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Factors Affecting Treatment Program Development in a Mental Health Facility Serving Prisoners

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**FACTORS AFFECTING TREATMENT PROGRAM DEVELOPMENT
IN A MENTAL HEALTH FACILITY SERVING PRISONERS**

by

Ruby Miranda Meriweather

**A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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School of Public Affairs and Administration**

**Western Michigan University
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FACTORS AFFECTING TREATMENT PROGRAM DEVELOPMENT IN A MENTAL HEALTH FACILITY SERVING PRISONERS

Ruby Miranda Meriweather, D.P.A.

Western Michigan University, 2005

There is a paucity of literature on how treatment programs for mentally ill prisoners are developed. Federal mandates require that services to mentally ill prisoners be comparable to what is offered in the community. Planners, therefore, must find ways to provide treatment programs that produce that outcome.

This research identified the most important factors that affect treatment program development and implementation to aid planners in designing treatment programs for mentally ill prisoners. This qualitative study, based on grounded theory, used a structured interview with 61 mental health staff (psychiatrists, nurses, psychologists, social workers, and activity therapists) across three categories (Administrative, Clinical, and Non-Clinical). Subjects identified 17 factors that affect treatment program development and 16 factors that affect treatment program implementation. A representative subsample of 30 subjects that included each category then rated these factors from most to least important using a Likert scale of 1 (most important) to 5 (least important). Factors were then rank ordered from the highest to lowest by their median score.

All categories combined identified "*staffing levels on the unit to do programming*" as the most important factor affecting treatment program development and the least important factor as "*political factors.*" Subjects identified the "*treatment team working together/a good functioning team*" as the factor having the most significant impact on treatment program implementation, and "*patient attitude/behavior/motivation*" as the least important. The structured interviews revealed that the central theme for program development was "*a blend of factors,*" depicted as the incorporation of many factors in the planning process. The central theme for program implementation was "*a linking process,*" depicted as connecting sets of factors where each has the potential to affect the implementation process. Recommendations for action and further research are presented.

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I would like to express my appreciation to each individual who participated in this project by taking the time to be interviewed and respond to questions. Without their participation I would not have been able to complete this research. I give thanks to the leadership of the facility for allowing this research at this facility. It is my hope that findings from the study will contribute to the existing knowledge on the provision of services to mentally ill prisoners.

I particularly want to give acknowledgement to Dr. Theresa Foley, Assistant Director of Nursing, for her insight and guidance in this field of correctional mental health. She, through her knowledge and experience has contributed to my understanding of the issues associated with the treatment of mentally ill prisoners.

I trust that this study will become the impetus for more research in the field of correctional mental health.

Ruby Miranda Meriweather

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CHAPTER I

INTRODUCTION

This study explores the thoughts and perceptions of mental health staff within a correctional mental health facility regarding variables that affect treatment program development. These variables are important in establishing a framework for planners and others who have responsibility to develop and implement effective treatment programs. Findings from this study will identify the initial planning criteria in terms of the salient variables and the relationship among the variables that should be considered in planning treatment programs. The planning process begins by isolating those variables that impact on program development, even before planning begins.

It is known that multiple factors, such as need determination, analysis of data, and prioritization of alternative approaches, impact the initial phases of planning. But it is important for the successful application of the planning process to assure that relevant variables are clearly identified and incorporated into the planning process early. Planners can utilize this information to guide organizational decisions and policy formulation towards the desired results.

This research project was done at a prison mental health facility with an active treatment planning agenda. The database consists of information obtained from all classifications of staff involved in the process of treatment program development and implementation. Through a formal interview process, psychiatrists, psychologists,

social workers, registered nurses, activity therapists, and mental health workers were asked to identify variables affecting treatment program development and which of these variables are most important in treatment program development and implementation. These responses were analyzed and compared to identify specific variables thought to be important in the construction and development of treatment groups. Consistent and overriding themes were identified. One measure by which a variable was included in the final set of variables is the frequency with which certain variables appear in the responses.

The terms *programs* and *services* imply planned systematic, structured activities directed towards groups of patients with the aim of supporting normal or routine functioning. Other terms used in this study are described on page 10.

Gunderson (1978) refers to treatment programs as *therapeutic milieu programs*.

Statement of the Problem

The variables affecting treatment program development, that is, programs as defined above, are not clearly identified in the literature in a method that highlights what should be considered when developing treatment programs for mentally ill prisoners. No research reviewed has addressed this area from a research approach. The lack of this information presents problems in at least three major areas: (a) planning to assure the availability of appropriate program services, (b) program design and its effect on the services to be provided, and (c) program implementation and the achievement of the desired outcome.

Authors who have studied treatment program development have identified related problems. Teplin (1990) indicates that at times mental health treatment may be largely confined to offenders who exhibit disruptive behaviors and symptoms, whereas less conspicuous disorders such as depression may go untreated because they are not noticed or do not present behaviors disruptive to the general population. Unavailable or ineffective treatment results in prisoners not receiving adequate treatment. Untreated or ineffectively treated mentally ill prisoners affect the setting and the security of patients, staff, visitors and ultimately the larger community (Teplin, 1990).

Mentally ill inmates in state and federal prisons as well as those in jails are more likely than others in those facilities to have been involved in a fight, or to have been hit or punched since their incarceration. Consistent with their more frequent involvement in fights are disciplinary problems that are more common among mentally ill untreated inmates than other inmates (Monahan & Davis, 1983).

This researcher's experience in program planning indicates that the following are potential problems when developing treatment programs:

1. Planning for program development begins but stops before the program plan is developed and implemented.
2. Program planning occurs but no resources exist for implementation to begin.
3. Planning occurs but the targeted outcome is unrealistic and therefore the program cannot be implemented or outcomes cannot be achieved.

4. Implementation occurs but is interrupted for one reason or another.

MacKain and Streveler (1990) indicated that correctional institutions are generally ill equipped and unprepared to take on the role of treatment provider, and find treatment of mentally ill offenders difficult because of security priorities, interagency conflicts, and lack of resources. These authors identified the need for trained staff, and a structured, cohesive set of teaching tools as resources to teach patients and staff. They further indicated that the program effectiveness depended on a number of factors that were resolved through intensive study and cooperation between the Department of Mental Health and the Department of Corrections. Although these factors were not elaborated, inference was made to an unrealistic treatment focus, the difficulty of working in a prison setting, the requirements for security, and the limitations in application and accessibility created when treatment is provided or treatment implementation is attempted in the prison setting.

Other authors address similar issues. Greene (1988), in his article, "A Comprehensive Mental Health Care System for Prisons; Retrospective Look at New York Ten Year Experience," makes reference to communication, coordination, and cooperation as essential features of the New York System.

Rice, Harris, Sutherland, and Leveque (1990) sum it up by saying, "Sources are seldom specific to guide policy" (p. 21). There are a number of difficulties that make development of treatment programs as defined earlier, a task that requires planning and coordination. Such difficulties include the prison setting and issues associated with confinement, security, restricted movements, prisoner rights, patient

rights, conflicting treatment philosophies, and patient needs versus prisoner needs. The setting that attempts to combine a correctional philosophy with a mental health treatment philosophy has established, in such an approach, a uniqueness that creates challenges for the formulation and implementation of treatment programs. For organizations, a sound planning process is essential in determining treatment program choices. Treatment choices are affected by (a) length of stay decisions, (b) treatment expectations of the population, (c) availability of consistent staff, and (d) support of unit staff towards program activities and group therapies (Rice, Harris, Sutherland, et al., 1990).

These organizational issues can create problems in the delivery of treatment services that, in turn, affect treatment outcome. The question that therefore arises is: Have the variables affecting treatment program development and implementation in a correctional mental health facility been identified? These variables must be understood if one is going to be effective in both developing treatment programs and achieving outcomes.

Purpose of the Study

The purpose of this study is to provide a description of the relevant factors affecting treatment program development and implementation for mentally ill prisoners. The planning of treatment programs needs to be based on increased knowledge of these factors or variables that affect treatment program development and implementation in prison settings. Knowledge and application of these variables

would make program development and implementation in this setting relevant and appropriate to the setting. Knowledge of the variables, this researcher believes, may influence how some decisions are made regarding treatment programs, thereby impacting how programs are designed, and how resources are allocated. The overall benefit will be more input in the planning process and a more desirable outcome in terms of implementation of service. To gain knowledge of these variables, the researcher will draw from the experience and knowledge of those who are participating, or have previously participated, in treatment program development and implementation in this setting through the following questions.

The Research Question: *In the planning of treatment programs, are some variables more important than others in achieving an effective outcome?*

Variables Pertaining to the Research Question:

1. What are the system variables that are perceived by staff to impact treatment program development and implementation in this setting?
2. What are the differences in perception of these variables among the disciplines?
3. Which variables are viewed as having greater or lesser significance?
4. Are there relationships between the variables?
5. What is the strength of the relationship of each variable to the other variables?
6. Of all the variables, what variables have the most significant impact on treatment program development?

7. Of all the variables, which ones have the most significant impact on treatment program implementation?
8. Is there a difference in perception among the disciplines about which variables are most significant?
9. Is there a difference between administration and clinical staff, and between administration and the other disciplines about which variables are most significant?
10. From the findings, can a common theme be deduced about variables that impact the planning of treatment program development and implementation?

