unique, each module focuses on maladaptive thought processes related to the specific topic.

The Butler Update

In 2015, the School of Criminology and Criminal Justice's graduate student and NCJR's research assistant Daniel Butler presented findings from an evaluation of Transformation Project's Restrictive Housing program at the Nebraska Justice Alliance Annual Conference in Omaha, Nebraska, and at the Annual American Society of Criminology conference in Washington D.C. Daniel presented an overview of findings from the evaluation and discussed the complexities associated with programming in restrictive housing. Findings from the evaluation revealed inmates who completed more TP modules engaged in fewer misconducts than the comparison group. Daniel also described the complexities associated with implementing programming in restrictive housing units. For instance, inmates are traditionally unable to participate in classroom settings to receive the program while in restrictive housing, which may increase inmates' responsiveness to the program. Inmates may also serve varying lengths of time in restrictive housing that prohibits some inmates from completing the program. Together, these findings inform policy and practice by identifying "what works" and also highlighting areas that merit additional research. Daniel completed an evaluation of TP's restrictive housing program, and subsequently submitted it to an academic journal for publication (see Butler et al., 2018 below).

Program Update 2015-2016

As a part of the 2016 Council of State Governments NDCS programming review, it was recommended that NDCS work to ensure programs are implemented with quality and fidelity standards. Understanding that facilities experience unique barriers when it comes to implementing programming, a consulting firm was utilized to develop a Facility Readiness Assessment to accurately evaluate each facility's strengths and weaknesses when it comes to executing programming effectively. Category One Consulting (C1C) was selected to develop, deploy, and analyze the Facility Readiness Assessment. C1C is committed to helping nonprofit agencies maximize their impact. They use research, analytics, and evidence-based practices to develop, implement, and evaluate the most effective practices regarding people and programs.

The assessment was designed to understand staff attitudes and perceptions across 14 domains related to facility readiness. It was deployed at both the women's and youth facilities. The key findings are provided below:

Facility Readiness Assessment: Common Themes among Women's and Youth Facilities

- Most pressing for the implementation of Transformation Project is that most staff do not currently make the connection between past exposure to trauma and current exhibited behaviors.
- Many participants indicated it may be a challenge to get staff support for additional inmate programs.
- Staff would like to have a larger voice when it comes to programming at the facility and receive more communication about programming.
- Staff would like to have more access to training.
- Staff who are involved with TP are more engaged.





Transformation Project facilitators are required to have training in Motivational Interviewing, a communication style that engages one's own personal motivation for change. In 2016 UNO offered three MI training sessions reaching over sixty NDCS staff.

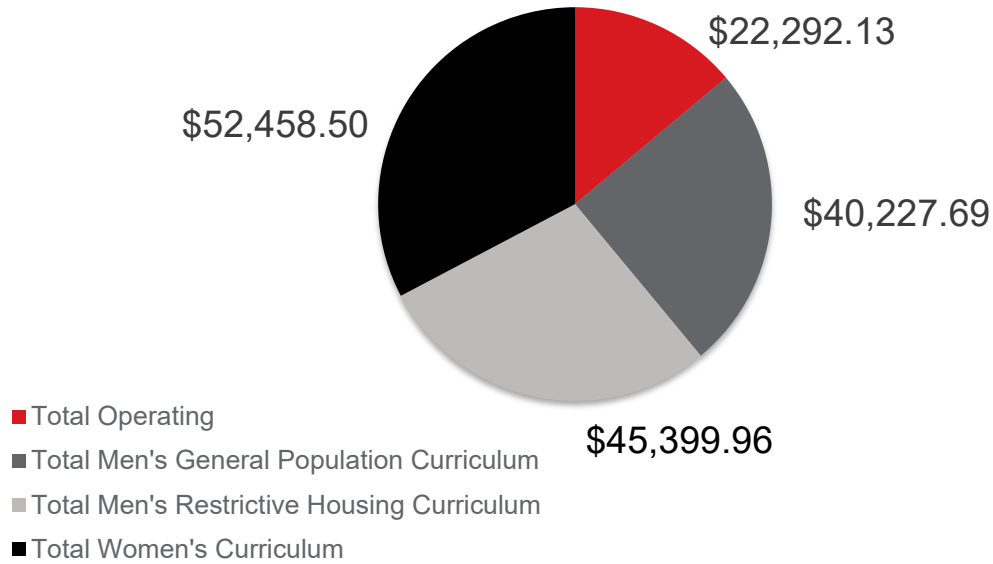
To address limitations in implementation readiness identified by the Facility Readiness Assessment conducted by Category 1 Consulting, UNO provided Trauma Informed Care training for over sixty staff at the Nebraska Correctional Youth Facility. Sharon Wise, a trauma survivor and expert in trauma informed care, conducted the training.

TP was originally intended to initiate, guide, and encourage transformative experiences for inmates. In its most basic form, the program was intended to change lives and reduce recidivism. The program was designed to change general anti-social attitudes and maladaptive behaviors into pro-social attitudes that are pro-social and fulfilling.



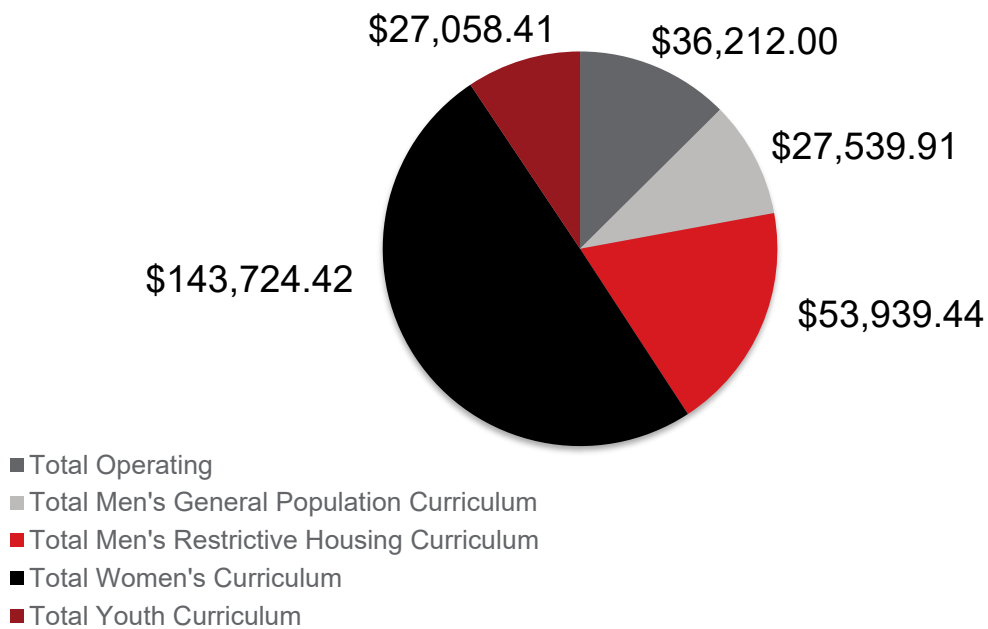
2015 Total Expenses by Population

\$160,378.28



2016 Total Expenses by Population

\$288,474.17



TP Misconduct and Visitation Evaluation 2016

In 2016, NCJR conducted an outcome evaluation on the effects TP has had on misconduct and visitation rates. The evaluation created an historical control group and examined the differences between those who participated and those that did not. Participants were selected from three facilities:

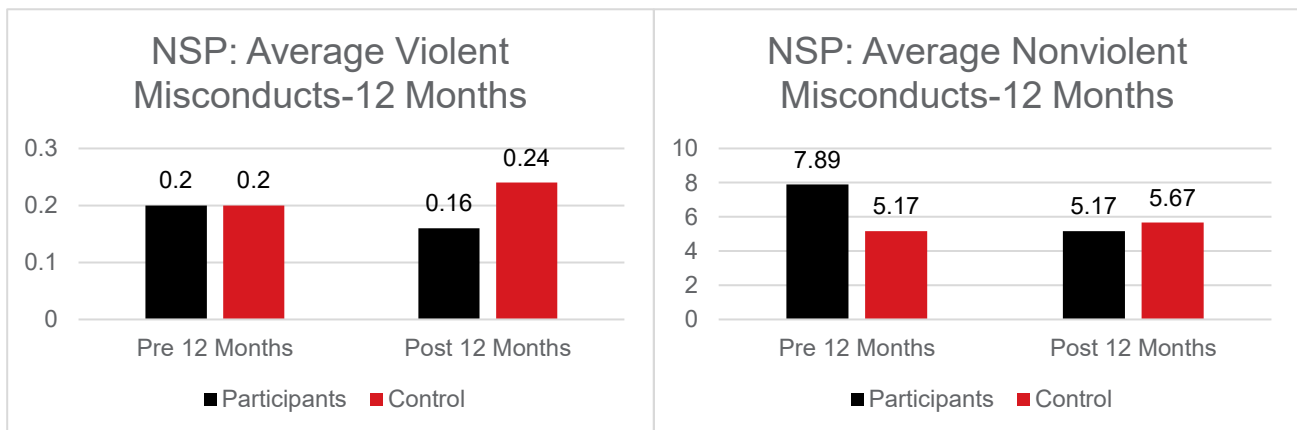
- Nebraska State Penitentiary (NSP)
- Lincoln Correctional Center (LCC)
- Tecumseh State Correctional Institution (TSCI)

The test sample consisted of participants who were housed in segregation between 2012 and 2014 and the control group consisted of randomly selected individuals between 2010 and 2011. The analysis indicates that TP participants committed fewer misconducts at NSP, LCC, and TSCI. Further, LCC participants received significantly more family visits.

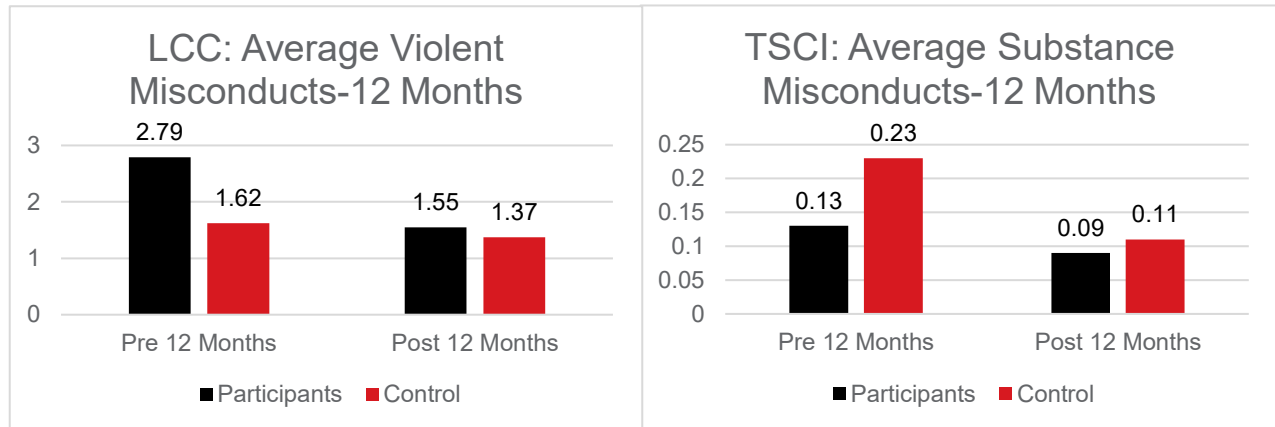
621
participants
in restrictive
housing

Misconducts

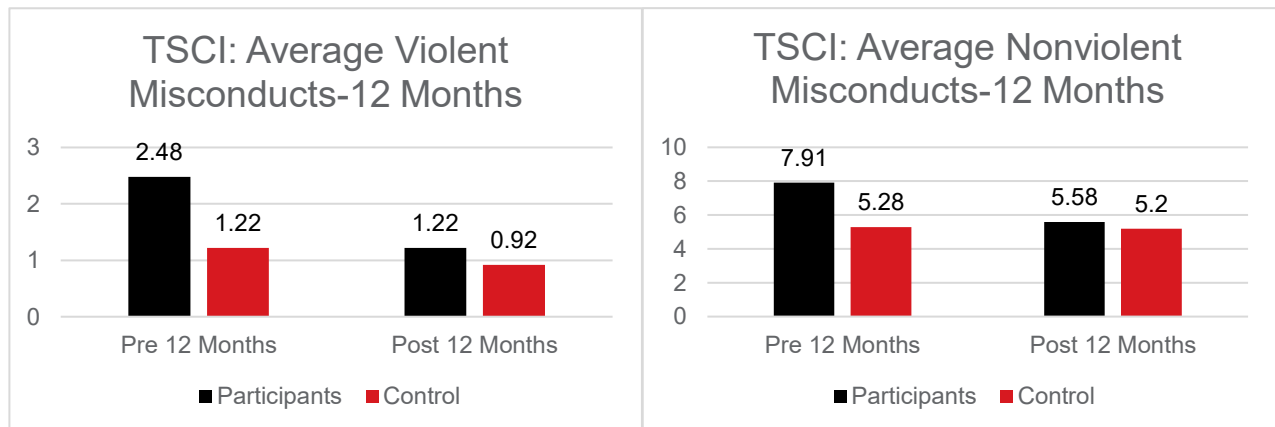
NSP participants committed significantly fewer misconducts at 12-months after final module completion. The NSP control group committed fewer misconducts during the post measurement compared to the pre measurement. While random assignment was not possible, these results tentatively demonstrate a positive treatment effect.



LCC Transformation Project participants experienced a statistically significant decline in assault misconducts 12 months after participation, however, the LCC control group also experienced declines in assault misconducts.