Answers to the above questions should provide direction to organizational questions such as, How should programs be designed and managed? What organizational processes, structures, and policies should be given priority in the institution of treatment programs? What amount of funding should be allocated for program development and implementation? and, What are the pitfalls that should be avoided when developing and implementing treatment program development? The multifaceted nature of the disciplines involved in decision-making necessitates specification of a given framework for decision-making.

Significance of the Study

The significance of this study is closely related to the context or environment in which this analysis occurs. The context for this study is a state mental health hospital serving mentally ill prisoners. Prison settings create unique challenges for the treatment of mentally ill prisoners. The mentally ill prisoner has unique needs that

require specialized mental health services. Mentally ill patients who are prisoners are viewed as different from “typical inmates” in prisons, as well as different from the “typical patient” in a state mental health hospital, or the “typical client” at a community mental health center (Jemelka, Trupin, & Chiles, 1989). Within prison settings, the presence of mentally ill prisoners creates a need for specialized mental health services.

The need for mental health treatment services in prison settings is well established. In an article on “Inmates with Mental Disorders: A Guide to Law and Practice,” Cohen and Dvoskin (1992) identified three reasons for providing mental health treatment within a prison environment: (a) to reduce the disabling effects of serious mental illness in order to maximize the inmate’s ability to participate in correctional rehabilitative programs within the prison; (b) to reduce the needless extremes of human suffering caused by mental illness; and (c) to help keep the prison safe for staff, inmates, volunteers, and visitors.

The Supreme Court’s decision in *Estelle v. Gamble* (1976) made it clear that inmates have a constitutional right to treatment. More effective treatment programs assist in assuring that the prisoner’s right to receive treatment is met through well-planned treatment programs.

This research study provides an opportunity to explore further rational program development and implementation in a prison setting. At this time no comprehensive analysis of the variables affecting treatment program development and implementation exists to assist in planning programs within correctional settings.

Once a set of variables has been identified, the most common and significant variables noted by the participants can be targeted for further measurement and evaluation, and for incorporation into decisions that affect program design and implementation. These results would be expected to receive major consideration by department directors and program planners in structuring treatment programs.

Information from this study provides an opportunity to link evaluation to program planning. The effects of this linkage can be used to predict outcomes, improve outcomes, reduce negative outcomes, and produce more goal relevant outcomes. The kinds of feedback and information provided could also be used towards formulating program changes and interventions that would assure attainment of, rather than hinder, the objectives of treatment programs. In addition, the outcomes of this study are intended to validate what is, at this time, only experiential knowledge among professionals. The dissemination of findings from the study will hopefully also assist others in prison settings to programs that are research based.

Lastly, findings from this study could directly and indirectly affect staff performance and competence. The program changes mentioned above and the interventions should positively affect staff confidence by providing assurance that the interventions and practices utilized are derived from a validated practice base. The incorporation of findings into policy is a natural outcome of an evaluation process. Transforming experiential practice into theory that in turn guides practice is the ultimate benefit that can be derived from this study.

Definition of Terms

De-institutionalization: The name given to the policy or process of moving severely mentally ill people out of large state institutions, which mostly results in closing part or all of those institutions.

Program Development: The process of planning, designing structured groups and planned activities to address the treatment needs of patients.

Program Implementation: The process of bringing into reality plans designed and outlined as part of program development.

Expert: Professional having extensive training and knowledge in a special field. For the purpose of this study, the term *expert* applies to registered nurses, psychologists, psychiatrists, social workers, and activity therapists who have completed formalized education in their field and have at least 10 years of experience working in a psychiatric setting.

Group Therapy: A treatment process designed within a specific theoretical framework. Persons with an advanced degree in psychology, social work, nursing, or medicine usually lead this process.

Interdisciplinary Team: Care for clients in which members of various disciplines work together with common goals and shared responsibilities for meeting those goals. Members may consist of a psychiatrist, psychologist, social worker, registered nurse, activity therapist (music therapist, occupational therapist), licensed practical nurse, and forensic security aide.

Licensed Practical Nurses: Licensed nurses who have completed a one-year program, who perform nursing tasks under the supervision of registered nurses. One of their primary functions is the administration of medication and related teaching to patients individually or in groups.

Mental Illness: Maladaptive responses to stressors from the internal or external environment, evidenced by thoughts, feelings, and behaviors that are incongruent with local and cultural norms, and interfere with the individual's social, occupational, or physical functioning.

Mentally Ill Offender: Those individuals in prisons or jails who have a diagnosable major psychiatric disorder.

Psychologists: Trained professionals who provide psychological, intellectual, and behavioral assessments, and diagnostic testing of patients and individuals.

Psychiatric Nurses: Registered nurses with at least one year of professional experience working with mentally ill patients.

Social Workers: Trained clinicians, usually in the field of social work. They provide services to patients and their families, and conduct social assessments of patients.

Therapeutic Group: This group differs from group therapy in that there is a lesser degree of theoretical foundation. The focus is on relations between group members, interactions between group members, and the consideration of a selected issue. Leaders in therapeutic groups do not require the degree of educational

preparation required for group therapy leaders where the members are taught effective ways of dealing with emotional stress.

Treatment: Specific planned, goal-directed procedures intended to remedy or improve some abnormal (unusual and undesirable) condition. The goal of treatment is normalization. The primary beneficiary of treatment is an individual patient or client.

Treatment Program: Structured activity designed to meet a goal-directed plan to improve a patient's mental, physical, or social condition. One or more individuals may engage in the same treatment program. Treatment programs may take the form of therapeutic groups.

CHAPTER II

BACKGROUND

This chapter presents a brief overview of mental illness in prisons, including a perspective on the prevalence of this disorder in prison settings, an estimate of what that prevalence might be in the State of Michigan, an overview of legal cases that influence mental health treatment approaches in prisons and jails, and a discussion of the issue of de-institutionalization.

As Cohen and Dvoskin (1992) observed, "The presence of effective mental health services within prison is as valuable to prison staff as it is to the inmates who live there" (p. 462). Paul and Menditto (1992) assert that the "primary goal of any residential facility is, or should be, to provide effective treatment. Effective mental health service delivery may take many forms but must reflect some definite outcome for the patient" (p. 42).

Paul and Menditto (1992) identified three major treatment approaches: social learning, milieu/ therapeutic communities, and individual supportive care. Social learning and milieu/therapeutic community approaches, as described by these authors, are characterized by systematic unit-wide psychosocial programs that typically emphasize clarity of communication, patient responsibility, problem-solving, and staff-to-patient interaction. Individual supportive care is characterized by emphasis on

individual or group modalities in the absence of a systematic psychosocial program addressed to all patients (p. 47).

The authors clearly identified what is known and not known about program effectiveness for some population groups in public psychiatric facilities, such as chronically disabled patients. They assert that decisions regarding unit programs within these settings are at times based more on subjective predilection, traditional, and ideological "correctness," politics, or simple cost containment than on treatment effectiveness and the rational fit of components within the overall system of services. They call for further work in determining which treatment programs are needed or are effective for other populations (p. 42). Included in the settings in which the effectiveness of treatment programs should be evaluated are federal and state prisons and local jails.

Mentally Ill in Prison

Mental health services in prison have been well documented by several authors who have examined the number and prevalence of mental illnesses in prisons. The National Coalition produced one of the most comprehensive references for the Mentally Ill in the Justice System. This monograph, entitled *Mental Illness in America's Prison* (Steadman & Cocozza, 1993), contains a compilation of research articles on the mentally ill in the criminal justice system. The eight chapters in the book do indeed, as described by the project director, represent one of the most

thorough and up-to-date reviews of empirical research on the prevalence of mental disorders among prison inmates and prison mental health services.

The article by Jemelka, Rahman, and Trupin (1993), "Prison Mental Health: An Overview," provides a statistical report from an epidemiological perspective on prison inmates with mental illness. In this article, the authors give estimates of prevalence rates of mental illness in prisons and prevalence rates by mental disorder.

Data were obtained from studies and national surveys of offenders detained in 1978 in state and federal mental health and correctional facilities (Jemelka et al., 1993). From these surveys the authors estimated that 6.6% of the total detainees were designated as mentally ill offenders. Of these, 8% were categorized as not guilty by reason of insanity, 32% were incompetent to stand trial, 6% were mentally disordered sex offenders, and 54% were convicted prisoners who had been admitted previously to incarceration to mental health facilities (Jemelka et al., 1993).

Nationally, prevalence rates for schizophrenia in prison range from 1.5% to 4.4% (2.5 times the rate in the general population) and major depression ranges from 3.5% to 11.4% or 3.3 times the rate in general population (Jemelka et al., 1993).

Other methodologies and studies cited by Jemelka, Trupin, and Chiles (1989) include a reference to a 1987 Michigan study that assessed prevalence rates of the mentally ill in prison. The Jemelka, Trupin, and Chiles study reported prevalence rates of 4.4% for schizophrenia, 1.0% for depression, and 3.7% for mania. The findings from this study have not been substantiated by any other studies.