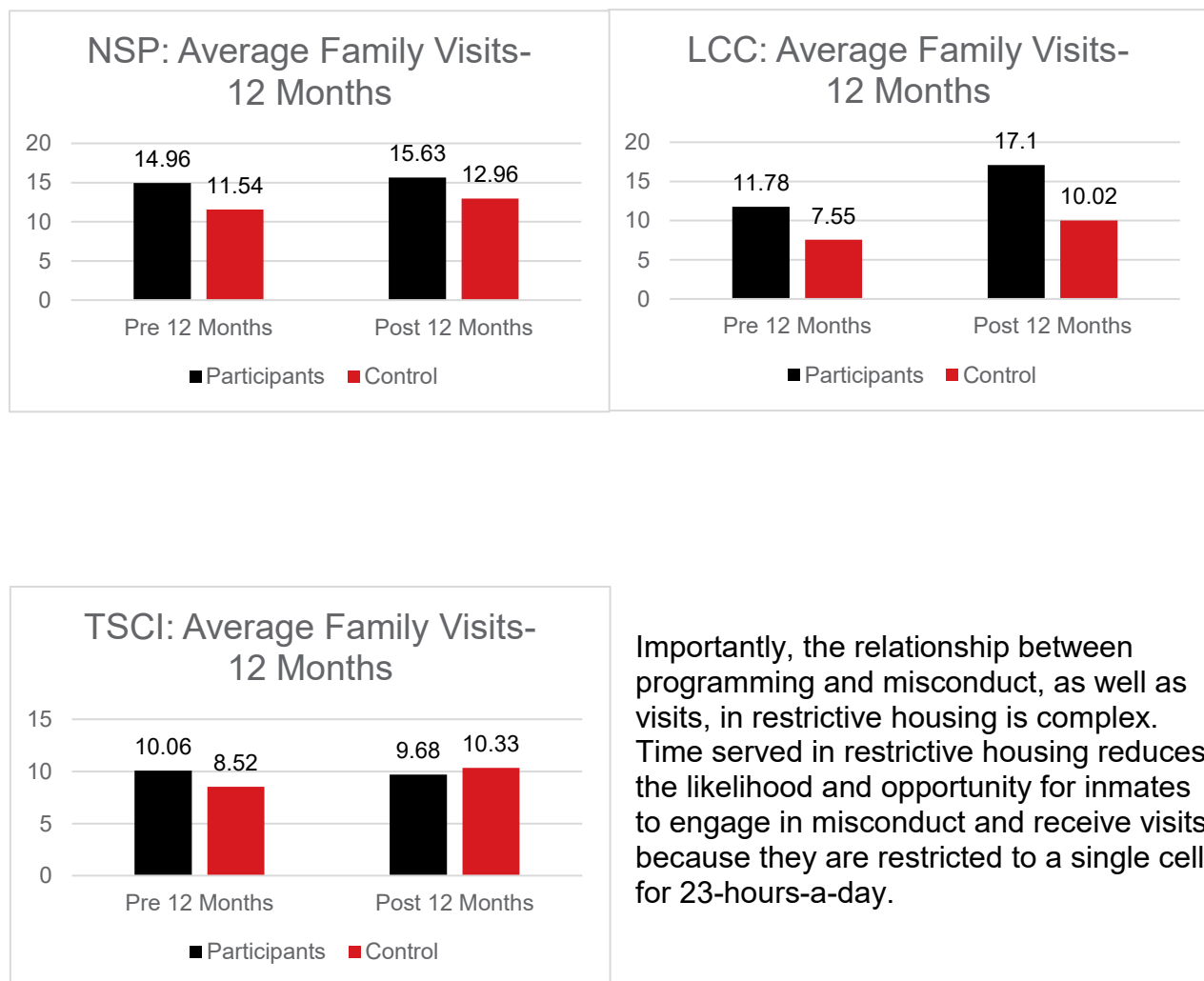


TSCI Transformation Project participants misconducts 12 months after final module completion. The TSCI control group also experienced declines in assault, drug/alcohol, and nonviolent misconducts during the evaluation period.



Visits

NSP participants did not experience statistically significant increases in visits. However, LCC Transformation Project participants did experience statistically significant increases in family visits (e.g., parent, sibling, child). The LCC control group did not experience any significant increases in family visits. TP Participants at TSCI did not experience significant increases in family visits, while the TSCI control group did experience a significant increase in family visits during the evaluation period.



Importantly, the relationship between programming and misconduct, as well as visits, in restrictive housing is complex. Time served in restrictive housing reduces the likelihood and opportunity for inmates to engage in misconduct and receive visits because they are restricted to a single cell for 23-hours-a-day.

This evaluation better targeted the time aspect plaguing the former evaluation. It also introduced basic control variables that allowed participants to be more comparable to the TP group.

TP Recidivism Evaluation – 2017

This evaluation was also conducted by NCJR. It sought to reconcile the shortcomings of previous TP evaluations, however, it is still very descriptive and unable to draw causal relationships between the TP and subsequent recidivism. Programmatic and institutional data were collected for 175 inmates who participated in the general population Transformation Project program from 2009-2011. The programmatic data were collected by NCJR staff and the institutional data were extracted from the NDCS database. This evaluation explores whether inmates who completed the general population TP curriculum were less likely to recidivate than inmates who participated in, but did not complete, TP. Recidivism was measured as returning to prison after being paroled or discharged.

Analytical Strategy

First, we provide descriptive recidivism information for all TP participants. Second, we provide three year recidivism information for TP participants. Third, we compared whether TP completion reduced the likelihood of recidivism for parolees. Finally, we compared whether TP completion reduced the likelihood of recidivism for inmates who were discharged from prison.

Findings Summary

- 175 inmates participated in TP from 2009-2011
- 122 inmates completed TP
- 100 inmates were paroled, 53 were discharged, and 22 were never released
- TP completers had a lower recidivism rate than inmates who did not complete TP.

Descriptive release information

One-hundred and seventy-five inmates participated in the general population TP program from 2009-2011. One-hundred and twenty-two inmates completed the program.

- 57.1% of TP participants were paroled.
 - 57.4% of TP completers were paroled.
 - 56.6% of TP non-completers were paroled.
- 30.3% of participants were discharged from prison.
 - 28.7% of TP completers were discharged from prison.
 - 34.0% of TP non-completers were discharged from prison.
- 12.6% of participants were never released from prison.
 - 13.9% of TP completers have not been released from prison.
 - 9.4% of TP non-completers have not been released from prison.
- 38.6% of TP participants were re-incarcerated after being paroled or discharged from prison.

Three year recidivism trends

- One-hundred and fifty-three inmates were released from prison through discharge or parole after participating in TP¹.
- Fifty-seven inmates, 35 TP completers and 22 non-completers, returned to prison after release.
- For all TP participants, the average time until return to prison was 1.84 years.
- The three year recidivism rate for all TP participants was 29.8%, which is lower than the average three year recidivism rate in Nebraska of 31.8%².
- The three year recidivism rate for TP completers (28.1%) was lower than the three year recidivism rate for non-completers (33.3%) and lower than the Nebraska average (31.8%).
- *TP completers had a lower recidivism rate than inmates who did not complete TP.*

Recidivism information for parolees

- 36.4% of TP completers had parole revoked
- 42.3% of TP non-completers had parole revoked.
- Although a greater percentage of TP non-completers returned to prison than TP completers, this difference was not statistically significant. There is no significant difference in the likelihood of parole being revoked by completion status. TP completers were not less likely to have parole revoked than non-completers.
- 8.7% of TP completers returned to prison after completing parole.
- 21.1% of non-completers returned to prison after completing parole.
- A greater percentage of TP non-completers returned to prison than TP completers, however, this difference was not statistically significant.
- There is no significant difference in the likelihood of returning to prison after completing parole by completion status. TP completers were not less likely to have parole revoked than non-completers.

Recidivism information for discharged inmates

- 25.7% of TP completers returned to prison after being discharged.
- 38.9% of TP non-completers returned to prison after being discharged.
- A greater percentage of TP non-completers returned to prison than TP completers, however, this difference was not statistically significant.
- There is no significant difference in the likelihood of returning to prison after being discharged by completion status. TP completers were not less likely to return to prison compared to non-completers.

¹ 22 Transformation Project participants were never released from prison.

² Data comes from the NDCS Quarterly Data Sheet, July-September 2017

Butler, Solomon, & Spohn (2018) Publication

In 2018, the academic journal *Criminal Justice and Behavior* published NCJR's report on TP (i.e., Butler et al., 2018). This peer-reviewed journal is ranked in the top 15 for criminology and top 60 in clinical psychology with a two-year impact factor of 2.1. The following is an excerpt from that publication, including a description of the program, methodology, and findings.

Excerpt:

The purpose of this study is to perform an outcome evaluation of Transformation Project to examine whether program participation reduces misconducts and whether several factors (i.e., administrative vs. disciplinary segregation, time served in restrictive housing) influence estimations of the treatment effect. We begin by examining the average length of program participation for inmates in our sample. As discussed earlier, there is considerable variation in the amount of time individuals serve in restrictive housing, and we examine whether this influences program completion. Next, we examine the effect of the program on assault, drug/alcohol, and other nonviolent types of misconduct during a 6-month evaluation.

After this initial assessment of the program, we examine whether the delivery of the program in disciplinary segregation or administrative segregation influenced misconducts. It is important to note that the program was designed for offenders confined in administrative segregation, and so the delivery of the program in disciplinary segregation would not be in accordance with program design. Finally, the amount of time served in restrictive housing during evaluation periods may bias estimations of a treatment effect because confinement in restrictive housing reduces opportunity for certain types of misconduct (e.g., assaults). However, confinement in restrictive housing does not preclude inmates from engaging in misconducts. Therefore, we estimate a treatment effect with a sample of inmates who served 90 days or less in restrictive housing and another treatment effect with inmates who served more than 90 days in restrictive housing.

Results

The amount of time individuals serve in restrictive housing during the evaluation period may also influence the estimation of a treatment effect. Inmates who served more than 90 days in restrictive housing during the evaluation period engaged in slightly more assault misconduct than inmates who served less than 90 days (34% vs. 28%). However, inmates who served more than 90 days in restrictive housing during the evaluation period engaged in slightly less drug/alcohol (6% vs. 9%) and other nonviolent misconduct (68% vs. 73%). Although these comparisons do not include program participation, it shows that exposure to restrictive housing during an evaluation period may influence estimations of a treatment effect. Furthermore, our evaluation was limited by a small subsample of inmates that inhibited matching groups based on no exposure (0 days) or complete exposure (180 days) during the evaluation period. Evaluations of the effectiveness of a program in restrictive housing, and potentially any institutional

corrections program, should control for time served in restrictive housing. Future research could also use a measure of recidivism that includes return to restrictive housing during the evaluation period. However, such an evaluation would need to identify the type of restrictive housing that inmates were returned to due to differences in admission processes (e.g., behavior vs. perceived threat to institutional security; Butler et al., 2013).

There are limitations with this study that merit discussion. First, the comparison group was drawn from a sample of inmates exposed to restrictive housing prior to the start of Transformation Project to eliminate threats to the evaluation of the study (e.g., we are certain no inmates in the comparison group received the program). Although we are unaware of any major changes to the use of restrictive housing between the two different sampling periods, there may be unmeasured differences between the treatment and comparison groups that coincided with the provision of programming in restrictive housing. Sample size was also a limitation for some of the supplemental analyses. For instance, we were unable to generate matches on subsamples that included various amounts of time served in restrictive housing (e.g., inmates who served almost the entirety of time during the evaluation period in restrictive housing) due to sample size. There are also important covariates related to misconduct that are not captured with our data. These covariates include prior criminal record (e.g., prior incarceration), misconduct commitment offense, housing unit of inmate, and sentence length. Future research should further examine whether exposure to restrictive housing incapacitates or aggravates the likelihood of certain types of misconduct. Finally, no participant completed the program. It is important to note that despite these limitations, this is one of the first studies to examine programming in restrictive housing. We recommend administrators, practitioners, and researchers to consider these potential threats when developing or evaluating programming in restrictive housing (Butler et al., 2018, p. 1187).

TP Process and Outcome Evaluation 2019

The current section presents the most current NCJR outcome evaluation of the TP. First, descriptive statistics are presented for the program as a whole. Second, more detailed information is provided on the participants in the program, including comparisons between completers and non-completers. Third, the evaluation scales are examined. Finally, limitations demonstrate the difficulties in providing a sound, systematic process, or formative evaluation.

Outline of the Evaluation

The current evaluation differs from previous TP evaluations in its ability to estimate treatment effects. The version of TP being evaluated here was only offered in restrictive housing (RH) in three medium to maximum custody state prisons (LCC, NSP, TSCI), which house only male inmates. Since TP is voluntary, only those who accepted the program while in RH in these three facilities had the opportunity to be in the population examined. Therefore, no information was collected on individuals in the RH units within these three facilities who 1) did not accept or 2) were not offered the TP modules.

546 participants

completing **4,232** modules

over **18** months

Further, we do not compare completers to non-completers due to the lack of measures available to simulate random assignment (e.g., propensity score modeling). This means we are not able to present a comparison model that is flawed in its ability to separate self-selection bias from program effects. In absence of good measures, we present descriptive statistics of participants who completed separate from the participants who opted in to (and were eligible for) at least one TP module.

Further, daily institutional procedures include frequently moving inmates between and within facilities throughout the course of their incarceration. Medical, legal, institutional, and statutory reasons apply. One may be moved to a medical facility, the courts, out of restrictive housing, or out of prison. TP was unable to follow the participants once these moves had been made. Thus, these moves contribute to one's completion of the modules and scale scores to varying and unknown degrees. We treat these reasons for not completing modules as random. The overall population of individuals analyzed in this section is 546.

History of Coordination and Implementation

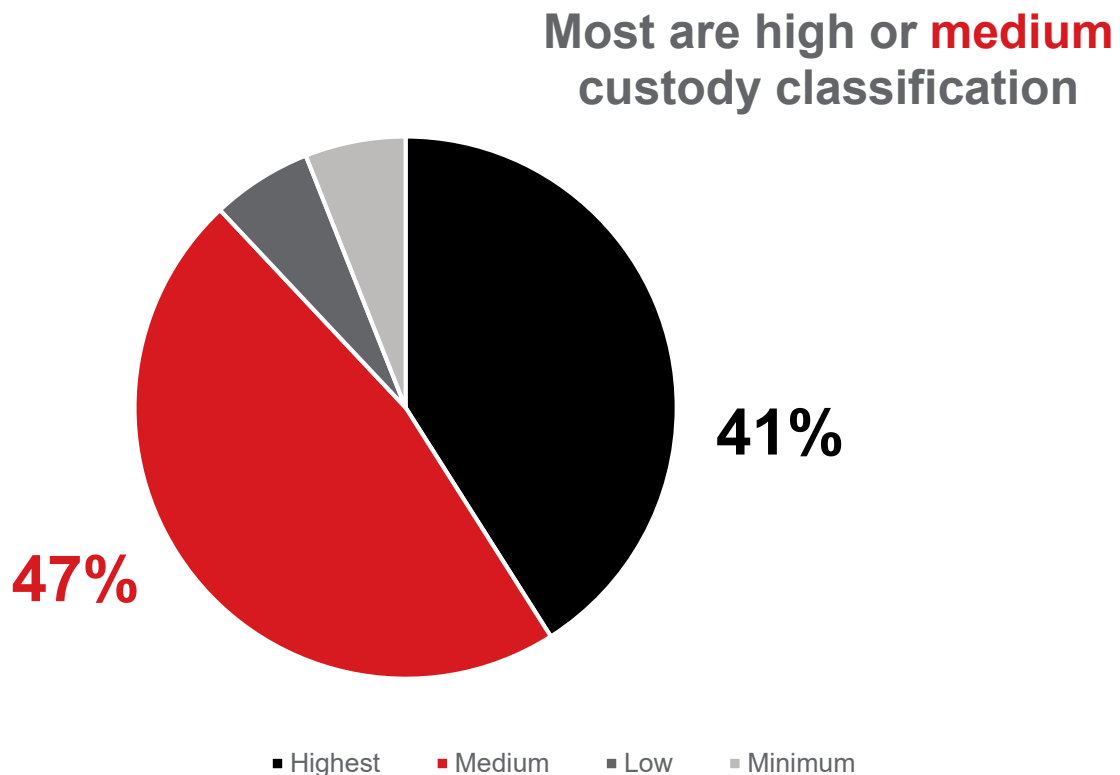
TP was developed by humanities professors at the University of Nebraska at Omaha at the request of an unnamed wealthy philanthropist in the mid-2000's. The developers were not qualified to implement the program in a prison setting, thus an agreement was reached between UNO and NDCS for NDCS to implement the program with coordination and evaluation functions provided by the Juvenile Justice Institute and then the Consortium for Crime and Justice Research (CCJR), both research units within the UNO College of Public Affairs and Community Service. Unfortunately, evaluation of the program was not a priority and little to no efforts were put forth prior to the beginning of the program. When funding from the original donor expired, the Scott Family and the Sherwood Foundation began funding all aspects of TP. Eventually, the Sherwood Foundation became the sole funder. In 2014, CCJR became NCJR, with a new director and expanded capacity, and thus the TP was transferred to NCJR's purview. At that point, TP was essentially not running (for an undetermined amount of time). NCJR restarted the program at the end of 2014. An NCJR evaluation in 2015 showed fidelity of TP implementation was extremely low, partially due to the inability of NDCS staff to complete necessary tasks and partially due to insufficient coordination of program administration by NCJR. Subsequently, in the middle of 2017, implementation functions were significantly transferred to NCJR. The current evaluation assesses TP activities from 6/1/17 to 12/31/18.

Separation of Evaluators and Implementers

Best practices in evaluation maintain that programs be implemented by one entity and evaluated by another. This is to ensure that the evaluation is free from bias, in order to determine objective tangible evidence of program effects. The funding history and deficiencies in staffing of both NDCS and NCJR led to the evaluation and implementation being conducted by the same entity, NCJR, with considerable responsibilities of data collection and timetables of administration still being conducted by NDCS. Whether NDCS case manager, unit managers, or some other staff were tasked with these responsibilities is unknown. The author of the current report was hired by NCJR on 6/18/18, and had very little influence on the implementation, organization, coordination, procedural development, day-to-day operations, data collection, and development of the evaluation. Regardless, potential conflict of interest should be considered when examining this evaluation.

Data Collection

All information contained herein was stored by NDCS and collected by UNO students paid by NCJR. TP data collection completed on March 19, 2019, including module completion forms, summarized module completion tracking sheets, and Motivation for Change (MFC) and Client Evaluation for Motivational Interviewing (CEMI) measurement scales. On April 3, 2019, NDCS transferred institutional behavior, admissions information, and demographics to NCJR for analysis.



Custody level represents the classification the individual is assigned by the NDCS that determines housing and procedures used by staff to move the individual within and between secure facilities. The level is determined by case managers with the assistance of an inventory and/or classification instrument. NDCS claims to have not used restrictive housing for disciplinary purposes since 2015, meaning all participants in the current study are in restrictive housing for administrative, holding, or protective purposes, or have been identified as a security threat to the institution (e.g., a gang member).

1,634

felony convictions

Of the 1,712 crimes used as causes to send participants to prison, only 4.5% were misdemeanor convictions, while the remaining were felony convictions.

While most have been incarcerated only in the 21st century, some participants have been incarcerated for over 18 years. Additionally, the misconducts measured in the current study only represent misconducts recorded from 2009 forward due to a change in the computer system at the turn of the year.

Participants

Table 1 presents descriptive statistics for the full population at the individual level, ranging from May 5, 2017 to December 5, 2018. These represent those in RH between 2017 and 2019 for whom a record was kept as having completed at least one module. The average number of modules completed was just over half of the 13 available modules, which is a considerable increase from previous TP evaluations. This increase in program dosage completed may be a result of the change in facilitators from NDCS staff to NCJR staff, but no participants or NDCS staff were interviewed to verify.

78

misdemeanor convictions

Table 1: Descriptives Population (N = 546)

Variable	Mean/%	SE	Range
Modules Completed	7.75	0.25	37
Age on 4/4/2019	32.03	0.36	52
Race			
<i>Black</i>	33.52		
<i>Hispanic</i>	18.68		
<i>Native American</i>	7.87		
<i>Other</i>	0.55		
<i>White</i>	39.38		
Felony	2.99	0.10	22
Misdemeanor	0.14	0.02	4
Days Incarcerated	2,168.12	79.19	15,102

1.2
million days
incarcerated

Due to lack of dates collected on the orientation module, a fixed period of time was used to determine frequencies of days incarcerated and age. Days incarcerated was calculated as the days admitted to an NDCS facility between 1/1/1970 and 4/4/2019, accounting for occasional releases and readmissions. Age was calculated by subtracting the participant's date of birth from 4/4/2019 in whole years.

In 2009, NDCS implemented a new system to track rule infractions while incarcerated (i.e., misconducts). After consulting with NDCS data administrators, it was determined that the highest accuracy of measures of misconducts was using the new system, and therefore the misconduct measure represents the number of misconducts on which the participant was found guilty after 2008.

Considering the program's focus on the life transformation of Malcolm X, a more in-depth analysis of outcomes by race is warranted. Racial category was self-identified to NDCS as part of the regular intake process upon entering custody. The largest racial identification was White, representing just under 40 percent of those completing at least one module. The researchers subsequently collapsed all categories except African American/Black (hereafter referred to as Black) into one category, in order to examine

36 thousand prison misconducts

how the population and program outcomes varied depending on whether someone identified as Black or not. Those identifying as Black were no less likely to complete the program ($p = .09$), but completed significantly fewer modules ($p < .05$). Blacks were incarcerated longer than non-

Blacks ($p < .05$) despite committing the same number of felonies on average ($p = .990$); however, the felony seriousness was not taken into account when measuring felonies. Further, Blacks were approximately the same age as non-Blacks ($p = .105$), and were found guilty of significantly more misconducts ($p < .001$). These findings suggest that for these participants, Blacks were generally higher risk participants than non-Blacks.

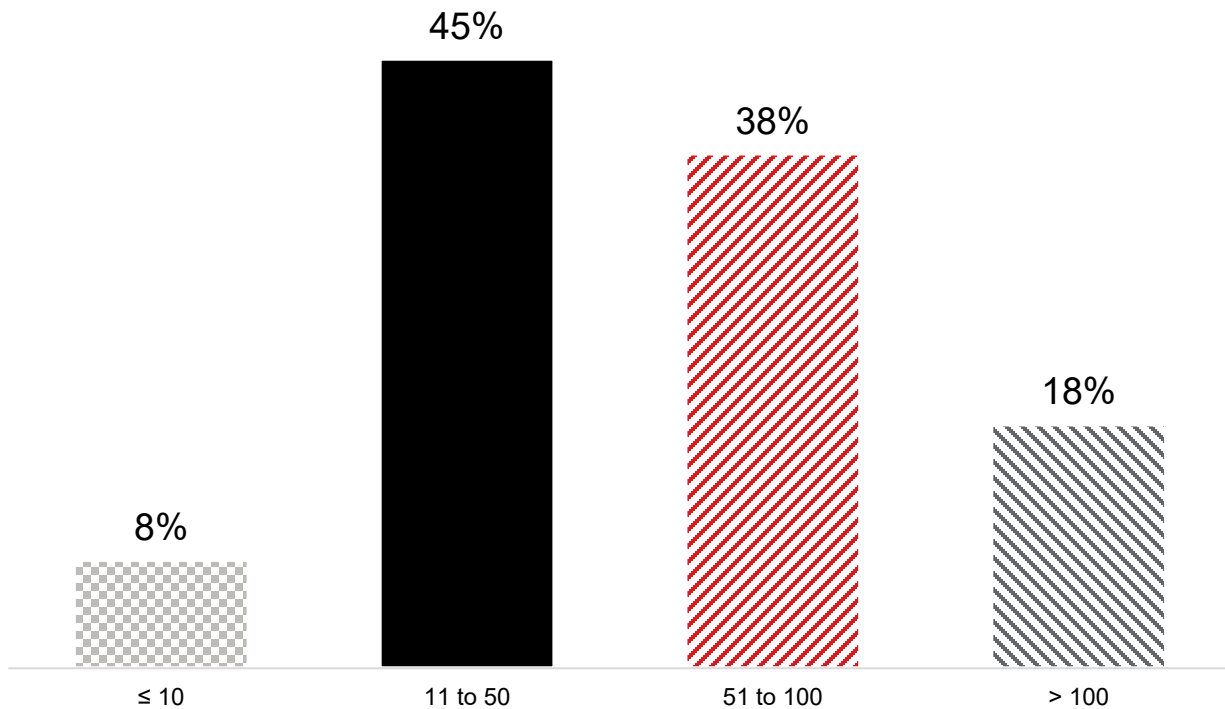
Overall, the average number of felonies was just under three, with a maximum of 22. The average participant also was incarcerated for over 2,100 days during the study period. Twenty percent of individuals were released and readmitted at least once during the study period and just over seven percent were released at least twice.

Almost 9 in 10 participants had fewer than 5 felony convictions.



Prior program participations are measured from 1970 until the participant's orientation date. Programs may include substance abuse therapy, violence replacement, and anger management among others. The average number of programs participated in before orientation was 1.8 for 138 participants who had an orientation date (i.e., $n = 241$).

Misconducts (full sample → N = 546)



Completers

In order to complete the TP, a participant was required to advance through each of the 13 modules. Advancement was intended to only be considered by the facilitator if significant progress within the module was made. Thus, there is a quality component that is subjective to the facilitator. Facilitators were trained to recognize and reward development towards TP goals, gradually increasing expectations as the participant moved through the modules. Unfortunately, no empirical indicators were collected for this evaluation regarding quality of feedback. Ultimately, progress is relative and completion here is measured quantitatively only.

There were 91 participants on record who completed the full 13 modules. These 91 individuals represent a cohort of completers that have the post measure on at least one of the measurement scales (i.e., MFC or CEMI). This method to identify completers was chosen because of two observations made during data analysis. First, as the result of a plethora of data tracking complications, module sheets collected indicated fewer than 20 completers over an 18 month span. Second, participants may not complete the post

measure scales without completing the full array of 13 modules. However, out-of-sequencing may have occurred and NCJR staff were instructed to make note to NDCS when an out-of-order delivery of modules was detected (no records of these notes were kept). Thus there is considerable reason to doubt these 91 are the full number of individuals who have completed the TP. Their descriptive statistics are presented in Table 2.

Completers submitted 13 modules, which is the entire TP program. Comparatively, non-completers (n = 216) averaged 5 modules submitted. Age was calculated differently for completers than in the full sample (n = 546). To make it more meaningful, the age of completers was calculated at the age of orientation. Compared to non-completers, completers were approximately the same age.

Table 2: Descriptives Completers (n = 91)			
Variable	Mean/%	SE	Range
Modules Completed	15.29	0.54	37
Age at Orientation	30.51	0.74	34
Race			
<i>Black</i>	26.4		
<i>Hispanic</i>	22.0		
<i>Native American</i>	11.0		
<i>Other</i>			
<i>White</i>	40.7		
Felony	0.92	0.00	1
Misdemeanor	0.14	0.00	1
Days Incarcerated	2,596.16	202.55	11,595

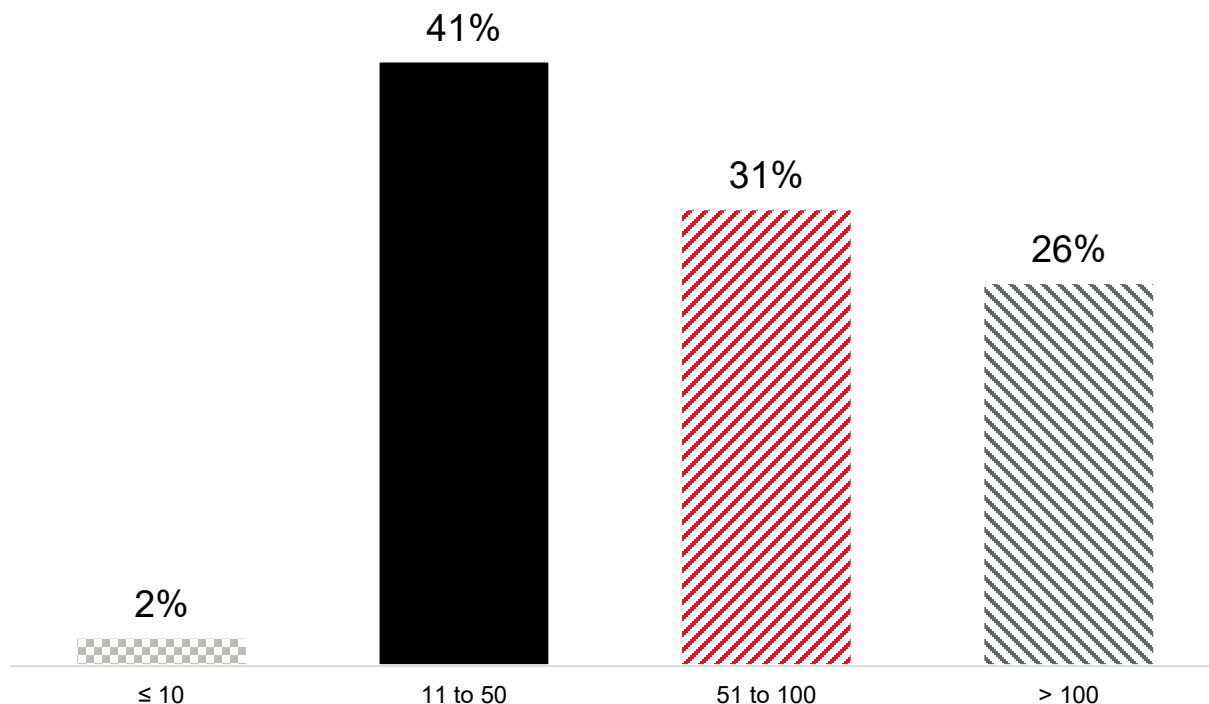
Once again, we consider the racial component of TP, this time with only the completers. The largest racial identification was White, representing just over 40 percent of those completing at least one module, which is similar to the full sample presented in Table 1. Returning to Table 2, Blacks were not incarcerated longer than non-Blacks ($p = .159$), which is different than the full sample where Blacks were incarcerated longer. Blacks committed the same number of felonies on average ($p = .111$), which is the same as the full sample. Further, Blacks were approximately the same age as non-Blacks ($p = .288$), which is the same as the full sample. They were also were found guilty of the same number of misconducts ($p = .064$), which is different than the full sample where they were found guilty of more misconducts. Overall, these findings suggest that for these completing participants, Blacks were generally the same risk level as non-Blacks and had overall similar characteristics than non-Blacks.