General Prison Population—State of Michigan

According to the Michigan Department of Corrections 1999 *Annual Report*, there were 43,560 offenders incarcerated in the State of Michigan's 39 prisons and 14 camps at the end of 1998. Another 1,300 were housed for the State of Michigan in a Virginia prison due to a shortage of bed space. For the month of December 1999, there were 46,955 prisoners. This was a 7.8% increase from the previous year (personal communication, Office of Public Information and Research, Michigan Department of Corrections, April 2000). The *Annual Report* from the Michigan Department of Corrections (1999) states the following facts about Michigan prisoners:

1. Ninety-six percent (96%) are male.
2. The average age of men is 34; the average age of women is 35.
3. Approximately 2,504 prisoners are serving sentences for first-degree murder.
4. Approximately 10,793 persons were classified as habitual offenders at the end of 1998.
5. A total of 62% of the male prisoners and 70% of the female prisoners were serving their first prison terms at the end of 1998.
6. Approximately 41.4% of all prisoners are white, 52.5% are black, and the rest are of other racial and or ethnic backgrounds, including Hispanic, Asian, or American Indian.

7. There were a total of 9,353 prisoners convicted of one or more sexual offense by the end of 1998. This number represents an increase of more than 98% since 1989.

8. Sixty percent (60%) of all prisoners were serving time for assaultive crimes.

9. About 20% of the men and women incarcerated in Michigan prisons reported completing 12th grade at the time they entered the system, and about 6% had some college level education.

10. Excluding life sentences, the population of prisoners serving sentences of more than 10 years tripled to 14,686.

In a report from the Bureau of Justice Statistics (BJS), Paula Ditton (1999) attempted to quantify changes in the prison population based on an assessment of the existing population in prisons or jails who were mentally ill. According to this report, an estimated 283,800 mentally ill offenders were incarcerated in the nation's state and federal prisons and local jails at mid-year 1998. In the same study, 16% of state prison inmates, 7% of federal inmates, and 16% of those in local jails reported either a mental condition or an overnight stay in a mental hospital. The highest rate of mental illness, 29%, was among white females in state prisons, with almost 40% of those age 24 or younger identified as mentally ill. Twenty percent (20%) of African American females and 22% of Hispanic females in state prisons were also identified as mentally ill.

The Ditton (1999) study identified persons with mental illness or emotional problems based on structured diagnostic interviews conducted with offenders sentenced to incarceration or probation, and interviews with persons held in local jails awaiting trial. The research determined that an estimated 0.6% of males and 0.8 % of females suffered at some point in their lives from schizophrenia or other psychoses, and 14.7% of males and 23.9% of females from an affective disorder such as depression or mania. In addition, state prison inmates with mental illnesses were more likely than other state inmates to be incarcerated for violent offenses (53% vs. 46%), and more than twice as likely to have been homeless in the 12 months prior to their arrest (Ditton, 1999).

Estimate of Mentally Ill Prison Population—State of Michigan

To arrive at a rough estimate of what might be the prevalence of severe mental disorders in Michigan's prisons, this writer applied the prevalence rates from various studies to the current population in Michigan prisons and jails. Prevalence rates ranged from 8% to 16% among some of the most recognized studies as described in the Bureau of Justice Statistics *Special Report*, July 1999. It is estimated that, on the average, the prevalence of severe mental disorder in Michigan prisons is approximately 5,300 individuals (see Table 1).

Table 1

**Prevalence Rates of the Mentally Ill Prison Population^a
Applied to Michigan's Prison Population**

Study	Sample	Prevalence Rate	Michigan Estimates ^b
Guy, Platt, Zwerling, & Bullock (1985)	Philadelphia Jail Pre-Trial Admissions	16%	7,153
Teplin (1990)	Cook County Jail Admissions (Males)	10%	4,696
Steadman, Fabisiak, Dvoskin, & Holohean (1987)	New York State Prisoners	8%	3,676

^aGenerally includes schizophrenia, bipolar, and major depression.

^bBased on 1999 prison population of 45,955.

Legal Requirements

This writer has found more literature written on the legal issues leading to treatment provisions in jails and prisons than has been written about treatment itself. Legal opinions have greatly influenced correctional administration in state and federal prison systems. The seminal court case of *Estelle v. Gamble* in 1976 established the prisoner's right to treatment for physical ailments, but treatment was mandated only for serious medical and mental health needs. In the above federal case, prisoners claimed a violation of their constitutional rights to freedom from cruel and unusual punishment guaranteed under the Eighth Amendment. This standard is defined as "the absence of deliberate indifference." In *Estelle v. Gamble* (1976), the U.S. Supreme

Court found that if correctional institutions do not demonstrate deliberate indifference to the health needs of prisoners, there can be no valid claim of medical mistreatment.

The majority opinion in *Bowring v. Godwin* (1977) asserted that there were no differences in the need for treatment of the physically ill and the mentally ill. This case established that correctional institutions have an obligation to provide necessary health care to prisoners in their custody. Health care was delineated which clearly extends beyond physical health to include the mental health of the incarcerated population.

In *Langley v. Coughlin* (1989), the New York Department of Corrections inmates in special housing units brought a class action suit against corrections and mental health officials that alleged unconstitutional conditions and practices in correctional facilities. The focal issues centered on whether mentally disturbed inmates received adequate medical care. In this case, the female inmates claimed the mentally ill were more isolated than other inmates and received no screening or care.

In *Ruiz v. Estelle* (1980), a landmark case in general prison reform and mental health care, the court outlined six basic components for a “minimally adequate mental health treatment program” for the Texas Department of Corrections:

1. A systematic program for screening and evaluating inmates must be provided in order to identify those who require mental health treatment.
2. Treatment must entail more than segregation or close supervision of the inmate patient.

3. Treatment requires the participation of trained mental health professionals who must be employed in sufficient numbers to identify and treat inmates suffering from serious mental disorder.

4. Accurate, complete, and confidential records of the mental health process must be maintained.

5. Prescription and administration of behavior altering medication must be supervised and evaluated.

6. A program for the identification, treatment, and supervision of inmates with suicidal tendencies is necessary for any mental health treatment program.

These court decisions led to changes in the correctional system. It now has a mandate to provide care to mentally ill prisoners.

Most changes in mental health service delivery arrangements and improvements in treatment programs have occurred within the context of the *United States v. Michigan* (1984), known as the Consent Decree case. As a result of this decree, both inpatient and outpatient psychiatric services to prisoners were expanded. Under the state's plan for compliance with the Consent Decree order, the Department of Corrections was directed to provide mental health services to meet contemporary professional standards, and to assure that services and practices are no less than those required in a non-prison setting.

Deinstitutionalization and the Mentally Ill in Prison

Some authors have pointed to the decline in state psychiatric hospital beds with a corresponding increase in the number of mentally ill persons being incarcerated. In addition, many of these authors imply that the decline in hospital beds has been accompanied by parallel increases in the number of mentally ill individuals among the homeless and those in jails and prisons—institutions that are typically outside the mental health system. One such author, E. Torrey (1997), gives a vivid description of the shift in the mentally ill population across the country. Torey (1997) describes de-institutionalization as having two parts: the moving of the severe mentally ill out of the state institutions and the closing of part or all of those institutions. The magnitude of de-institutionalization of the severely mentally ill qualifies this event as one of the largest “social experiments” in American history. Fuller describes the criminalization of the mentally ill as one of the most disturbing and unanticipated consequences of transferring persons with mental illness from state hospitals to community-based treatment facilities (p.8).

Jemelka et al. (1989) identified several factors that make it likely that the prevalence of mental illness in correctional populations will continue to increase in the future. These factors include: (a) the lack of adequate community support, treatment, and housing for all mentally ill persons; (b) the difficulty that mentally ill offenders experience in gaining access to services; (c) the changing demographic character of the mentally ill population; (d) the increasing overlap found in prisons and state

hospitals; (e) the availability of drugs in our culture; and (f) the legal trends toward imprisonment for the guilty but mentally ill (p. 484).

Teplin (1984) from Northwestern University Medical School also has talked about criminalization of the mentally ill. She stated that changes in sociocultural milieu may have set the stage for the criminalization of large numbers of mentally ill persons, i.e., de-institutionalization resulted in large numbers of persons being released into the custodial care in a state without adequate planning for their needs in the community. Modifications in the legal code regarding prisoner rights for the mentally ill have resulted in specific restrictions on psychiatric treatment. In addition, federal support for mental health treatment has actually declined since 1975 and has resulted in a lack of available treatment programs for the de-institutionalized persons. This in turn has resulted in criminal activity by some of the mentally ill and their subsequent imprisonment.

CHAPTER III

LITERATURE REVIEW

The review of the literature is divided into three parts: The first part, Planning, examines studies that utilized various approaches to determine the need for treatment services for mentally ill prisoners. This includes: the assessment of need; planning theories, concepts, and issues; treatment planning studies, and the concepts of replication and dissemination. Part two, Treatment Program Development, examines literature on the design and development of treatment programs and treatment approaches. The third part, Evaluation, discusses evaluation and the importance of linking evaluation to planning.

Planning

The idea to conduct a study of this nature was derived from the writer's experience with an actual treatment program development process that occurred within the research setting. That experience raised the question: What are the factors, i.e., characteristics, actions, behaviors, and processes of treatment program development, that significantly impact the treatment program planning process? It is clear that movement from one point in the planning continuum to another is affected by multiple factors, any number of which can cause change to occur. This study seeks to identify and describe the most influential factors in effective treatment program

development and treatment program implementation, and makes recommendations about which factors should be incorporated into the planning process.

The key to program development is centered in the planning process. The planning process provides an avenue for the input of variables that, if carefully selected, could have a positive effect on the desired outcome. Planning is thus “a procedure for arranging beforehand, by deliberately sequencing actions so as to achieve an objective” (Faludi, 1973, p. 24). Planning for treatment services, including treatment programs, begins with an assessment of need. In this instance, “the need” is based on the legal and moral right of prisoners to receive mental health services.