Overall, the average number of felonies for completers was just over three, with a maximum of 14. The average number of felonies was not significantly different than non-completers ($p = .461$). The average completer was incarcerated for almost 2,600 days during the study period, which is significantly higher than non-completers average of just over 2,000 ($p < .001$). The number of misconducts that a completer was found guilty of did not differ from non-completers ($p = .268$).

Completers were incarcerated longer

Only seven percent of completers were released and readmitted at least once during the study period, as compared to 23 percent of non-completers. The average number of programs participated in prior to orientation for completers did not differ significantly from non-completers.

Completers had more lifetime misconducts



Motivation for Change and Client Evaluation for Motivational Interviewing Scales

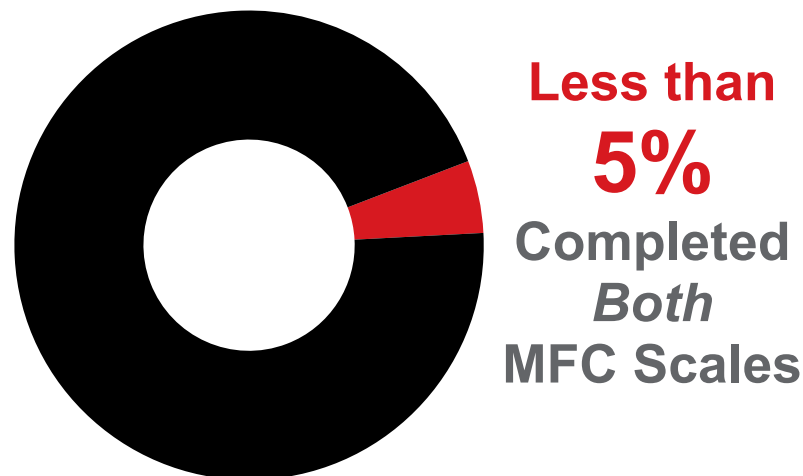
To assess the program effect, a dosage of systematically-delivered interventions must be compared to some outcome, holding known predictors of the outcome steady. However, there is very little information available on prison programming given in restrictive housing regarding types of programs, amounts of dosage, fidelity of implementation, and which outcomes and predictors (i.e., controls) are relevant. Therefore, all procedures in the TP and its subsequent evaluation are exploratory and are recommended to be replicated, preferably by parties independent of one another. Nonetheless, a program effect must be estimated to direct future programming and evaluations. Therefore, participants were administered two psychometrically validated scales in order to assess 1) progress towards TP goals and 2) program fidelity.

Prior to a description and analysis of the scales, multiple procedures of this evaluation must be presented. These include addressing the literature, missing identification numbers, duplicates, and missing values.

Literature

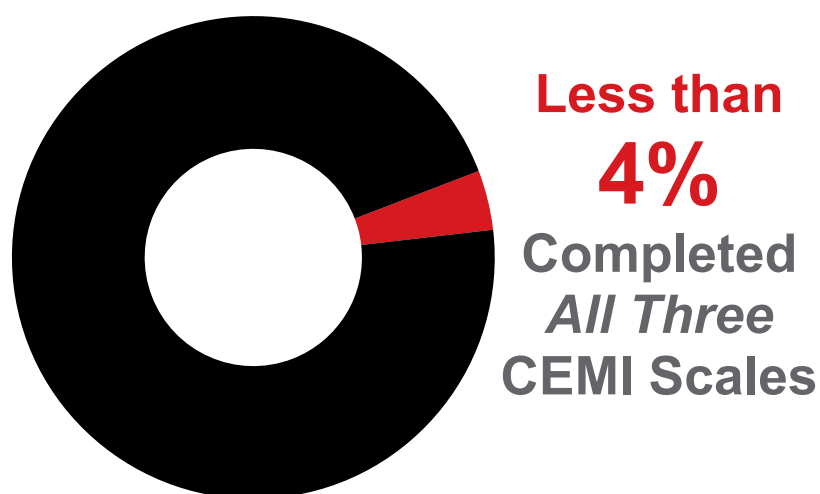
In restrictive housing, there is a complicated relationship between institutional misconducts (i.e., bad behavior in prison) and one's personal characteristics (e.g., anti-social attitudes, respect towards authority, desire to improve oneself, self-control, demographics) (Steiner, Butler, Ellison, 2014). On the one hand, the conditions one is subjected to regarding physical confinement within a small area are considered undesirable to many, which may be argued is the point of prison punishment. Solitary confinement has shown mixed results regarding its ability to degrade one's mental health. Haney (2003) demonstrated its harmful effects on individuals, and additionally found it was particularly salient for those with prior mental health diagnoses. Yet, others have criticized Haney's use of a limited sample in an extreme application and high-risk population (O'Keefe et al., 2013). O'Keefe and colleagues found solitary confinement was not harmful to the mental health of those who experience it. O'Keefe and colleagues' finding, however, is in the minority. Solitary confinement has been tied to countless psychiatric conditions (Toch, 2001) and intensifies prisoner maladjustment (Butler & Steiner, 2017), though some studies show it has no effect on institutional misconducts (Labrecque, 2015; Lucas & Jones, 2017; Morris, 2016; Woo et al., 2019). It additionally has been shown to decrease one's readiness to change (Campagna et al., 2019) and increase the breakdown of relationships with friends and family (Kurki & Morris, 2001). Increased surveillance would increase the time, and therefore the opportunity by which a correctional officer may have to catch someone breaking an institutional rule. Each of these conditions would suggest an increased likelihood of institutional misconduct.

On the other hand, the limited opportunities by which one may be exposed to situations and environments that may have a misconduct be assessed suggest misconducts by someone in restrictive housing would be less likely to occur compared to someone in the general population (Faithi, 2015). Ultimately, these two influences are difficult to disentangle (Mears & Reisig, 2006; Steiner & Wooldredge, 2008). Thus, misconducts in prison must be supplemented to empirically estimate a program effect. The Motivation for Change scale (MFC) was selected to provide this evidence. The MFC instrument is provided in Appendix II.



For the type of intervention being provided, high quality feedback to ensure program fidelity is essential. Transformation Project is administered in restrictive housing by program facilitators (e.g., caseworkers, Transformation Project Staff, correctional staff) who have completed resolution-conflict training (e.g., motivational interviewing [MI]). MI is a client-centered (i.e., inmate-centered) therapeutic approach used to enhance readiness for change by resolving ambivalence (Hettema, Steele, & Miller, 2005; Miller & Rollnick, 2013). MI recognizes that clients have differing levels of readiness to change. The role of MI practitioners is to help clients become aware of the consequences of changing or not changing in a nonjudgmental manner (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Miller & Rollnick, 2013). MI emphasizes client autonomy and allows clients to assess whether change is necessary, when to change, and how to change. In corrections, MI techniques have been used with probationers and an international sample of prisoners (Anstiss, Polaschek, & Wilson, 2011; Armstrong, Atkin-Plunk, & Gartner, 2016). MI has been shown to be an effective tool for communication between probation officers and probationers (Armstrong et al., 2016), and participating in brief MI counseling sessions in prison reduced the likelihood of reconviction among a sample of New Zealand prisoners (Anstiss et al., 2011).

In order to assess how well the facilitators were adhering to MI principles, the Client Evaluation of Motivational Interviewing (CEMI) scale was administered to participants at modules 4, 8, and 12. The CEMI instrument is provided in Appendix III.



Missing identification numbers

The basics of survey administration suggest the participant willfully provide their consent and that anonymity be central to the process in order to reduce the potential for coercion that would bias the resulting answers (Dillman, 1978). This becomes difficult when the survey does not include a link to other databases to be used in the analysis. Further, in a prison setting, the power-dynamics of everyday life make coercion central to survival for both inmates and correctional staff (Western, 2018). Thus, while the program would benefit from the participant identifying oneself, not identifying oneself may be one potential “win” in an otherwise oppressive accountability-driven environment that prison is designed to be. Ethically, the program cannot force the participants to identify themselves. However, facilitators were not present during the distribution or collection of modules and the potential coercion from correctional staff for the participant to identify themselves is possible.

Of the 686 surveys collected (i.e., the MFC's and CEMI's), there were 23 with no identification numbers. These 23 were included to develop the factor scores (see below), but eliminated from analysis due to the inability to connect them to one of the 546 participants.

Duplicates

Due to multiple factors, duplicates of the scales and modules were found during the data-cleaning process. The first factor relates to the moving of participants between facilities. Participants reportedly sometimes could not remember which module they last received and thus started over or were given a random module or scale at the discretion of the correctional staff. The correctional staff's non-communication between facilities and shifts likely contributed to this inconsistency. The second factor relates to the inconsistency of tracking modules. Modules were sometimes scanned into digital form, but reportedly sometimes were discarded by correctional staff. This instance led to duplicate modules and scales being completed at unknown rates. The third factor relates to the data-collection specialists hired by NCJR. The specialist appears to have copied the data tracking sheet for the MFC and CEMI (but not the modules) into the incorrect facility folder, thus recording many surveys into the datasheet twice. This error was identified as systematic and the incorrect cases were omitted from all analyses.

Missing values

On all items, there were some missing values. These were values that were simply not completed by the participant, or had vague answers such as two answers. These values represented between 1 to 8 percent of the available values collected. The logical solution to missing data is to insert the series average, but this has been shown to increase error in analyses. Luckily, statisticians have developed a procedure (i.e., Multiple Imputations) by which to use the available data to "impute" missing values. The multiple imputation dataset was subsequently used in all analyses. Further, since the scale developers recommend using weighted least squares instead of maximum likelihood as estimators for the factor scores, the multiple imputations dataset was used in the development of the factor scores.

Participant Progress – the Motivation for Change Scale (MFC)

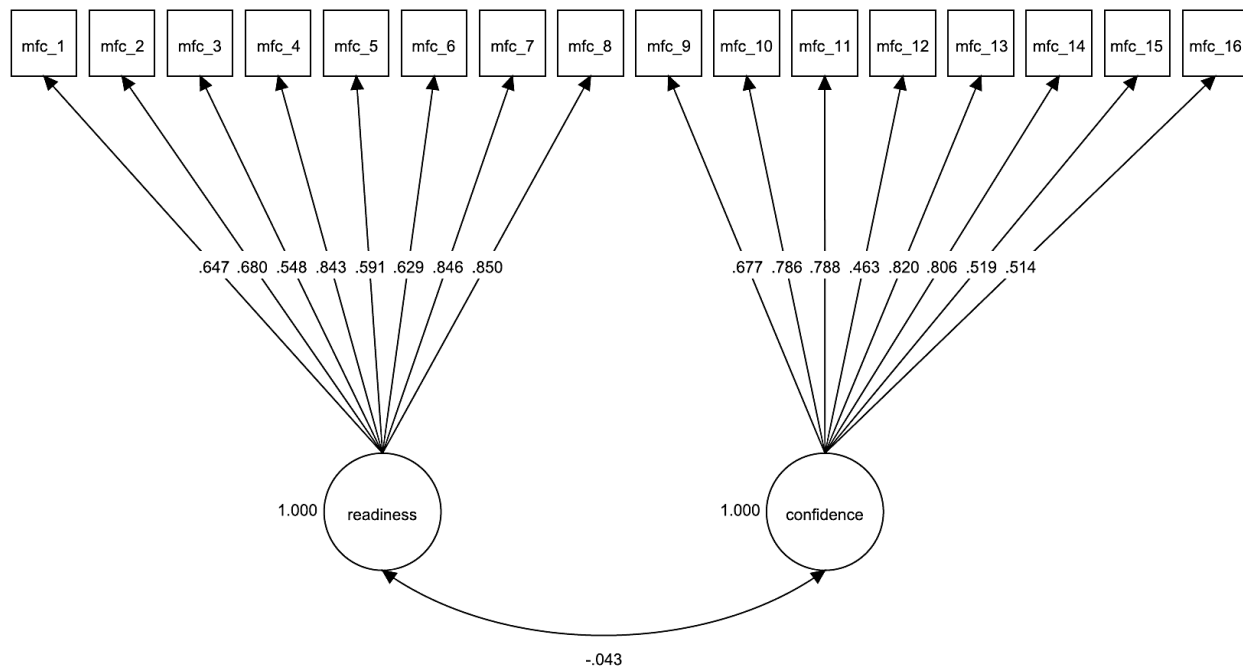
Considering the conditions of and context in which the TP was to be administered, the MFC was selected to assess participant progress. To evaluate progress to utmost standards, the implementers and the evaluators should be conducted by separate entities to reduce the potential for bias (discussed above in the *Separation of Evaluators and Implementers* section). The current section is divided into two parts. The first provides an overview of the concepts and processes used to examine one's motivation for change. The second provides procedural details.

Overview: MFC factor creation

The MFC scale is a multi-dimensional scale that examines the participant's decision-making confidence and readiness to change. It uses eight questions per concept. The procedure by which the scales measure the concepts has been replicated in multiple studies, giving the current evaluation empirical and theoretical guidance on modeling procedures. Items 1, 2, 4, 6, 12, and 15 were reverse coded as required. The procedure used is termed Confirmatory Factor Analysis (CFA), which uses the variance in the question answers to estimate an underlying, unmeasured factor (i.e., latent concept).

There were 332 surveys for 307 individuals used to develop the latent concepts' factor scores. All time points of and questions on the MFC were used to develop the factor scores, meaning a total of 5,312 data points were utilized. In Diagram 1, the circles represent the factors (i.e., concepts) being developed, and the squares represent the individual questions. The arrows represent the strength to which the factors predict the individual question answers. These coefficients are termed "factor loadings". All the loadings except for question 12 are sufficiently strong, however, the wording of this question for the population may be problematic and thus leading to less accurate relationships with other items and thus the factor. The developed factor scores were then compared pre and post (see Table 3).

Diagram 1: CFA of MFC scale, including Readiness to Change and Decision-Making Confidence.



Specifics: MFC factor creation

The statistical program MPlus was used to estimate the factor scores with a CFA procedure. A weighted least squares using means and variance was used as an estimator. The factors were given a variance of one, and the items were allowed to load freely. The analysis used a probit link function. There were 81 free parameters and the chi-square was 803.076 (df = 103). The RMSEA was 0.137 ($p < .000$). The CFI was 0.887 and the TLI was 0.869. The factor loadings presented in Diagram 1 represent the standardized model coefficients (i.e., STDYX).

Fidelity – the Client Evaluation of Motivational Interviewing (CEMI)

In any evaluation of an intervention, the fidelity, or quality, of the procedures used to administer the intervention are important to determine the degree to which any effect observed is valid. Further, the implementers and the evaluators should be conducted by separate entities to reduce the potential for bias (discussed above in the *Separation of Evaluators and Implementers* section). The current section is divided into two parts. The first provides an overview of the concepts and processes used to examine one's evaluation of the adherence to the relational and technical aspects of motivational interviewing. The second provides procedural details.

Overview: CEMI factor creation

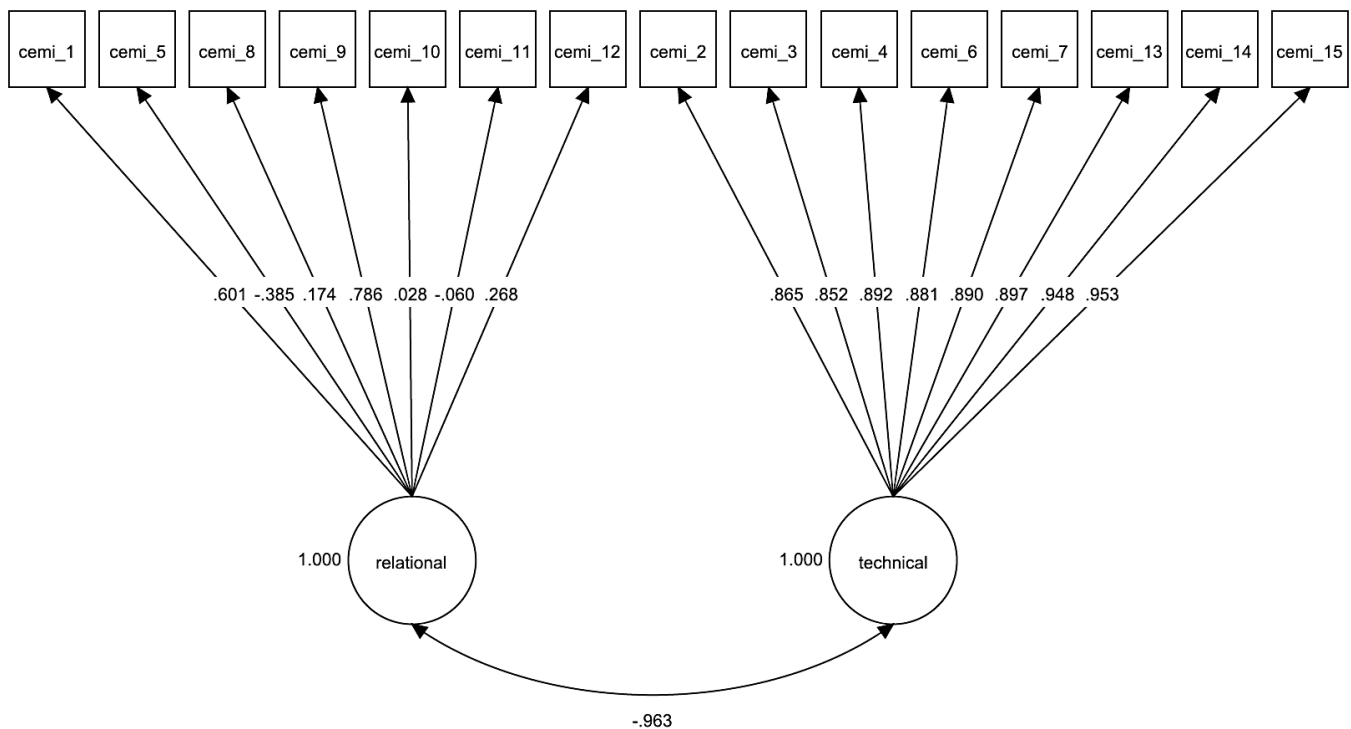
The CEMI is a multi-dimensional scale that examines the participants' perceptions of the program facilitators' adherence to motivational interviewing principles. The concepts measured include relational and technical components (i.e., factors, concepts) of MI. It uses seven questions (i.e., items) to measure the relational factor and eight questions to measure the technical factor. The procedure by which the scales measure the concepts has been replicated in multiple studies, giving the current evaluation empirical and theoretical guidance on modeling procedures. Items 1, 5, 8, 9, 10, 11, and 12 were reverse coded as required by the CEMI coding scheme. As with the MFC, the procedure is CFA.

There were 321 surveys for 217 individuals used to develop the latent concepts' factor scores. All time points of and questions on the CEMI were used to develop the factor scores, meaning a total of 4,815 data points were utilized. All the loadings for the technical factor are sufficiently strong. However, the relational loadings present a problematic picture which is the result of multiple conditions. Subsequent analysis of this problem is presented in the *Analysis* section below.

Specifics: CEMI factor creation

MPlus was used to estimate the factor scores with a CFA procedure. A weighted least squares using means and variance was used as an estimator. The factors were given a variance of one, and the items were allowed to load freely. The analysis used a probit link function. There were 61 free parameters and the chi-square for model fit was 2,559.543 (df = 89). The RMSEA was 0.292 ($p < .000$). The CFI was 0.843 and the TLI was 0.815. The factor loadings presented in Diagram 2 represent the standardized model results (i.e., STDYX).

Diagram 2: CFA of CEMI scale, including Relational and Technical components.



Analysis of the MFC and CEMI Scales

After creating the factor scores for each concept and for each individual measured (see previous section), the scores were compared across two time points for the MFC and three time points for the CEMI. Prior to those comparisons, descriptives for the full sample are presented. Recall that although 91 individuals were estimated to complete all 13 modules in TP, only 25 completed both the orientation and completion surveys that included both MFC scales (i.e., two measures of decision-making confidence and two measures of readiness to change, with time-ordering established) and only 22 completed all three surveys that included both CEMI scales (i.e., three measures of relational quality and three measures of technical adherence, with time-ordering established). Ultimately, only 11 of 546 participants completed all five surveys over the course of 18 months.

Table 3: Descriptives for full sample

Variable	Median	Skew	Min	Max	n
Relational	-0.116	0.115	-2.055	1.825	321
Technical	-0.121	0.121	-2.060	1.830	321
Decision-Making	-0.017	0.169	-2.730	2.070	340
Readiness to Change	-0.022	0.026	-2.240	2.520	340

Table 3 presents factor scores for each concept and each participant who completed the surveys at set progress points of TP. Factor scores are considered standardized, thus the means will typically be approximately zero. The medians are presented to provide an estimate of the skewness of the distribution. Note that skews are positive, but the readiness to change factor is the most normally distributed. Most relevant to this report are the numbers completed (i.e., “n”). Over half of the participants received at least one scale. Subsequent analyses showed only 45 percent of those who began TP received the first orientation MFC scale. Further, 70 percent of those who completed 13 modules received the final MFC, but not the orientation MFC. This suggests the administration of the MFC was perceived and used as a post-only measure.

For the CEMI, the first prescribed scale is to be administered at module 4. This module was set as such to ensure the participant had enough feedback from the facilitators to make informed ratings on their facilitator’s adherence to MI principles. Of the approximately 68 percent of participants who reached module 4, only 38 percent received the module 4 CEMI. Additionally, 20 percent of those who reached module 8 missed module 4 CEMI but did receive the CEMI for module 8. Likewise, 48 percent of those who reached module 12 missed module 4 CEMI but did receive the CEMI for module 12. These numbers depict a process of administration of the CEMI as disorganized and unsystematic. There appears to be little fidelity as to whether the CEMI would be administered, regardless of if the module was prescribed to have it administered. There perhaps was an instance where the correctional officer providing and collecting the survey would forget or refuse to administer the CEMI, however, it is

also possible that the participant would refuse to take the survey with the prescribed module. Ultimately, the program coordinator failed to recognize and address this implementation flaw. Regardless, instances' occurrences were not recorded by NDCS staff, the coordinator, or program facilitators for the evaluators to take into account.

The relational factor had poor model fit, as evidenced by the multiple low factor loadings of questions as well as two pointing in the incorrect direction. Considering the CEMI has in past studies demonstrated considerable cohesion regarding its psychometric properties (i.e., all questions fit – the factor loadings on the latent factor are generally all above .7 and pointing in the same direction), this demonstrates a considerable obstacle in the administration of the CEMI in this setting, in this context, or to this population (none have been attempted and tested before). First, the sample size is likely affecting the variance of the items, with a few scores inflating the variance of scores. Second, the questions focus on interpersonal conflict, which is a key component of the relationships between inmates and correctional officers. *It appears as though participants may have been conflating the correctional officer who feeds, escorts, and disciplines the participant 24 hours per day (consider the average number of days spent incarcerated for this sample) with the NCJR student facilitator providing the feedback.* Without interviewing the participants and correctional officers assigned to restrictive housing (which rotate with general population officers regularly), there is no sure way to determine if the participant was rating the correctional officer or the facilitator. This is a considerable obstacle to the estimation of program fidelity within a setting such as restrictive housing.

Comparisons of MFC scores

This section provides the score changes from the pre to post administrations of the MFC. Table 4 presents scores from all MFC surveys. This includes participants who either had only the orientation MFC, only the final MFC, or both. This is non-experimental and can only be used for descriptive purposes. Causality should not be inferred from this table. As such, significance tests are not presented. However, for descriptive purposes, the scores for the post tests had higher averages than the pre-tests for both the decision-making confidence factor and the readiness to change factor. Recall that higher scores suggest better decision-making confidence and more readiness to change, according to the theory used to derive the original scales.

Table 4: Independent Samples Motivation to Change for full sample

Variable	Mean	Pre SE	n	Mean	Post SE	n
Decision-Making	-0.014	0.06	241	0.129	0.09	91
Readiness to Change	-0.022	0.06	241	0.025	0.09	91

Table 5 presents a pre-post design with the 25 participants who completed both. Considering the multitude of obstacles TP faced to obtain these surveys to assess a program effect size, an argument might be made that these scores were essentially obtained randomly – thus giving partial credence to the ability of findings to be extrapolated to general processes outside of this sample. We do not make that argument here, but further exploration into the implementation of the TP would reveal the viability of the degree to which external validity may be determined. Note that for the 25 individuals who completed both pre and post scales, there was no significant change found. However, ignoring significance tests, the scores actually are lower for the post test, suggesting TP made the participants worse. Considering the small sample size, insurmountable unsystematic fashion by which these scores were obtained, and the subsequent insignificant finding, there is little reason to believe the TP made the participants worse – but there is even less evidence to suggest the alternative.

Table 5: Dependent Samples Motivation to Change (n = 25)

Variable	Pre		Post		t	p
	Mean	SE	Mean	SE		
Decision-Making	0.217	0.21	0.013	0.17	0.478	0.637
Readiness to Change	0.301	0.23	0.117	0.20	1.398	0.175

Comparisons of the CEMI scores

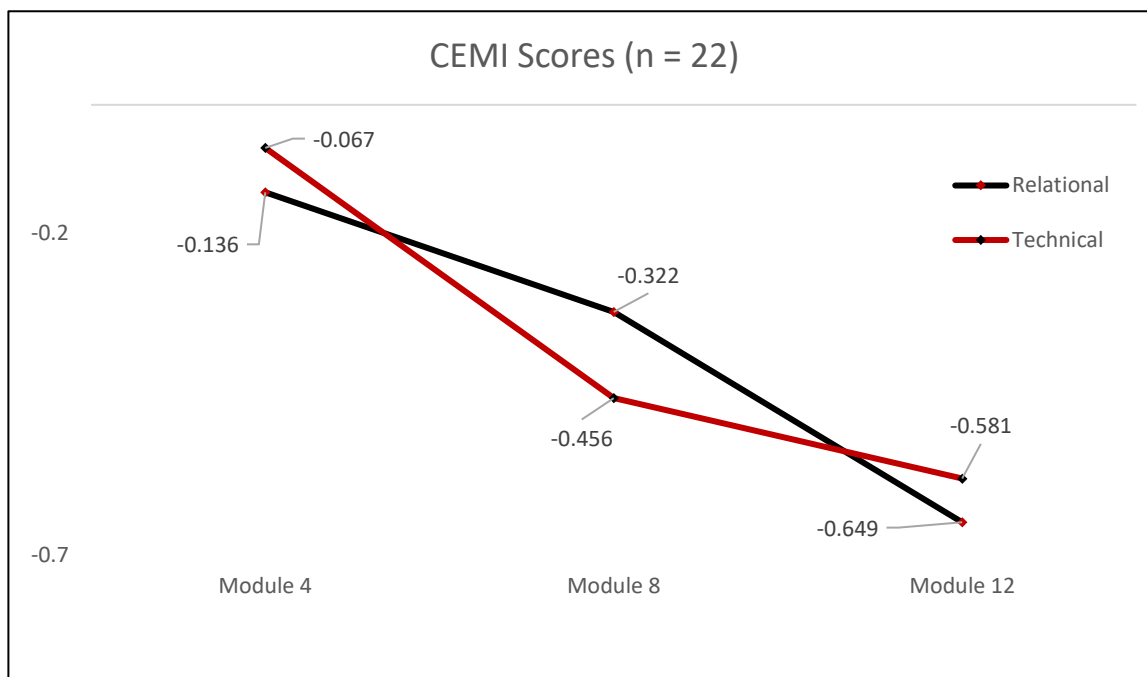
This section provides the score changes from the administrations of the CEMI at modules 4, 8, and 12. Table 6 presents scores from all CEMI surveys. This includes participants who either had only the module 4 CEMI, only the module 8 CEMI, only the module 12 CEMI, or some combination of the former. This is non-experimental and can only be used for descriptive purposes. Causality should not be inferred from this table. As such, significance tests are presented only for descriptive purposes, to demonstrate the degree of change observed. Only for descriptive purposes, the scores (and apparently significantly) gradually increased for the relational factor. Recall that higher scores suggest better relational adherence and better technical adherence, according to the theory used to derive the original scales. This finding would have been very encouraging to the continuation of TP if the implementation of the scales would have been consistent. For the technical factor, the scores gradually decreased over the modules. This points to a reduced adherence to the principles of MI as participants progressed in the program. This may be due to changing perceptions of the participant regarding the content of the question as the participant develops cognitive skills gained from the program – which may be interpreted as a measurable program effect. However, it is more likely that the facilitators 1) provided different types/levels of feedback to participants advancing to latter modules or 2) the facilitators became less effective over time due to job complacency, increased barriers in working in the prison due to an uncontrollable exogenous factor, or some combination of the former.

Additionally, it is also possible the coordinator's communication with the facilitators degraded over time. Ultimately, a variety of factors likely contributed to this finding, and considering the non-experimental nature of data collection and program implementation, no definitive conclusion may be made.

Table 6: Independent Samples CEMI for full sample					
Variable	Mean	SE	n	F	p
Relational @ 4	-0.127	0.07	145	4.366	0.013
Relational @ 8	0.016	0.10	95		
Relational @ 12	0.202	0.20	80		
Technical @ 4	0.130	0.07	145	3.213	0.042
Technical @ 8	-0.021	0.10	95		
Technical @ 12	-0.203	0.12	80		

Table 7 also presents scores from the CEMI scales. These participants each completed all three CEMI scales. For these 22 participants, time-ordering is established. However, as in each of the disclaimer statements throughout this document, the fidelity by which the program was implemented makes the findings only descriptive and not able to be generalized to a larger population. Nonetheless, the scores decreased as the module number increased. This suggests the program progressively degraded in its adherence to MI principles. While the omnibus test showed a non-significant relationship between the modules, the trend can be considered descriptive for this program in this setting with this population and implementers. The average scores are depicted in the subsequent line graph.