Assessment of Need

Two studies attempted to define the extent of the need for mental health treatment in Michigan prisons to facilitate the development of mental health services in the state. First, a study was conducted in 1987 by the Michigan Department of Corrections in collaboration with the University of Michigan, School of Public Health, and Michigan State University, Department of Sociology and Urban Affairs. The study, entitled *The Prevalence of Mental Disorder in Michigan Prisons* (Neighbors et al., 1987), was conducted over a 2-year period utilizing clinical and nonclinical staff as interviewers to survey 1,000 prisoners. Two instruments were used in this study: (a) the Diagnostic Interview Schedule (DIS), and (b) the Structured Clinical Interview (SCID).

The Diagnostic Interview Schedule (DIS) is a sophisticated technique for case detection and can be used by nonclinicians to measure the prevalence of discrete psychiatric disorders as defined by the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R)* (American Psychiatric Association, 1987). Of the respondents, 33% in the DIS survey were re-interviewed by clinicians using the Structured Clinical Interview (SCID). The SCID permitted the clinician to utilize open-ended questions, observations of nonverbal behavior, and written information in making a psychiatric diagnosis. Clinical interviewers grouped diagnostic categories and made clinical judgments on the appropriate treatment of the clinical symptoms identified. Predictions were made about patients needing psychiatric treatment and the level of treatment needed, such as inpatient, comprehensive, transitional, or outpatient treatment. The researchers asserted that their methodology resulted in "the most comprehensive, sophisticated psychiatric epidemiological study ever conducted in a prison at that time" (Neighbors et al., 1987, p. 14).

This study was unique in a number of ways. First, a truly representative sample of the entire prison system was drawn. Second, a rigorous survey research interviewing technique was employed. Third, highly structured, diagnostically explicit procedures were used to assess mental status. In this study, 23 *DSM III-R* (1987) disorders and their related prevalence rates were identified. For example, the researchers found the prevalence rates varied by diagnosis as follows: Schizophrenia

(2.8%), Alcohol Abuse Dependence (46.5%), Bipolar Disorder (6.4%), and Antisocial Personality Disorder (50.1%).

Other data drawn from the study indicated that 10% of the population had a current psychotic disorder, 8.4% had a substance abuse dependency or abuse, 19.7% were judged to be severely mentally impaired, 47.5% were found to be moderately impaired, and 32.8% had minimal or no impairment. The researchers concluded that 4.4% of the prison population required inpatient treatment, 1.9% required treatment in a comprehensive setting, 3.4% required treatment in a transitional setting, and 56.6% required treatment in an outpatient setting. They also concluded that mentally ill prisoners would require a broad range of diagnostic, treatment, and rehabilitative services.

Another study to determine the need for mental health services was conducted in February of 1999 by the Michigan Department of Community Health, Office of Psychiatric Affairs. The purpose of this study was to investigate the proportion of prisoners presently in Michigan jails who suffer from serious mental illness. In the state of Michigan, three jails were selected for study. Interviews were conducted over a 6-month period with 25% of the inmates who had a history of previous mental illness. Inmates were screened on admission and separated into one of two groups: (a) inmates in need of inpatient mental health treatment, and (b) inmates who needed outpatient mental health services. A total of 242 subjects were interviewed and an additional 14 individuals who were regarded as "weekenders" in the system were added to the total number of individuals interviewed. The study results provided a

profile of inmates in jails with serious mental illness that included: age, race, marital status, income, education, religion, diagnostic classification, and use of psychotropic medication. Results of the study found that 34% of inmates in jails had a serious mental illness. Serious mental illnesses included: Schizophrenia/Psychotic Disorder (8%), Bipolar Disorder (18%), Major Depressive Disorder (8.5%), Mood Disorder (26.4%), and Substance Abuse (34%). Overall, about 10% of prison and jail inmates reported they had a mental or emotional condition, and 16% were reported to be mentally ill (Michigan Department of Community Health, 1999). Limitations of the study with respect to methodology included differences in the interpretation of responses, and of the respondents in recalling. These limitations have the potential to affect the accuracy of the findings.

Planning Theories, Concepts, and Issues

The work of Alexander (1986), in *Approaches to Planning: Theories, Concepts, and Issues*, indicates that in any discussion on planning, one has first to understand the concept of rational decision-making. Rationality, he states, is a central feature of the planning process. He describes rational planning as a way of thinking about a problem that forces one to consider what ought to be done in light of what needs to be accomplished. He asserts that rationality helps individuals communicate the reasons for their decisions, and rational analysis is simply a tool that enables one to make choices according to standards of consistency and logic as well as to communicate the reason for the decision (p. 12). Rationality also implies that a plan,

policy, or strategy for action is based on valid assumptions and includes all relevant information relating to the facts, theories, and concepts on which it is based.

The rational planning model, as proposed by Alexander, is helpful in providing a systematic framework for putting together the facts and judgments that determine choices or courses of action. The rational planning model assumes that objectives can be identified and articulated, outcomes of alternative strategies can be projected, their usefulness can be assessed, and the likelihood of occurrence can be predicted based on the information available. According to Alexander (1986), one of the axiomatic standards of rational planning and decision-making addresses the issue of values and preferences. Preferences, he states, must be transitive, meaning that they must be ranked in order from best to worst.

Not everyone agrees with Alexander's positive views of rational planning. When asked about planning theory, Hemmens (1980), in "New Directions in Planning Theory," states that we are inclined to talk about the four, five, six, or seven steps of the rational model, but in practice we operate from some amalgam of experience, intuition, technique, context, and personality. "There are many alternatives and modifications to the rational model. Some people scoff at a single theory of planning. The discussion of planning theory is stuck and in need of renewal" (p. 259). Through interaction and communication, planners help people bring together the objective facts of a situation and the subjective feelings. Hemmens claims, "Planning is a technical activity: planners are analysts; planners use the scientific method to explain behavior to the extent possible" (p. 260). In deciding what and how to plan, one must

understand how planning works. That position is supported by Alexander (1986), who notes that planning is “seen as a sequential, multi-staged process in which many of the phases are linked together. Conclusions reached at later stages may lead to reviews of earlier stages” (p. 44).

The writer concurs with Friedman (1987) in his article, “Planning in the Public Domain: From Knowledge to Action,” that the approach to the factors that affect treatment planning are grounded in the planning process. He implies that the rational decision-making process is no different from “classical” steps in the planning processes, and that planning has all of the following characteristics:

1. Definition of the problem or the articulation of goals to be addressed;
2. Analysis of the situation and relevant resources;
3. A design of potential solutions, strategies, or courses of action;
4. Projections of likely outcomes of alternatives; and
5. Detailed evaluations in light of goal-related criteria (Freidman, 1987, p. 37).

Friedman (1987) also indicates that “planning appears as a mode of decision making in advance, as an activity that precedes both decisions and actions” (p. 16). This statement has implications for treatment program development. Alexander (1986) supports Friedman’s assertion when he claims that planning is not a purely individual activity. Individuals do it, but it is done in order to affect the actions of groups, organizations, or government. Planning has little or nothing in common with “trial and error” approaches to problem solving. Myerson (1961) also agrees with this position, as noted by his statement that “Planning depicts a desirable future state of

affairs, but specifies the means of achieving it" (p. 182). These authors concur that program planning should begin with an understanding of the condition, the facts, or a statistical representation of the phenomenon under study.

Treatment Planning

Two studies have addressed treatment-planning efforts for psychiatric patients. One of these studies addressed the mental health treatment needs of prisoners in maximum-security prisons. Harris and Rice (1990), in a study entitled, "An Empirical Approach to Classification and Treatment Planning for Psychiatric Inpatients," attempted to find different ways to group patients for the purpose of treatment. This study was conducted at a regional psychiatric institution that served a primarily non-urban population. While most mental health institutions organize treatment programs according to such factors as length of stay, age, diagnosis, or level of difficulty, these researchers utilized questionnaires developed from another survey by Quinsey, Cry, and Lavelle (1988). Staff at the institution was asked to respond to a number of questions about each patient. In addition, clinical experience and judgment were also incorporated into the factor analysis. A variety of cluster analytical techniques were used to determine how patients could be organized into homogenous groups for the purpose of treatment planning. The patients were asked questions on problems that may have occurred in the year prior to the patient's current hospitalization, and on problems exhibited during the last 3 months of current hospitalization. One hundred and seventy-eight ($n = 178$) patients completed the

questionnaire. Each item of the survey question was rated on a 0–5 point Likert type scale with 0 corresponding to “not present” and 5 to “very severe.” Based on the data analysis, a number of common and severe problems were identified, and the mean severity of each problem was determined. The most common and severe institutional problems were identified as psychotic speech, poor work skills, impulsivity, poor conversational skills, poor self-care, and anger. These problems were identified as being more related to functional deficits and were not classic or diagnostic symptoms.

The individual problems identified were similar to those found in another study by Rice and Harris (1988). The most common and severe community problems Harris and Rice (1990) identified were anger, psychotic speech, social withdrawal, difficulty in supportive housing, and marital and family problems. The authors concluded that to target the most common problems among these patients’ rehabilitation needs, one had to include treatments such as life skills training, social skills training, cognitive therapy, substance abuse, and token economy.