Table 7: Dependent Samples CEMI					
Variable	Mean	SE	n	F	p
Relational @ 4	-0.136	0.20	22	1.571	0.216
Relational @ 8	-0.322	0.20	22		
Relational @ 12	-0.649	0.21	22		
Technical @ 4	-0.067	0.19	22	1.687	0.193
Technical @ 8	-0.459	0.22	22		
Technical @ 12	-0.581	0.12	22		



Limitations

The current evaluation has several limitations. The most pertinent is the lack of input from the coordinator. Despite multiple meetings, months, and close proximity to the current evaluator, the coordinator did not provide information to inform the current evaluation. This led to institutional knowledge gap that the current evaluation cannot address. The potential for interviews with the UNO facilitators and NDCS staff was promising, but ultimately unable to be completed due to this lack of input.

Another pertinent limitation is the evaluation's lack of qualitative analysis to describe processes and actual (and potential) outcomes. A qualitative content analysis describing the themes present in the change documented in the module worksheets could provide TP with previously unobserved obstacles. Further, focus groups or interviews with NDCS could have informed the evaluation on obstacles not apparent by an analysis of the current quantitative data.

The lack of a fixed data tracking sheet on an accessible drive to NDCS staff and UNO facilitators/coordinator also contributed considerably to the accuracy of the current evaluation. Reports from the NCJR agent tasked with extracting data (not the coordinator) included duplicate tracking sheets within facilities, lost sheets on the NDCS computer holding the tracking sheets, and the denial of access to the tracking sheet by an NDCS employee for weeks.

Quantitative analysis relies on sample size, reliability, and accuracy of data to make general inferences regarding causality. Due to the many issues in the evaluation and implementation of TP noted throughout this report, the findings should not be considered causal in any fashion or in any context. Doing so would ignore the potential spurious relationships between the program dosage and observed effects.

The considerable missing data and incoherent factor loadings on the relational component on the CEMI make the reliability of the data questionable at best. There is little reason to believe the data is even moderately accurate in its ability to depict actual program effects of the TP.

Conclusion

Making the best of the situation, the current evaluation attempted to objectively analyze any available data. The data is limited to module completions and a small number of psychometric measurement scales. There is no qualitative data, aside from the module worksheets that would take considerable resources and time to analyze. There are no interviews, and no examination of procedures – as there is no written account of procedures to the evaluator's knowledge, and the coordinator is unable to communicate procedures used. The current evaluation did not set performance measures. It did not have any recognizable logic model, outcome measures, or process measures. Implementation and coordination appear to be ad hoc.

Future Implementation and Evaluation Recommendations

The following is a list of recommendations for the future implementation and evaluation of the TP. “Implementers” refer any staff involved in any procedure, and not the evaluators. “Evaluators” refer to anyone contracted/directed to perform an objective analysis of procedures and outcomes. Implementers and Evaluators should be mutually exclusive, but in constant contact with one another. While not exhaustive, the following list is what may be derived from the current data and evaluator’s knowledge on the TP’s implementation. Certainly other considerations to improve the evaluation should be considered and discussed between the implementers and evaluators prior to the implementation of the TP.

- 1) *Evaluators should be employed by a different agency/organization than the implementers.* To limit bias in an implementation evaluation and to calculate a true program effect, the evaluators should not be employed by the same agency as the implementers. The two entities should work as a team to develop measures and procedures throughout the project.
- 2) *Employ one lead on the TP, with no other responsibilities in the department/agency.* Coordination and authority to change procedures in the best interest of the program and evaluation is essential. The lead should be educated on the characteristics and particulars of the participant population, the literature pertaining to correctional interventions and correctional procedures/setting, and social science research methodology. The lead should be allowed to freely submit disciplinary recommendations to the agency on non-compliant staff without the fear of retribution by the agency or staff. The lead should be allowed to recommend the hiring of and supervise staff dedicated specifically to the TP. The lead should be in daily/weekly direct contact with an executive in the organization implementing as well as the executive in the organization evaluating. Finally, the lead should hire and supervise employees solely dedicated to TP, with no other institutional responsibilities.
- 3) *Consult with hired evaluators prior to the start of the TP.* While evaluators should have no authority to change the program, they should be made aware of all implementation and procedural rules prior to the start of the program. A pilot may be run before including the evaluators to hash out the rules, but the data collected for the pilot should not be included in any true evaluation of progress or procedure. The evaluators should be involved at all levels and points of the evaluation to ensure the best picture and examination of processes to provide **both lagging and leading measures** to assist the implementers to improve procedures towards participant success and the evaluators to improve the fidelity of the evaluation.

- 4) *Update the logic model with the evaluators and follow as best as possible.* An updated logic model would provide a visual, easily-digested representation of the program theory linking the intervention to the proposed outcomes. It gives the reasoning behind the actions, which is crucial for when a practice appears to be inefficient, cumbersome, or having no practical value. The current logic model is presented in Appendix III. The current logic model has not yet been applied in a meaningful manner outside of planning periods between contracts. A logic model is a roadmap for the program, and given the inevitable loss of institutional knowledge due to staff turnover and promotions/transfers, it is a good way to keep the program implementation steady.
- 5) *Develop process measures with the evaluators.* Process evaluation measures may include adherence to Motivational Interviewing techniques, days to first module completion, module completion rates, failures of completed modules, ordering of CEMI and MFC administrations, administration dates the risk assessment to both treatment and comparison groups, demographic and attitudinal characteristics of risk assessment administrators and facilitators of among others. The existing process evaluation documents for the general population version of TP can be used as a guide for TP in restrictive housing.
- 6) *Develop outcome measures with the evaluators.* These measures should include outcomes, indicators, data collection methods, data sources, and degree of difficulty in obtaining data. Measures should be taken pre and post intervention on both the treatment and comparison group. They should include both qualitative and quantitative data that can be analyzed by evaluators. All data components' usefulness, accuracy, and reliability should be assessed by the implementers and evaluators annually. Data components that are collected and not used by the evaluators or implementers after one year should cease from being tracked as an outcome for TP, to ensure the best use of implementers' resources. The existing outcome evaluation documents for the general population version of TP can be used as a guide for TP in restrictive housing.
- 7) *Store all data digitally.* All data should be stored on a dedicated secure drive only accessible to the data entry employees of the implementers and the evaluators. The modules may be completed by hand, but each individual module should have a tracking number. For example, for the first person to be administered module 1, the tracking number should be printed or hand-written by the implementer (not the participant) on the sheet like this: "Tracking # 1-00001". Prior to handing 1-00001 to the participant, form 1-00001 would be entered into a dedicated computer system on the secured drive with a time stamp. MFC's and CEMI's should also have a dedicated tracking number associated with them. Missing forms would therefore be able to be identified as to who was on shift and responsible for the missing forms. Using excel sheets is not

recommended, rather a specific software platform dedicated to this procedure should be utilized. Excel spreadsheets can be saved incorrectly, saved in the wrong folder, duplicated, or renamed in error. Standardizing the tracking procedure of the modules and MFC and CEMI scales is essential to determining fidelity and program effects. Ensure the data can be pulled from the data system in its raw form, with appropriate units of analysis. This is to inform the evaluation at the module-level, without having to enter each participant or module screen individually.

- 8) *Track all procedure changes.* The evaluation should track all procedures changes in organization and implementation to account for differences in type and quality of dosage/administration. The division of labor between individuals hired specifically for TP should be set prior to the start of the program.
- 9) *Track all activities, including completions, failures, and other obstacles.* Ensure all activities (including non-completions) have outcomes, reasons, and dates attached. Track the date and time down to the minute (or 15 minutes) that the form is provided and collected. Track all communication between the implementers and participants during a completion session. For example, if the participant needs to know what a specific word means and asks an implementer, some measure should be included to indicate such in the data entry form when the form is returned into the system. The information should be put into a data platform before the end of shift. If data is found to be incomplete, the employee should not be allowed to clock out or leave the facility.
- 10) *Develop a comparison group.* The evaluation would need a comparison group to determine program effects, and the administration of the outcome measures for both the treatment and comparison groups. A risk assessment for both the comparison group and the treatment group should inform a propensity score model to eliminate the differences between groups, absent random assignment to treatment or comparison group.
- 11) *Track outcomes in the facility.* Outcomes may include misconducts, quality of life scores, cognitive strengths, motivation for change, pro-social attitudes, mental health, visitations, and participation in other programming.
- 12) *Track outcomes upon release from facility.* Once released from the institution, participants and comparison groups should be tracked for at least three years, with six or 12 month follow-ups. Outcomes could include arrests, returns to prison, revocations, meaningful and stable employment, family stability, mental health diagnoses, substance abuse, parenting abilities, other psychological constructs related to criminal activity, and other constructs related to quality of life measures. Data sources may

derive from NDCS, Parole, AOC, sheriffs' departments, the department of labor, the department of health and human services, FBI, the states of Iowa, Missouri, Kansas, Illinois, and South Dakota. Tracking an individual is difficult when they are released from supervision. Ensuring multiple points (i.e., at reentry, at release from parole/community supervision), contacts (e.g., parents, siblings, children, extended family, employer, mental health clinician, recreational leagues/organizations, case worker, any/all institutions affiliated with any of the former) and modes (e.g., phone numbers, addresses, emails, social media websites) of contact before release from any supervision is tedious and requires strong commitment from the TP coordinator, institution, community agencies (private and public), and social network of the individual, but the benefits of a good tracking method cannot be understated for proper evaluation.

- 13) *Ensure participants are re-included in the "in the facility" tracking system if re-incarcerated.* A re-incarceration is not necessarily a failure or success, but tracking an individual regardless of the setting is essential.
- 14) *Ensure proper control measures are available.* Using a risk assessment can allow future evaluations to control for the various influences that may be directing program progress for each individual. The assessment should be given as many times as possible, pre and post intervention. At prison intake, at RH intake, during RH, post-RH, at prison release, and every 12 months thereafter is a decent measurement timeline. The assessment should also be as customized to the population as possible. This means agreeing on an outcome for the assessment (e.g., misconducts, return to prison, new crimes), as well as domains of concern (e.g., mental health, aggression, anti-social attitudes, motivation for change).
- 15) *Gain and maintain buy-in from all levels of administration.* Believing in the importance and ability of the program to affect the lives of participants is essential for proper implementation and evaluation. This case must be applied to all levels of administration: Director of Corrections, Parole Board, Courts administering probation, the evaluation entity, and all mid-level managers/supervisors and line-staff of each of the former organizations. Viewing the program as "just another program" will threaten the ability of the program to be implemented and evaluated properly, thus diluting any real or observed effects on the participant. Individuals identified by the program coordinator to hold negative views about the program should be immediately removed from contact with the participants to ensure fidelity and other implementers to avoid contamination.
- 16) *Ensure the evaluators are qualified.* While there is no official credential for an evaluator in the social sciences, resumes and prior work should be examined in the application process by a subject matter expert trusted by the implementer. At the very least, the lead evaluator should have at least

three years of evaluation and be well-versed on corrections, restrictive housing, the criminal justice system, behavioral development, conflict resolution, and research methodology in the social sciences.

17) *Examine performance measures of TP facilitators.* Implementers and the evaluators should develop a procedure to evaluate the quality of feedback given by the facilitators. The procedure might include the coordinator randomly selecting feedbacks from the facilitators monthly and rating the feedbacks on quality and adherence to MI techniques. Importantly, the ratings should be reviewed with the facilitators to ensure potential or actual issues are addressed. The procedure should encompass multiple measures of quality based on program logic model and MI techniques. Further, the training and re-training of facilitators is important to the integrity of the program. Trainings should occur on a biannual or quarterly basis. Brief quizzes on the TP and MI should be given at the beginning and end of each training. The quizzes and training materials should change in content for each training. At the very least, the instructions in Appendix I should be modified and adhered to by the facilitators and enforced by the coordinator.

18) *Ensure TP facilitators are clearly distinguished from correctional staff.* There was some evidence from the CEMI factor analysis in the current evaluation that suggests participants did not clearly distinguish between facilitators providing substantive feedback and the correctional staff member delivering the paper-based modules. In a prison setting, participants may have difficulty distinguishing between authority figures and rehabilitative figures. A comprehensive plan on how the modules will be delivered should be developed during the planning phase and revisited by the implementers and evaluators periodically to ensure participants are rating facilitators and not the correctional staff.

Conclusion

In its current form, the TP is a module-based program that uses a cognitive-behavioral approach to promote inmate change, and decrease institutional misconduct and community recidivism. In the literature, there is very little evidence that programs such as TP being are used in restrictive housing, let alone evaluated (see Butler et al., 2018). Indeed, the evaluation presented here can provide context to inform future implementation and evaluation efforts of this and other novel programs in correctional settings (Rossi, Lipsey, & Freeman, 2004).

However, considerable challenges remain in the implementation and evaluation of TP. While the modules have great potential to initiate and accelerate cognitive, emotional, interpersonal, and moral change within participants, their capacity has been underutilized to date. Using the current evaluation as a baseline, the recommendations put forth should be examined prior to implementation and evaluation efforts, but by no means should be considered exhaustive.

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Appendix I

Instructions for Transformation Project Implementation: Restrictive Housing

1. Facility Coordinators should identify potential facilitators.
 - a. Contact TP program coordinator to let them know you have potential facilitators.
2. Potential facilitators complete facilitator readiness questionnaire and return to UNO Transformation Project Staff.
3. Facilitators complete *Network Authorization Form* to gain access to the *Q-drive*.
 - a. The Q-drive is a network folder where documents related to Transformation project are stored. Each facility has their own Transformation Project Folder.
4. Eligible facilitators **must** complete **two** trainings:
 - a. Motivational Interview training.
 - b. Transformation Project training provided by Transformation Project Staff.
5. Running the program:
 - a. Explain the program to participants.
6. Distribute modules *one at a time* to participants.
 - a. *Review* modules and provide feedback. Early modules will be used in the final phase of the program.
 - b. *Scan* completed modules *and feedback forms* to save copies on the Q-drive.
7. *Track* participants progress on the *Participant Tracking Sheet*:
 - a. Mark inmate ID, when modules were distributed, when modules were returned to participants, and fill out the appropriate code for module progress (e.g., completed, participant withdraw, disciplinary events, institutional transfers, or other reason).
 - b. *Update and save* the tracking sheet to the Q-drive.
 - c. *Note*: Facilitators should be using and updating previously saved versions of the tracking sheet stored on the Q-drive. Facilitators should not be saving multiple copies of the tracking sheet. There should only be *one copy* of the tracking sheet.