Quinsey et al. (1988) conducted a study entitled, “Treatment Opportunities in a Maximum-Security Psychiatric Hospital: A Patient Problem Survey.” It surveyed a number of problems that prisoners in a maximum-security psychiatric institution may present. The major purpose of the study was to identify patient problems that call for targeted future interventions. The authors called for a rational and incremental strategy to program development and promoted an approach called “Program Development Evaluation.” This approach, they claimed, would increase the clarity of program rationales and also address the multifarious problems of treatment programs

in a security institution in an incremental manner. The authors claimed that by obtaining a comprehensive list of patient problems, the most common and most important problems could be targeted for more precise measurement. In addition, programs relevant to those problems could be designed and implemented. The authors also asserted that the distribution and clustering of problems across types of patients would be expected to be a major consideration in the structuring of treatment programs, and that individual patient problems are often correlated with certain other problems but not others. The authors, therefore, used an a priori method of classifying individual problems into larger categories. The chief advantage of using a survey approach was identified as the ability to characterize an entire population at a single instant in time.

The methodology of the Quinsey et al. (1988) study was divided into two parts. First, a Staff Survey of patients was conducted. This involved staff surveying 254 patients ($n = 254$) in 15 treatment units. Since the focus of the study was on the presence or absence of a particular problem, the staff that conducted the interviews scored a problem as present, absent, nonapplicable, or unknown. Clinical files of the patients were also reviewed to determine scoring of a problem. Data were also crosschecked with diagnosis for the purpose of chi-square analyses. In addition, data were grouped into a priori scales to reduce the data. Items that did not correlate with a scale's total were deleted. Discriminate analysis was used to compare against the a priori scales. The a priori scales and some individual items were then used in

discriminate analysis to examine differences among groups of patients on the basis of diagnosis, documentation, and criminal history.

Of the 254 subjects surveyed, data were analyzed on 212 patients and discriminate analysis was used on these different data sets to successfully differentiate groups from each other. Most of the patients were diagnosed as Psychotic (47%) or having a Personality Disorder (36%). The five most common community problems identified by staff were inappropriate anger (70%), marital/family problems, unemployment, poor use of leisure time, and budgetary problems (56%). Within the institution, the five most commonly observed problems were anxiety (65%), insulting, teasing and obnoxious verbal behavior, poor use of leisure time, lack of consideration of others, and psychotic speech (46%). One of the most important findings resulting from the methodology used by Quinsey et al. (1988) was that problem distribution, as a function of diagnosis, was not previously captured.

Second, patients completed a "Patient Self-Report." These self-reports were conducted 2 months after the staff survey was completed, and were similar to the staff survey but shorter. Staff, on the basis of their "typicality" and ability to understand questions, selected three patients from each of the units to interview. Patients were interviewed in groups of three, and at times they were interviewed individually by one of the research authors. Forty-four ($n = 44$) patients were interviewed for this component of the study. Results revealed moderate agreement between the two surveys. Among the institutional problems, the most common problems identified were anxiety (75%), boredom (66%), mood changes (75%), and sadness/depression

(61%). Within the community the problems identified as being the most frequent were anxiety (82%), mood changes (75%), sadness/depression (68%), and no friends (66%).

The researchers found by using discriminate analysis that individual problems clustered together. They suggested that patients could be identified who share particular problems, and treatment can be targeted and directed at these problems (Quinsey et al., 1988). One of the limitations of this study was the use of a limited or small sample size that restricts generalization of the findings and can affect the validity of interpretations of the results.

Replication and Dissemination

Program development in human service agencies presents challenges and opportunities as a number of authors have noted. In a study by Fixen and Blasé (1993), concepts from industry related to product development and dissemination were applied to human service delivery systems. These concepts generally encourage efforts to develop and fine-tune a model or prototype that could be used by others. Fixen and Blasé indicated that creating realities is not easy. They asserted, "We search to develop good prototype programs or products. We need to continue to do research to refine our product and adapt to change" (p. 600). Thus, they contend, a program developer must determine over time the critical features that are sufficient to replicate the desirable outcomes found in the prototype program. Consistent implementation of

critical features with similar results is essential. Implementation relates to the ability of the users to actually put into place the critical features of the program (p. 604).

Fixen and Blasé (1993) further describe what they have learned in creating new realities for delinquent, abused, and emotionally disturbed children and youth over a 27-year period. The authors used a case study of group homes to describe strategies that can be used to facilitate replication and dissemination of other treatment services. The following views are described as helpful for those in program development.

1. An interactive view: a highly flexible, immediately adjustable and very responsive approach to each situation and each person so treatment can more precisely fit the person.
2. An interactive, contextual view: the social environment in which the person lives. Treatment programs must have an impact on the person-in-context in order to be effective. This view requires a consistent therapeutic approach to the person-in-context.
3. An integrative view: a well-integrated treatment program. Treatment planning must fit the technology being used to promote therapeutic changes and both must be supported by staff selection, training, consultation, evaluation, and other organizational components.
4. A long-term view: a few people consistently present and personally involved in order to continually modify the construction of reality and try to produce a better outcome (Fixen & Blasé, 1993, p. 608).

In summary, the techniques comprising a particular program application must be completely identified and described if replication and dissemination of the program is to occur. Planning includes a view of reality that is described and documented in many ways. For example, Scarr (1985) presents the "constructivist" view of reality. According to her, the constructivist frees us to think the unthinkable, because our view of "reality" is constrained only by imagination and a few rules of the scientific game. The constructivists view the entire world as a stage since "each of us has our own reality of which we try to persuade others. Facts do not have independent existence. Facts are created within theoretical systems that guide the selection of observations and the inventions of reality" (Scarr, 1985, p. 499).

Fixen and Blasé (1993) explain that planners can make only modest claims of the ultimate truth. Planners can modify ineffective attempts to change others because they recognize the problem may have been constructed inappropriately for the time and space. These views also make easier the possibility of new approaches to a perceived problem. Varela (1977), for example, indicates that we have to get started and let the realities of the effort teach us how to do it better. These efforts to find new possibilities were depicted by L. Whyte (1948) decades ago when he wrote, "Thought is born of failure. The greater the failure, the greater they become" (p. 7). Fixen and Blasé (1993) further elaborate on this position stating, "We need to begin in the real world on the programs we want to make better. We need to view failure as a teacher. We need to be flexible and construct new realities" (p. 598). For his part, Butler (1976) questioned, how then does industry create new realities? He verified that new

realities occur through the continuing professional, well organized, and effective search for a slightly better way (Butler, 1976, p. 7).

Fixen and Blasé (1993) assert that the ability to replicate the program or create another is one of the critical phases that separate “demonstration projects” from “program development.” They attribute this to the fact that most of the components program development planners thought would be critical will be tested by demonstration projects, and some will be discarded.

Replication and dissemination of programs have many benefits. Fixen and Blasé (1993) state, “The road to dissemination starts with a prototype program unit, a working model of what can be achieved” (p. 615). Backer, Liberman, and Kuehnel (1986) assert that the disseminating of new treatment methods among clinical practitioners and in clinical settings requires careful promotional strategies. They argue that in addition to empirically validated methods, clinical trials, data-based field-testing, and systematic replication to other sites and populations, the innovation must be relevant to the practitioner’s need and appropriate to the environment.

Backer et al. (1986) identified barriers to the adoption of efforts, which can be viewed as similar to factors affecting a new treatment program development approach. They listed the following factors:

1. Professional Values: The authority of professionals at the top of the decision structure and the strategies they use affect opportunity for broad involvement, and are shown in empirical research to be effective or ineffective in introducing change.

2. **Civil Service Bureaucracies:** The constructs under which mental health organizations are organized at times de-emphasize incorporating the feelings, attitudes, and preferences of participants. These reactions may be critical to successful adoption.

3. **Outside Influences:** The impact of legislatures, regulatory agencies, community advisory boards, and citizen groups on decisions.

4. **Diversity of Interests and Motivation within the Organization:** These internal concerns also influence decisions.

5. **Coordination of Power within Medical Model Institutions:** Such power is found in the administration, medical professions, and boards that govern these institutions. Separate sources of power are vested in each of these three systems, making coordination difficult (p. 112).

Other factors Backer et al. (1986) identified as useful to the development and adoption of programs included: (a) involvement of potential users in the planning, (b) use of consultants to advise on the development strategies, and (c) personal contact between the planner and the users.

Backer et al. (1986) found that personal contact between planner and user was the best validated principle affecting knowledge transfer. It was also found to be the single most critical variable in promoting the adoption of an innovation among mental health professionals regardless of the nature of the innovation (p. 113).

Fixen and Blasé (1993) identified factors that must be part of treatment planning and development. They asserted that treatment planning must be supported

by staff selection, training, consultation, evaluation, and other organizational components. The authors described how to develop prototype programs. They identified the need for program planners to specify clearly what they think are the “critical” treatment and administrative components, and tested these on a small scale. Further, they asserted that program developers must figure out over time what the “critical features” are that are sufficient to replicate the desirable outcomes found in a prototype program (p. 610).

Delbecg and Van de Ven (1971) pinpointed factors that affect outcomes and discussed these in their “Program Planning Model.” They identified five phases of program planning and development, and the factors associated with each, as part of the orderly process of structuring decision making at different phases of planning. These phases were:

1. Problem Exploration: Involvement of clients/consumer groups and first-line supervisors.
2. Knowledge Exploration: Involvement of external personnel and organizational specialists.
3. Priority Development: Involvement of key administrators.
4. Program Development: Involvement of line administrators and managers.
5. Program Evaluation: Involvement of client or consumer groups (p. 469).

In each of these five phases, Delbecg and Van de Ven (1971) identified factors that influence the developmental processes. First, the involvement of customers, line staff, and first-line supervisors was very important in the problem exploration phase of

program planning. These groups need to be asked to identify problems associated with the issue to be resolved, and to prioritize those problems as to which ones are most crucial. Second, use needs to be made of organizational experts in discipline and functional skills related to the priority item identified. These experts are used to review the suggestions of previous groups and to arrive at innovative program solutions. The study by Delbecg and Van de Ven justified the appropriate use of gathering data based on perceptions of problems, the appropriateness of prioritizing those concerns, and the value given to the role of experts in re-conceptualizing the priority problems/factors and arriving at adequate solutions.

In summary, the need for planning is captured by Fixen and Blasé (1993) who stated:

It is clear that creating realities is not easy: We research to develop good prototype programs or products. We need to continue to do research to refine our product and adapt to change. Thus a program developer must figure out over time, what the "critical features" are that are sufficient to replicate the desirable outcomes found in the prototype program. (p. 600)

The authors further assert that consistent implementation of critical features with similar results is essential (p. 604).

Treatment Program Development

Not many studies have attempted to capture and outline for planners the specific factors that affect the designing and development of treatment programs for the mentally ill prisoner. Even fewer studies have attempted to gather this information through retroactive analysis by consulting staff or other persons involved in the

planning or delivery of services. However, some studies have studied patients' perceptions of their treatment to measure which treatment programs are helpful and which ones are not. This part of the literature review is divided into two sections: Designing Treatment and Treatment Approaches.

Designing Treatment

Maxmen (1973) used a questionnaire in a study to identify patients' perceptions of treatment. He considered patient perceptions as influencing how programs are designed. The study, entitled "Group Therapy as Viewed by Hospitalized Patients," used subjects from a facility that provided inpatient psychiatric treatment to adults. The clinical unit at the facility consisted of 28 beds, and the treatment program provided crisis intervention and short-term hospitalization for a wide variety of mental disorders. The major treatment modalities consisted of individual, group, and family activities as well as pharmacological therapies. One hundred and twenty ($n = 120$) individuals who attended the therapy groups were given an extensive questionnaire. The first 100 ($n = 100$) who completed the questionnaire were included in the study.

The types of questions included demographic and diagnostic characteristics, number of treatment groups attended by each patient, and the general attitude of patients towards group meetings. Patients were asked to rate these items using a global rating scale from positive (extremely helpful or very helpful) to neutral (a little helpful or neither helpful nor harmful) to negative (very harmful or extremely

harmful). Patients were also given a list of 12 different factors that others had listed as helpful, and were asked to rank order them from most to least helpful. Each factor rated as first received 12 points. Factors rated second received 11 points and so on in decreasing point value to the least helpful factor, which received 1 point. Benefits of this approach to data collection, and its application to individual perception, are that (a) the perceptions of staff and patients are only one of several parameters considered when evaluating effectiveness, and (b) certain factors can be identified as being more helpful than others. This approach proved useful to obtain specific information for developing and designing treatment programs (Maxmen, 1973).

Treatment Approaches

Factors that affect treatment program development can be extrapolated from a number of other studies. These studies address behavioral treatment approaches in inpatient settings. Three major approaches to inpatient treatment for the adult mentally ill offender were identified and are discussed below. These are social learning, milieu therapy, and individual supportive therapy. Structured psychosocial programs that emphasize communication skills, interpersonal interaction, and problem-solving skills characterize social learning and milieu therapy. In contrast, individual supportive therapy is characterized by its emphasis on individual and group treatment modalities (Lieberman, 1988; Paul & Menditto, 1992). Finally, a study comparing treatment approaches is discussed.

Social Learning Treatment Approach

Inpatient treatment programs differ in the degree and nature of the structure designed for patients, and in the theoretical orientation that guides the unit operations. One example of a social learning program is the "token economy," which is a unit-based system that actively involves patients and staff. The intent is to motivate patients to modify their behavior. Such a system utilizes special cards or "tokens" in association with activities (e.g., participation in a social skills training or therapy group) and the use of tokens toward something desired by the patient (e.g., the buying of playing cards at the store). Over time this approach gradually shapes patient behavior in a positive direction, such as functional self-care. The token economy approach is strongly supported in the literature as it promotes independent and cooperative behavior, and it encourages patients to participate in social learning skills programs that teach them functional skills one needs in life. Such functional skills include outcomes such as achieving academic success or progression, acquiring self-care life skills, and learning or developing self-help behaviors (Harris & Rice, 1992; Milan, 1987; Rice, Harris, Quincy, & Cyr, 1990). The authors concluded that the overwhelming evidence on the effectiveness of the social learning treatment approach demands that clinicians consider the use of a token economy program (Rice, Harris, Quincy, et al., 1990). Factors identified as affecting implementation of such a program included the training and orientation of staff. The authors recommended that trained professional staff be used as opposed to custodial staff.

Milieu Therapy Treatment Approach

Milieu therapeutic communities are characterized as focusing on attitudes and values. This approach utilizes a high level of patient/staff interaction and group activities, and the development of social groups to reflect the principle that patients are responsible adults and can participate in their own treatment (Lieberman, Nuechterlin, & Wallace, 1982; MacKain & Streveler, 1990; Paul & Lentz, 1977).

Individual Supportive Care Treatment Approach

Individual supportive care is derived from the medical view that the hospital is a place to provide specific treatment for patients' mental disorders and diseases. This approach utilizes specific biomedical and psychosocial treatment in an individualized and coordinated manner to treat patients. Psychotropic drugs and individual psychotherapy are the primary treatment in this approach (Paul & Menditto, 1992).

Comparison Studies of Treatment Approaches

Another primary study, "Psychosocial Treatment of Chronic Mental Patients: Milieu vs. Social Learning Programs," was conducted by Paul and Lentz (1977). Over a 6-year period of time, the authors conducted a comparative study of inpatient treatment outcomes. The focus of the study compared the effectiveness of comprehensive social learning and milieu therapeutic community programs in relationship to each other and to traditional hospital treatment. Participants were chronically institutionalized psychotic patients between the ages of 18 and 55 years of

age. Twenty-eight male and female subjects ($n = 28$) were randomly assigned to groups of 3. Patients in the program groups were equivalent in the distribution of race, gender, and major personality characteristics. The number and level of staff included in the study were also equally distributed. Psychotropic prescribed drugs for each patient were monitored in all programs. The program treatment groups were then compared on a number of variables. Clinical staff used structured forms to document ongoing patient behaviors and staff responses. These forms were then used in this study to measure staff behaviors and staff-patient interactions.

Paul and Lentz (1977) found that of these three treatment approaches, the social-learning programs were the most therapeutic and cost effective. Social learning programs treated more patients and produced sustained improvement on all measures of functioning. The milieu therapeutic community group programs were less effective than the social learning groups, but more effective than individual supportive care.

In summary, the studies reviewed here described a method for comparing the effectiveness of inpatient treatment and implementation approaches, as perceived by patients. There is a paucity of information about factors that result in effective treatment program development and treatment program implementation. Questions remain on whether the factors affecting such treatment programs differ, and whether some factors have more significant influence than others.

Evaluation

A brief inclusion of the literature on the evaluation of treatment programs is referenced in this section because of its close link to the planning process. The literature clearly links planning and evaluation to program planning development. Evaluation, as part of the planning process, allows information to be fed back into designing and developmental stages to create a better product. In addition, evaluation is a principal avenue by which accountability of programs is assessed by external sources.

In an article entitled "Program Evaluation in Psychosocial Rehabilitation," Spaniol (1986) highlighted the significance of including evaluation in the planning phases of program development. He notes that evaluation calls for verification that the expected outcome was achieved. In addition, internal and external pressures call for improved planning, and improved planning in turn calls for evaluation. Spaniol described evaluation as a systematic, continuous process of providing information about the value of a program for the purpose of decision-making. He described it as a continuous series of inputs that affect decisions. Program evaluation is concerned with providing information that can assist key decision makers with program improvement, continuation, modification, and termination. Further, it is a continuous, systematic process of providing information about programs for the purpose of improving decision-making and treatment outcomes.

Poister (1986) poignantly noted that planning is the function that makes use of evaluative information to develop improvements in such factors as program targeting,

program configuration, and service delivery arrangements. Planning of programs at various stages of their development is clearly important, but planning, as a necessary prior function, is equally important.

VanVoorhis, Cullen, and Applegate (1995) conducted a study to identify the interrelationship between program design and program evaluation. They looked at issues that are impediments to conducting sound evaluation. The factors they identified included: the environment; lack of organizational support; and staffs' ability to articulate the components of a program, e.g., who the clients are, what interventions fit the client's problems, and how the effectiveness of the interventions are evaluated. The authors recommended that sound planning must become a structural component of programming at both the administrative and staff levels of responsibility (VanVoorhis et al., 1995, pp. 19–22).

The significance of the concept of incorporating evaluation early in the planning process reinforces the need for evaluation to be part of program development. The core of the study being conducted by this writer is evaluative in nature. Information obtained through feedback on factors that affect treatment program development and treatment program implementation can then be incorporated into future planning activities.