8. There are various surveys embedded within modules for participants to complete. *If* a participant leaves the program before reaching module 12 the facilitator must ensure that participants *complete the **Motivation to Change survey and Participant debrief survey.***
 - a. The *Participant debrief survey* is embedded in Modules 4,8, and 12.
 - b. The *Motivation to change survey* is embedded in the Orientation module and Module 12.
 - c. Facilitators *scan and save a copy to the Q-drive* when they receive the documents.
9. All facilitators should complete an *online survey* related to Transformation Project *every six months* distributed by UNO Transformation Project Staff.
10. Facility Coordinators should:
 - a. Complete survey related to Transformation Project *once per year*.
 - b. Periodically review program facilitation by reviewing facilitator module feedback forms and completing the *Facilitator Evaluation* sheet.
11. For questions or comments please contact Laura Schoenrock
lschoenrock@unomaha.edu.

Appendix II

The current appendix provides the MFC and CEMI scales, slightly formatted for this report – the content remains the same.

Coding Notes: Motivation for Change

ID Number: _____

Please select the response that best describes you. Please answer the questions by placing an “X” in the box that corresponds with your response.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. You have too many outside responsibilities to be in this program*	1	2	3	4	5
2. This program seems too demanding for you*	1	2	3	4	5
3. This program may be your last chance to help you solve your problems	1	2	3	4	5
4. This kind of program will <i>not</i> be very helpful to you*	1	2	3	4	5
5. You plan to stay in this program for a while	1	2	3	4	5
6. You are in this program because someone else made you*	1	2	3	4	5
7. This program can really help you	1	2	3	4	5
8. You want to be in this program	1	2	3	4	5
9. You consider how your actions will affect others	1	2	3	4	5
10. You plan ahead	1	2	3	4	5
11. You think about the probable results of your actions	1	2	3	4	5
12. You have trouble making decisions*	1	2	3	4	5
13. You think of several different ways to solve a problem	1	2	3	4	5
14. You analyze problems by looking at all the choices	1	2	3	4	5
15. You make decisions without thinking about the consequences*	1	2	3	4	5
16. You think about what causes your current problems	1	2	3	4	5

Participant Debrief Survey
Modules 4, 8, & 12

ID Number: _____

Please select the response that best describes Transformation Project Facilitators. Please answer the questions by placing an "X" in the box that corresponds with your response.

How much did the facilitator:

	Never	Sometimes	Often	Almost Always
1. Focus on your weakness	1	2	3	4
2. Help you talk about changing your behavior	1	2	3	4
3. Act as a partner in your behavior change	1	2	3	4
4. Help you discuss your need to change your behavior	1	2	3	4
5. Make you feel distrustful of him or her	1	2	3	4
6. Help you examine the pros and cons of changing your behavior	1	2	3	4
7. Help you feel hopeful about changing your behavior	1	2	3	4
8. Argue with you to change your behavior	1	2	3	4
9. Push you forward when you become unwilling to talk about an issue further	1	2	3	4
10. Act as an authority on your file	1	2	3	4
11. Tell you what to do	1	2	3	4
12. Argue with you about needing to be 100% ready to change your behavior	1	2	3	4
13. Show you that he or she believes in your ability to change your behavior	1	2	3	4
14. Help you feel confident in your ability to change your behavior	1	2	3	4
15. Help you recognize the need to change your behavior	1	2	3	4

Motivational Interviewing Strategies and Techniques: Rationales and Examples

ASKING PERMISSION

Rationale: Communicates respect for clients. Also, clients are more likely to discuss changing when asked, than when being lectured or being told to change.

Examples of Asking Permission

- *“Do you mind if we talk about [insert behavior]?”*
 - *“Can we talk a bit about your [insert behavior]?”*
 - *“I noticed on your medical history that you have hypertension, do mind if we talk about how different lifestyles affect hypertension?”* (Specific lifestyle concerns such as diet, exercise, and alcohol use can be substituted for the word “lifestyles” in this sentence.)
-

ELICITING/EVOKING CHANGE TALK

Rationale: Change talk tends to be associated with successful outcomes. This strategy elicits reasons for changing from clients by having them give voice to the need or reasons for changing. Rather than the therapist lecturing or telling clients the importance of and reasons why they should change, change talk consists of responses evoked from clients. Clients’ responses usually contain reasons for change that are personally important for them. Change talk, like several Motivational Interviewing (MI) strategies, can be used to address discrepancies between clients’ words and actions (e.g., saying that they want to become abstinent, but continuing to use) in a manner that is nonconfrontational. One way of doing this is shown later in this table under the Columbo approach. Importantly, change talk tends to be associated with successful outcomes.

Questions to Elicit/Evoke Change Talk

- *“What would you like to see different about your current situation?”*
- *“What makes you think you need to change?”*
- *“What will happen if you don’t change?”*
- *“What will be different if you complete your probation/referral to this program?”*
- *“What would be the good things about changing your [insert risky/problem behavior]?”*
- *“What would your life be like 3 years from now if you changed your [insert risky/problem behavior]?”*
- *“Why do you think others are concerned about your [insert risky/problem behavior]?”*

Elicit/Evoke Change Talk For Clients Having Difficulty Changing:

Focus is on being supportive as the client wants to change but is struggling.

- *“How can I help you get past some of the difficulties you are experiencing?”*
- *“If you were to decide to change, what would you have to do to make this happen?”*

Elicit/Evoke Change Talk by Provoking Extremes: For use when there is little expressed desire for change. Have the client describe a possible extreme consequence.

- *“Suppose you don’t change, what is the WORST thing that might happen?”*
- *“What is the BEST thing you could imagine that could result from changing?”*

Elicit/Evoke Change Talk by Looking Forward: These questions are also examples of how to deploy discrepancies, but by comparing the current situation with what it would be like to not have the problem in the future.

- *“If you make changes, how would your life be different from what it is today?”*
- *“How would you like things to turn out for you in 2 years?”*

EXPLORING IMPORTANCE AND CONFIDENCE

Rationale: As motivational tools, goal importance and confidence ratings have dual utility: (a) they provide therapists with information about how clients view the importance of changing and the extent to which they feel change is possible, and (b) as with other rating scales (e.g., Readiness to Change Ruler), they can be used to get clients to give voice to what they would need to do to change.

Examples of How to Explore Importance and Confidence Ratings

- *“Why did you select a score of [insert #] on the importance/confidence scale rather than [lower #]?”*
- *“What would need to happen for your importance/confidence score to move up from a [insert #] to a [insert a higher #]?”*
- *“What would it take to move from a [insert #] to a [higher #]?”*
- *“How would your life be different if you moved from a [insert #] to a [higher #]?”*
- *“What do you think you might do to increase the importance/confidence about changing your [insert risky/problem behavior]?”*

OPENED-ENDED QUESTIONS

Rationale: When therapists use open-ended questions it allows for a richer, deeper conversation that flows and builds empathy with clients. In contrast, too many back-to-back closed- or dead- ended questions can feel like an interrogation (e. g., *“How often do you use cocaine?” “How many years have you had an alcohol problem?” “How many times have you been arrested?”*). Open-ended questions encourage clients to do most of the talking, while the therapist listens and responds with a reflection or summary statement. The goal is to promote further dialogue that can be reflected back to the client by the therapist. Open-ended questions allow clients to tell their stories.

Examples of Open-Ended Questions

- *“Tell me what you like about your [insert risky/problem behavior].”*
- *“What’s happened since we last met?”*
- *“What makes you think it might be time for a change?”*
- *“What brought you here today?”*

- *“What happens when you behave that way?”*
- *“How were you able to not use [insert substance] for [insert time frame]?”*
- *“Tell me more about when this first began.”*
- *“What’s different for you this time?”*
- *“What was that like for you?”*
- *“What’s different about quitting this time?”*

REFLECTIVE LISTENING

Rationale: Reflective listening is the primary way of responding to clients and of building empathy. Reflective listening involves listening carefully to clients and then making a reasonable guess about what they are saying; in other words, it is like forming a hypothesis. The therapist then paraphrases the clients’ comments back to them (e.g., *“It sounds like you are not ready to quit smoking cigarettes.”*).

Another goal in using reflective listening is to get clients to state the arguments for change (i.e., have them give voice to the change process), rather than the therapist trying to persuade or

lecture them that they need to change (e.g., *“So, you are saying that you want to leave your husband, and on the other hand, you worry about hurting his feelings by ending the relationship. That must be difficult for you. How do you imagine the two of you would feel in 5 years if things remain the same?”*). Reflections also validate what clients are feeling and doing so communicates that the therapist understands what the client has said (i.e., *“It sounds like you are feeling upset at not getting the job.”*). When therapists’ reflections are correct, clients usually respond affirmatively. If the guess is wrong (e.g., *“It sounds like you don’t want to quit smoking at this time.”*), clients usually quickly disconfirm the hypothesis (e. g. *“No, I do want to quit, but I am very dependent and am concerned about major withdrawals and weight gain.”*).

Examples of Reflective Listening (generic)

- *“It sounds like”*
- *“What I hear you saying...”*
- *“So on the one hand it sounds like And, yet on the other hand....”*
- *“It seems as if....”*
- *“I get the sense that....”*
- *“It feels as though....”*

Examples of Reflective Listening (specific)

- *“It sounds like you recently became concerned about your [insert risky/problem behavior].”*
- *“It sounds like your [insert risky/problem behavior] has been one way for you to [insert whatever advantage they receive].”*
- *“I get the sense that you are wanting to change, and you have concerns about [insert topic or behavior].”*
- *“What I hear you saying is that your [insert risky/problem behavior] is really not much of a problem right now. What you do think it might take for you to change in the future?”*
- *“I get the feeling there is a lot of pressure on you to change, and you are*

not sure you can do it because of difficulties you had when you tried in the past.”

NORMALIZING

Rationale: Normalizing is intended to communicate to clients that having difficulties while changing is not uncommon, that they are not alone in their experience, or in their ambivalence about changing. Normalizing is not intended to make clients feel comfortable with not changing; rather it is to help them understand that many people experience difficulty changing.

Examples of Normalizing

- *“A lot of people are concerned about changing their [insert risky/problem behavior].”*
- *“Most people report both good and less good things about their [insert risky/problem behavior].”*
- *“Many people report feeling like you do. They want to change their [insert risky/problem behavior], but find it difficult.”*
- *“That is not unusual, many people report having made several previous quit attempts.”*
- *“A lot of people are concerned about gaining weight when quitting.”*

DECISIONAL BALANCING

Rationale: Decisional balancing strategies can be used anytime throughout treatment. A good strategy is to give clients a written Decisional Balance (DB) exercise (see Appendix 4.11) at the assessment session and ask them to bring the completed exercise to their first session. A sample of a completed exercise is shown in Appendix 4.10b. The DB exercise asks clients to evaluate their

current behaviors by simultaneously looking at the good and less good things about their actions. The goal for clients is two fold: To realize that (a) they get some benefits from their risky/problem behavior, and (b) there will be some costs if they decide to change their behavior. Talking with clients about the good and less good things they have written down on their DB can be used to help them understand their ambivalence about changing and to move them further toward wanting to change. Lastly, therapists can do a DB exercise with clients by simply asking them in an open- ended fashion about the good and less good things regarding their risky/problem behavior and what it would take to change their behavior.

Examples of How to Use a Decisional Balance Exercise

- *“What are some of the good things about your [insert risky/problem behavior]? [Client answers] Okay, on the flipside, what are some of the less good things about your [insert risky/problem behavior].”*

After the clients discuss the good and less good things about their behavior, the therapist can use a reflective, summary statement with the intent of having clients address their ambivalence about changing.

COLUMBO APPROACH

Rationale: The Columbo approach can also be characterized as deploying discrepancies. The goal is to have a client help the therapist make sense of the

client's discrepant information The approach takes its name from the behavior demonstrated by Peter Falk who starred in the 1970s television series *Columbo*. The Columboesque approach is intended as a curious inquiry about discrepant behaviors without being judgmental or blaming and allows for the juxtaposing in a non- confrontational manner of information that is contradictory. In other words, it allows the therapist to address discrepancies between what clients say and their behavior without evoking defensiveness or resistance. When deploying discrepancies, when possible, as shown in the example below try to end the reflection on the side of change as clients are more likely to elaborate on the last part of the statement.

- *"It sounds like when you started using cocaine there were many positives. Now, however, it sounds like the costs, and your increased use coupled with your girlfriend's complaints, have you thinking about quitting. What will your life be like if you do stop?"*

Examples of How to Use the Columbo Approach: While the following responses might sound a bit unsympathetic, the idea is to get clients who present with discrepancies to recognize them rather than being told by their therapists that what they are saying does not make sense.

- *"On the one hand you're coughing and are out breath, and on the other hand you are saying cigarettes are not causing you any problems. What do you think is causing your breathing difficulties?"*
- *"So, help me to understand, on the one hand you say you want to live to see your 12-year old daughter grow up and go to college, and yet you won't take the medication your doctor prescribed for your diabetes. How will that help you live to see your daughter grow up?"*
- *"Help me understand, on the one hand I hear you saying you are worried about keeping the custody of your children. Yet, on the other hand you are telling me that you are using crack occasionally with your boyfriend. Since you also told me you are being drug screened on a random basis, I am wondering how using cocaine might affect your keeping custody of your children."*

STATEMENTS SUPPORTING SELF-EFFICACY

Rationale: Eliciting statements that support self-efficacy (self-confidence) is done by having clients give voice to changes they have made. Because many clients have little self-confidence in their ability to change their risky/problem behaviors, the objective is to increase their self- confidence that they can change. Self-confidence statements can be sought from clients using scaling techniques (e. g, Readiness to Change Ruler, Importance and Confidence related to goal choice). For example, when using a Readiness Ruler, if clients' readiness to change goes from a lower number (past) to a higher number (now), therapists may follow-up by asking how they were able to do that and how they feel about their change.

Examples of Eliciting Statements Supporting Self-Efficacy

- *"It seems you've been working hard to quit smoking. That is different than*

- *before. How have you been able to do that?"*
- *"Last week you were not sure you could go one day without using cocaine, how were you able to avoid using the entire past week?"*
- *"So even though you have not been abstinent every day this past week, you have managed to cut your drinking down significantly. How were you able to do that?"*
- *"Based on your self-monitoring logs, you have not been using cannabis daily. In fact, you only used one day last week. How were you able to do that?"* Follow-up by asking, *"How do you feel about the change?"*

After asking about changes clients have made, it is important to follow-up with a question about how clients feel about the changes they made.