CHAPTER IV

METHODOLOGY

The research design is presented in two sections: the first section addresses the following seven areas: the qualitative method used; the rationale for structured interviews, the setting, Human Subjects Institutional Review Board approval, the interview process, data collection process, and the participant profile. The second section describes the steps in data analysis that includes how data are organized and how factors were rated. These findings identified the most important factors affecting treatment program development and implementation.

The Research Design

The Qualitative Method

This study used a qualitative research design to gather data about treatment program development and implementation in a facility that provides mental health services to mentally ill prisoners. The objective of the study was to explore all the factors affecting treatment program development to determine which factors should be considered most important when planning the development and implementation of treatment programs in prison settings. This study, unlike other studies on this subject, takes a retrospective look at the factors affecting treatment program development and

implementation, by means of staff interviews, to determine the perceptions of the staff that actively work in this area.

A “grounded theory” approach was used in analyzing the data in order to identify and explain the variables that significantly impact treatment program development and implementation processes. “Grounded theory,” as defined by Strauss and Corbin (1998), means theory that is derived from data systematically gathered and analyzed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship with one another (Strauss & Corbin, 1998).

Findings from this type of analytical approach, as opposed to those from statistical methods, allow for the discovery of concepts and relationships among raw data, and for the organizing of these into a theoretical explanatory scheme (Strauss & Corbin, 1998). By utilizing this approach, the researcher could elicit from the participants their thoughts, feelings, experiences, and opinions on the subject.

Rationale for Structured Interviews

Structured interviews of staff were selected, in preference to mailed questionnaires, as the primary data collection method. For a study of this nature, the interview method was selected as it provided a direct and immediate opportunity to gather relevant information that might otherwise be missed or could not be further explored by a questionnaire. In addition, interviews are less costly and have the potential to provide a larger sample size for analysis. Care was taken by the

researcher in not structuring the interviews too tightly, but rather allowing for the uncovering of relevant data (Strauss & Corbin, 1998). The interviews focused on staff perceptions of the factors that affect treatment program development and implementation. This was done as these staff were currently the ones involved in the development and implementation of treatment programs, and thus had the most knowledge and insight into factors that impact their planning and implementation.

The Setting

The facility referenced in this study is a state-operated psychiatric facility under a contract with the Department of Corrections. The facility governs the provision of forensic and psychiatric mental health services to inmates for the state correctional system. The facility's mission is to provide comprehensive treatment programs to mentally ill adult felons utilizing modalities developed both in academic centers and treatment communities.

The integration and coordination of services to patients is a responsibility of all departments and services of the hospital for the patient's entire length of stay. Patient care units are the primary mode for the delivery of patient care treatment. It is in these units that treatment programs, in the form of structured therapeutic groups, occur. Treatment programs are provided through five major disciplines: psychiatry, psychology, social work, activity therapy, and nursing. The treatment team, comprised of individuals from each of these disciplines, plans and prioritizes active treatment programs and treatment activities to address each patient's treatment goals.

Human Subjects Institutional Review Board

Approval was obtained from hospital authorities to interview hospital staff at the facility. The institution's process for the approval of research proposals was followed, including human subject review considerations. Approval was also obtained from Western Michigan University's Human Subject Institutional Review Board. During this review process, several stipulations were imposed that affected the final design of the study. These stipulations were:

1. The researcher could not participate in the recruitment and interview process and could not have knowledge of who participated or refused to participate in the study.

2. The names of all participants in the study are to remain confidential to avoid the identification of participants by peers, supervisors and others. Table 2 depicts the sample and percentage of each classification that participated in the study.

As noted in Table 2, 25% of the forensic security aides (FSAs) were identified as the number to be interviewed in order to adjust for the larger number of individuals in that job classification. The total sample size was projected to be 90 subjects subdivided as follows: Administrative—12, Clinical—29, and Non-Clinical—49.

Table 2
Sample Size by Clinical Discipline

Department	Number of Positions	Number Meeting Criteria	Percent Required by Classification	Sample Size
Psychiatry				
Administrative	3	3	50%	2
Clinical	8	7	50%	4
Psychology				
Administrative	3	3	50%	2
Clinical	8	8	50%	4
Social Work				
Administrative	1	1	50%	1
Clinical	9	8	50%	4
Activity Therapy				
Administrative	2	2	50%	1
Clinical	15	10	50%	5
Nursing				
Administrative	14	13	50%	6
Clinical	24	24	50%	12
LPNs	34	34	50%	17
FSA's AM Shift	65	64	25%	16
FSA's PM Shift	65	65	25%	16
Totals	251	242		90

The Interview Process

The Interviewers

Two individuals conducted interviews. The primary researcher did not participate in the interview process due to being employed at the facility in an administrative capacity. These two individuals who conducted the interviews in the study were both nurses at the baccalaureate level and had recently been involved in research projects. They were knowledgeable about all aspects of the study, were familiar with the institutional culture and procedures, and were perceived to be capable of securing the acceptance of potential participants. They were easily recognized based on their previous affiliation with the facility. This gave some credibility to the legitimacy of the study and the fairness with which it was carried out. Because of their prior affiliation with the facility, their ability to gain the trust of potential participants was a positive factor.

Promotional Activity

On two separate occasions fliers were distributed to the clinical units in the facility where the staff were assigned. These fliers were posted at key locations, such as entrances to the unit and on a billboard, as a means of notifying staff that this project had been initiated. One of the posters contained information inviting staff to an informational session conducted by the interviewers. Pizza and punch were

provided as an added incentive to encourage individuals to attend. Approximately 25 individuals attended the session.

At the onset of this informational session, the interviewers introduced themselves and described the role they would be playing in the study. They talked about whether participation was voluntary, the confidentiality of what was being discussed, and how confidentiality was maintained. During this session one of the physicians asked if the study was sponsored by a drug company "because they paid well."

These promotional sessions proved to be very beneficial in a couple of ways. In addition to providing information and answering questions, the promotional sessions helped to alleviate subtle fears such as who would know what was said and how the information would be used. Professional staff received an opportunity to ask more technical questions such as, How will participants be selected? What would happen to the information once the study was completed? In addition, an announcement was placed in the facility's newsletter informing all staff about the research project and how it would be conducted.

Recruitment of Potential Participants

There were three aspects to recruiting participants: (a) inviting potential participants to participate, (b) informing the potential participants about all aspects of the study, and (c) obtaining a consent to conduct an interview.

Inviting potential participants to participate. Potential subjects were contacted by phone or in person and invited to participate in the study. The potential subject was then screened for eligibility to be a participant. If the potential subjects met the study criteria, they were invited to meet with the interviewer who provided them with the following information: (a) the purpose of the study, (b) the participant selection process, (c) expectations of participants, (d) confidentiality and how it would be enforced, and (e) risks and benefits to the participant.

The initial group targeted was the forensic security aides on the morning and on the afternoon shift. This group was regarded as the most difficult to recruit, and the group least likely to be interested in participating in the study, because they were perceived to be the ones least involved in treatment planning. The researcher also knew that the scheduling of participants from this group would be the most disruptive to daily unit operations.

The names of the potential participants to be recruited were drawn from a master list containing staff names. The master list of names was provided to the interviewers by the researcher. Accompanying the master list was a list of phone numbers for each of the patient care units to which the staff were assigned, the names of each staff member with her or his job classification, and the specific name of each unit. This list of names was also provided to the interviewers in separate envelopes for each classification. To identify a particular potential participant, the interviewers pulled a name from the respective envelope. These individuals were contacted either by phone or by face-to-face contact.

Most of the interviews of forensic security officers were conducted on weekends as opposed to weekdays. This change came about as a result of the difficulty in contacting these individuals by telephone, and the difficulty the participants had being released from their unit assignment in a manner that was predictable and allowed for scheduling to meet unit operations. During the weekend, the units were less busy and the possibility of staff being released to participate in the study increased. The interviewers found the scheduled weekend time to be much more acceptable to all involved.

The venue for interviewing, like that of recruiting, was also changed. The interviewers went to the units, recruited staff on the units and interviewed where the participants worked. This approach provided the interviewers with easier access to potential participants to recruit them. When possible, consent was obtained, and participants were interviewed without scheduling a second meeting. At times some participants were interviewed during their assigned meal break. All interviews were done in an enclosed office which proved to be beneficial because:

1. Participants did not have to leave their assigned posts for long periods of time rendering them unavailable to provide assistance in case of an emergency.
2. Time was saved because the participant did not have to walk to another location and through security checkpoints to be interviewed.
3. More interviews were conducted on a given day.

The Recruitment Script. The recruitment script was designed to gain the interest of staff to participate in this study. It was written in a cordial invitational style to elicit the willingness and involvement of staff. Most potential subjects already had some information about the research questions in this study due to a description in the facility's newsletter and promotional fliers. During the recruitment process, staff in some classifications stated they had not had an opportunity to share their viewpoints on program development and implementation and had not experienced that what they had to say was worthy of being heard and included in a study of this sort. The recruitment script was designed to freely elicit feelings and opinions. The introductory words of the script were friendly, nonthreatening, and inviting, and this put the listener at ease.