- *"How do you feel the changes you made?"*
- *"How were you able to go from a [# 6 months ago] to a [# now]?"* [Client answers] *"How do you feel about those changes?"*

READINESS TO CHANGE RULER

Rationale: Assessing readiness to change is a critical aspect of MI. Motivation, which is considered a state not a trait, is not static and thus can change rapidly from day to day. Clients enter treatment at different levels of motivation or readiness to change (e.g., not all are ready to change; many are ambivalent about changing). In this regard, if therapists know where clients are in terms of their readiness to change, they will be better prepared to recognize and deal with a client's motivation to change. The concept of readiness to change is an outgrowth of the Stages of Change Model that conceptualizes individuals as being at different stages of change when entering treatment. While readiness to change can be evaluated using the Stages of Change Model, a simpler and quicker way is to use a Readiness to Change Ruler (Appendix 4.7). This scaling strategy conceptualizes readiness or motivation to change along a continuum and asks clients to give voice to how ready they are to change using a ruler with a 10-point scale where 1 = definitely not ready to change and 10 = definitely ready to change. A Readiness Ruler allows therapists to immediately know their client's level of motivation for change. Depending on where the client is, the subsequent conversation may take different directions. The Readiness to Change Ruler can also be used to have clients give voice to how they changed, what they need to do to change further, and how they feel about changing.

Examples of How to Use a Readiness to Change Ruler

- Therapist (T): *"On the following scale from 1 to 10, where 1 is definitely not ready to change and 10 is definitely ready to change, what number best reflects how ready you are at the present time to change your [insert risky/problem behavior]?"*
Client (C): *"Seven."*
T: *"And where were you 6 months ago?"*
C: *"Two."*
T: *"So it sounds like you went from not being ready to change your [insert risky/problem behavior] to thinking about changing. How did you go from a '2' 6 months ago to a '7' now?"*
- *"How do you feel about making those changes?"*
- *"What would it take to move a bit higher on the scale?"*

Clients with lower readiness to change (e.g., answers decreased from a “5” 6 months ago to a “2” now)

- “So, it sounds like you went from being ambivalent about changing your [insert risky/problem behavior] to no longer thinking you need to change your [insert risky/problem behavior]. How did you go from a ‘5’ to a ‘2’?”
 - “What one thing do you think would have to happen to get you to back to where you were 6 months ago?”
-

AFFIRMATIONS

Rationale: Affirmations are statements made by therapists in response to what clients have said, and are used to recognize clients’ strengths, successes, and efforts to change. Affirmative responses or supportive statements by therapists verify and acknowledge clients’ behavior changes and attempts to change. When providing an affirmation, therapists should avoid statements that sound overly ingratiating (e.g., “Wow, that’s incredible!” or “That’s great, I knew you could do it!”). While affirmations help to increase clients’ confidence in their ability to change, they also need to sound genuine.

Example of Affirmative Statements

- “Your commitment really shows by [insert a reflection about what the client is doing].”
 - “You showed a lot of [insert what best describes the client’s behavior—strength, courage, determination] by doing that.”
 - “It’s clear that you’re really trying to change your [insert risky/problem behavior].”
 - “By the way you handled that situation, you showed a lot of [insert what best describes the client’s behavior—strength, courage, determination].”
 - “With all the obstacles you have right now, it’s [insert what best describes the client’s behavior—impressive, amazing] that you’ve been able to refrain from engaging in [insert risky/problem behavior].”
 - “In spite of what happened last week, your coming back today reflects that you’re concerned about changing your [insert risky/problem behavior].”
-

ADVICE/FEEDBACK

Rationale: A frequently used MI strategy is providing advice or feedback to clients. This is a valuable technique because clients often have either little information or have misinformation about their behaviors. Traditionally, therapists and other health care practitioners have encouraged clients to quit or change behaviors using simple advice [e.g., “If you continue using you are going to have (insert health consequence).”]. Research has shown that by and large the effectiveness of simple advice is very limited (e.g., 5% to 10% of smokers are likely to quit when simply told to quit because smoking is bad for their health). The reason simple advice does not work well is because most people do not like being “told what to do.” Rather, most individuals prefer being given choices in making decisions, particularly changing behaviors.

What we have learned from MI is that how information is presented can affect how it is received. When relevant, new information should be presented in a neutral, nonjudgmental, and sensitive manner that empowers clients to make more informed decisions about quitting or changing a risky/problem behavior. One way to do this is to provide feedback that allows clients to compare their behavior to that of others so they know how their behavior relates to national norms (e.g., percentage of men and women drinking at different levels; percentage of population using cannabis in the last year; see Appendices 4.2c and 4.2d for examples of such feedback). Presenting personalized feedback in a motivational manner allows clients to evaluate the feedback for personal relevance (*"I guess I drink as much as my friends, but maybe we are all drinking more than we should."*).

When therapists ask clients what they know about how their risky/problem behavior affects other aspects of their life (e.g., health—hypertension) clients typically say, *"Well not much"* or they might give one or two brief facts. This can be followed-up by asking if they are interesting in learning more about the topic and then being prepared to provide them with relevant advice feedback material that the therapist has prepared or has available. Lastly, whenever possible, focus on the positives of changing. A good example of providing positive information about changing is evident with smoking. Within 20 minutes of stopping smoking an ex-smoker's body begins a series of changes ranging from an immediate decrease in blood pressure to 15 years after quitting the risk of coronary heart disease and death returns to nearly that of those who have never smoked [<http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=33568>]. What is interesting with this example is that many smokers are not aware of the multiple benefits that occur soon after quitting. In this regard, therapists can ask, *"What do you know about the benefits of quitting smoking?"* and follow-up with asking permission to talk about the client's smoking (*"Do you mind if we spend a few minutes talking about your smoking?"*).

Remember that some clients will not want information. In these cases, if the therapist uses scare tactics, lectures, moralizes, or warns of disastrous consequences, most clients are not likely to listen or will pretend to agree in order to not be further attacked.

Examples of How to Provide Advice/Feedback (often this can start by asking permission to talk about the client's behavior)

- *"Do you mind if we spending a few minutes talking about....?"* [Followed by] *"What do you know about....?"* [Followed still by] *"Are you interested in learning more about.....?"* [After this clients can be provided with relevant materials relating to changing their risky/problem behavior or what affects it has on other aspects of their life.]
- *"What do you know about how your drinking affects your [insert health problem]?"*
- *"What do you know about the laws and what will happen if you get a second drunk driving arrest?"*
- *"Okay, you said that the legal limit for drunk driving is 0.08%. What do you know about how many drinks it takes to get to this level?"*
- *"So you said you are concerned about gaining weight if you stop smoking. How much do*

- *you think the average person gains in the first year after quitting?”*
- *“I’ve taken the information about your drinking that you provided at the assessment, calculated what you report drinking per week on average, and it is presented on this form along with graphs showing levels of drinking in the general population. Where do you fit in?” [use with Appendix 4.2c]*
- *“On one of the questionnaires you filled out, the Drug Abuse Screening Test, you scored a 7. This form shows how scores on that measure are related to drug problem severity. Where do you fit in?” [use with Appendix 4.2d]*

SUMMARIES

Rationale: Summaries are used judiciously to relate or link what clients have already expressed, especially in terms of reflecting ambivalence, and to move them on to another topic or have them expand the current discussion further. Summaries require that therapists listen very carefully to what clients have said throughout the session. Summaries are also a good way to either end a session (i.e., offer a summary of the entire session), or to transition a talkative client to the next topic.

Examples of Summaries:

- *“It sounds like you are concerned about your cocaine use because it is costing you a lot of money and there is a chance you could end up in jail. You also said quitting will probably mean not associating with your friends any more. That doesn’t sound like an easy choice.”*
- *“Over the past three months you have been talking about stopping using crack, and it seems that just recently you have started to recognize that the less good things are outweighing the good things. That, coupled with your girlfriend leaving you because you continued to use crack makes it easy to understand why you are now committed to not using crack anymore.”*

THERAPEUTIC PARADOX

Rationale: Paradoxical statements are used with clients in an effort to get them to argue for the importance of changing. Such statements are useful for clients who have been coming to treatment for some time but have made little progress. Paradoxical statements are intended to be perceived by clients as unexpected contradictions. It is hoped that after clients hear such statements clients would seek to correct by arguing for change (e.g., *“Bill, I know you have been coming to treatment for two months, but you are still drinking heavily, maybe now is not the right time to change?”*). It is hoped that the client would counter with an argument indicating that he/she wants to change (e.g., *“No, I know I need to change, it’s just tough putting it into practice.”*). Once it is established that the client does want to change, subsequent conversations can involve identifying the reasons why progress has been slow up to now.

When a therapist makes a paradoxical statement, if the client does not respond immediately by arguing for change, the therapist can then ask the client to

think about what was said between now and the next session. Sometimes just getting clients to think about their behavior in this challenging manner acts as an eye-opener, getting clients to recognize they have not made changes.

Therapeutic paradoxes involve some risk (i.e., client could agree with the paradoxical statement rather than arguing for the importance of change), so they are reserved for times later in treatment when clients are not making changes and may or may not be aware of that fact. Such clients often attend sessions regularly but make no significant progress toward changing the risky/problem behavior for which they sought treatment. Another reason for caution is such statements can have a negative effect on clients. Lastly, the therapist must be sure to sound genuine and not sarcastic.

When using the therapeutic paradox, the therapist should be prepared that clients may decide that they do not want to change at this time. In such cases the reasons can be discussed, and the therapist can suggest that perhaps it might be a good idea to take a “*vacation*” from treatment. In such instances, therapists can tell clients that they will call them in a month or so to see where they are in terms of readiness to change. Another way to think about what a therapeutic paradox is doing is reflecting the person’s behavior in an amplified manner.

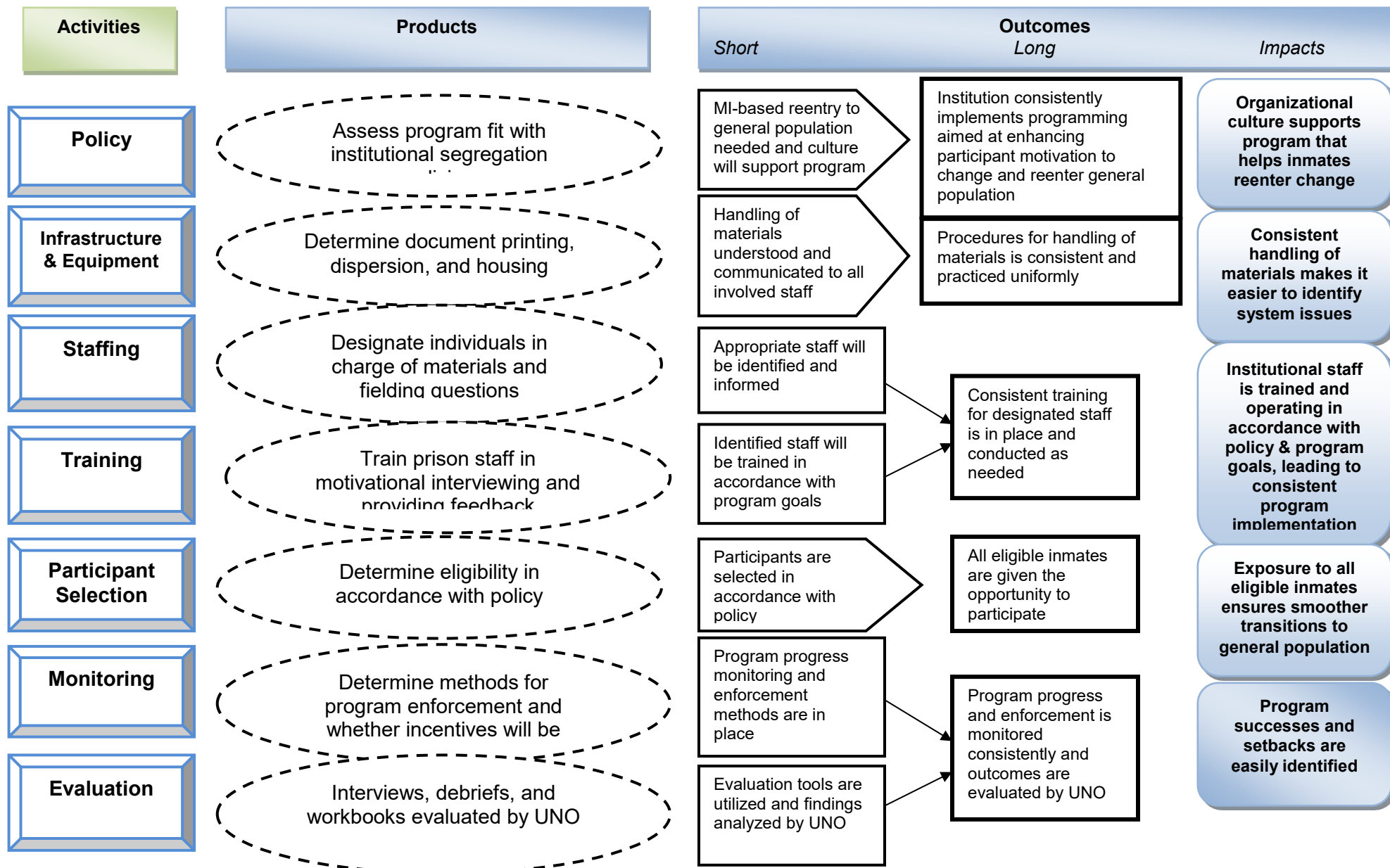
Examples of How to Use a Therapeutic Paradox

- *“Maybe now is not the right time for you to make changes.”*
- *“You have been continuing to engage in [insert risky/problem behavior] and yet you say that you want to [insert the behavior you want change—e.g., get your children back; get your driver’s license returned; not have your spouse leave]. Maybe this is not a good time to try and make those changes.”*
- *“So it sounds like you have a lot going on with trying to balance a career and family, and these priorities are competing with your treatment at this time.”*

Appendix IV Transformation Project Logic Model-Segregation



The Transformation Project



Appendix V

I would like to say Thank You to whomever created the Transformation Project. When I came into the Control Unit I was in a very Bad Place. I was taken from R.T.C. and placed in Segregation for something I didn't do. That's not to say I'm not deserving of my placement in this unit, I'm just down here for something I had Absolutely Nothing to do with. Instead of sitting Down here Dwelling on the Negative, I took this opportunity to work these packets whole-heartedly, and learn things about myself that will ultimately prepare me to succeed upon Release from Segregation, and then Prison. I have been Self-Absorbed for as long as I can remember. Worrying solely on how I can get what I want, and now I can strengthen the "Persona" of Reputation that I created in Prison. ~~This experience~~ ^{experience} (A.C., Transformation Project) has Humbled me. I, for the first time in years, am able to ~~be~~ concentrate on Bettering myself in preparation for ^{my} release from Prison.

So, I am thankful for this Entire Experience. I needed to Be Humbled. I needed to Hit "My Bottom." Being placed on A.C. & given the opportunity to participate in the Transformation Project has helped me ~~see~~ face the Reality that, if I was to continue down the same path I was on, I'd most assuredly Re-offend & come back to Prison. ~~I~~ instead, have Hope - Hope for the future. A future outside of Prison. A FUTURE OF SUCCESS!! So from the Bottom of my Heart I'd like to.....

Thank You

Sincerely,

Allen F. O.



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