The introductory paragraph of the recruitment script was also designed to approach the idiosyncratic differences among classifications. For example, the researcher expected that staff in the Non-Clinical classification would find that such a study would acknowledge the worthiness of each and every participant's contribution. On the other hand, the researcher expected that staff in the Non-Clinical classifications might hesitate to participate in a structured interview if they had no prior experience with a research study that utilized an interview. The introductory part of the script targeted the worthiness, curiosity and interest, as well as the cognitive insight and direct care experience of this classification of potential participants.

To appeal to the potential participants in the clinical classification, the introductory part of the recruitment script elicited interest in the study by addressing their cognitive knowledge and experience. To elicit participation from the administrative classification, the introductory script was slightly modified to appeal to their position and power, and was more formal in nature.

Overall, the recruitment script was kept simple and concise with the intent of giving potential participants a quick sense of what they were invited to do and what their role would be. Care was taken in clearly identifying to the participants not only how they were selected but also the precautions taken to assure that their participation was voluntary, would remain confidential, and presented no risk to them or their employment

The Consent Form. The Consent Form addressed the Human Subjects Institutional Review Board's requirements regarding what participants must know before consenting to participate in the study, including any known risks and benefits to the participant.

The Structured Interview

Discussion of the interview instrument is divided into three parts: Part I required the interviewers to document facts that were used to describe the sample. Part II used an open-ended format of questions to elicit a broad range of information on program development from the study subjects. These questions addressed the subject's current involvement in program development, and explored what factors he

or she viewed as important in treatment program development. The subject was given the opportunity to describe his or her thinking on the matter, and the challenges he or she has had to overcome to assure that effective treatment programs were developed. The interviewer explored the subject's thoughts about the similarities and differences in viewpoints among the different classifications that are involved in treatment program development in this prison setting. Finally, particular attention was given to how subjects applied and interpreted treatment program development in a prison setting, and any general themes that emerged. The term *program development* was defined for the subjects.

Part III used a similar format but focused primarily on program implementation. These questions addressed the subject's current involvement in program implementation. They were explored separately from program development because some subjects involved in program implementation were not involved in program development. In addition, factors affecting treatment program development were potentially not the same factors as those affecting treatment program implementation. This division of questions separated treatment program development from program implementation in the subject's mind, and focused the subject's thinking on those factors that might be different in each of the two stages. The participant's perspective on the subject was elicited using more than one approach. For example, the subject was hypothetically put into the position of power and authority for the purpose of determining what sort of action he or she would take in giving priority to a certain factor. The interview closed by asking the participant if

there was anything further she or he wanted to share with the interviewer. Again, the interviews were structured to elicit the emergence of themes important in program implementation, and the term *program implementation* was defined for the subject. The copy of the structured interview may be found in Appendix C.

Pilot Survey

The proposed interview questions were asked of 10 volunteer subjects selected at random from the facility's master list in proportion to each job classification (Administrative, Clinical, and Non-Clinical). These subjects were not included in the subsequent study sample. The pilot study results were used to determine the appropriateness of questions, timing, method of interviewing, appropriate location, and other related concerns. Participant responses were recorded and evaluated. As a result of the pilot survey, three questions were eliminated from the questionnaire as being redundant, and one question was rephrased.

Data Collection Process

Each interview was tape recorded. At the completion of the taping, the participant was assigned a code number from a master code list. This code was used throughout the data collecting and reporting process as the only identifier for the participant and was known only by the interviewers. Audiotapes with codes were given by the interviewers to a professional secretary to be transcribed. The transcribed interviews were then forwarded in written form to the researcher.

There were several issues and processes that had to be resolved at the onset of the interview process.

1. Supervisors in charge reported they were unable to release staff to attend scheduled interviews due to emergency situations on the unit. This resulted in supervisors having to reschedule participants' appointments with no assurance those appointments could be kept.

2. Some supervisors denied staff requests to attend the interview session, claiming they were not notified every time the interviewers were at the facility. This allegation was made even though supervisors were notified on every occasion.

To address the issue of supervisor notification, the researcher emailed all parties involved, notifying them of the planned visit by the interviewers. The researcher later also called the supervisor to notify them of the scheduled interviews as there was no assurance that the shared information would be communicated to the oncoming shift. The issue of communicating with the supervisor, particularly on other shifts, remained a problem. For example, on many occasions the interviewers arrived on a weekend, and the person in charge of allowing them into the facility was not informed of their pre-planned arrival. The interviewers resorted to carrying copies of the emails as evidence that permission was previously granted. Some supervisors also expressed that they felt it was unfair for individuals to be asked to volunteer their lunch breaks to participate in this project even though these participants were able to eat their meals during the interviews.

Participant Profile

The participants represented five different disciplines in three major categories (Administrative, Clinical, and Non-Clinical). These included physicians, psychologists, social workers, activity therapists, registered nurses, licensed practical nurses, and forensic security aides. With the exception of the forensic security aides and activity therapists, the remaining participants were required to have a license to practice on file at the facility. Physicians, psychologists, and social workers were educationally prepared at a Master's level or above. The educational preparation of the registered nurses, activity therapists, and forensic security aides varied from a high-school diploma to a 4-year college degree. In addition to their formal education, all participants were required to participate in an intensive 4-week orientation program at the facility that prepared them to work with felons who are mentally ill.

Table 2 presents a breakdown of the number of participants interviewed from each clinical discipline and by specific category (Administrative, Clinical, and Non-Clinical). Sixty-one individuals of the targeted sample of 90 potential participants were interviewed. This represented 68% of the potential sample.

Thirty-five percent (35%) of the licensed practical nurses participated in the study, followed by forensic security aides with a 56% participation rate. Of significance is the fact that more than half (60%) of the participants in the study were from the Department of Nursing, and of that group more than half were within the Non-Clinical classification.

Respondents were also arranged in one of three major categories:

Administrative, Clinical, and Non-Clinical. This was done to assure an added level of confidentiality. As discussed in the research design, the small number of individuals in certain classifications presented a risk to confidentiality for some participants. Collapsing of the data into larger categories was thus necessary.

Steps in Data Analysis

The following discussion presents an analysis of the data in two parts. The first part describes the organizing of the data, referred to by Straus and Corbin (1998) as “conceptual ordering” to make sense out of the data. The objective of this part of the data analysis was to develop a list of factors that reflected the perceptions of the participants on factors affecting treatment program development and implementation. Part two presents the rating of those factors identified in Part one.

Organizing of Data

The researcher relied primarily on the qualitative analysis process outlined in Strauss and Corbin (1998) to analyze the data. This process incorporates analytical tools to assist the researcher in moving from the specific found from data analysis to the more general by looking at properties, dimensions, and relationships found in the data.

First, the researcher sorted the interview transcripts by discipline to verify the number of transcripts received from each discipline. Each transcript had a code

number on it that identified the specific discipline and the category type of the participant (Administrative, Clinical, or Non-Clinical). This coding facilitated sorting the data by discipline.

Second, the researcher carefully read each participant's interview, scanning the document for words and phrases that were significant and provided interesting meaning to the topic. For example, some of the words and phrases identified in this manner were: the treatment team working together, a creative or innovative idea, a good assessment of the patient, responding to patient needs, and the need for materials and supplies.

Third, the researcher read each participant's response line by line. Participant comments that were made consistently by more than one respondent, general themes that surfaced representing basic beliefs or philosophies of the respondents, and concepts that surfaced frequently were highlighted.

Fourth, the researcher reviewed the individual responses of each discipline to the research questions. This process resulted in the compilation of a viewpoint representative of each discipline to each question, and allowed for comparisons within the disciplines as well as among the disciplines.

Fifth, a list of responses to questions 3 and 4 was generated. These two focus questions asked respondents to identify: (a) the factors that impact treatment program development, and (b) the factors perceived to be most important in treatment program development. This list was arranged according to discipline and by category (Administrative, Clinical, and Non-Clinical) within each discipline. Within this list the

researcher identified factors that were specified by more than one discipline, and highlighted them for inclusion among the factors to be rated. In the book *Basics of Qualitative Research*, this process is described by Strauss and Corbin as “selective coding” and “open coding” (Strauss & Corbin, 1998). Open coding generates categories and their properties, and then determines how categories vary dimensionally (Strauss & Corbin, 1998). Selective coding is a process of integrating and refining categories.

Sixth, responses for all questions were compared. This was accomplished through a review of the 12 research questions answered by all the disciplines. The researcher identified responses that had similar meaning, including responses that were worded differently but had similar meanings. These were subsequently sorted by their meaning. For example, the term *staffing numbers* was previously associated with individual general category labeled Staffing Numbers, or Staffing Levels, giving a quantitative meaning. The researcher listed these factors under a general factor labeled as “Resources” that established a more financial and economic relationship.

Another type of analysis involved the interpretation of responses to arrive at an intended meaning. The following is an example of responses that had the same meaning but were worded differently. The researcher asked: “Are these factors related?” Responses included: “they go hand in hand,” “they are all related,” “all connected,” “all work together,” “a little related,” “they are all equal,” and “all relate to each other.” These responses were determined to have the same intent.

Seventh, responses to the focus question: "What are the factors that affect treatment program development and implementation?" were grouped according to the factors identified, and a general list was made of these factors. This resulted in a list of 17 factors related to program development and 16 factors related to program implementation.

Rating of Factors

This phase of the research design rated all the factors identified in the first phase of data collection from most important to the least important. The rating of the factors was conducted by a random sampling of 30 participants from the original sample.

Participants

The participants chosen to rate these factors were identified from the Administration, Clinical and Non-Clinical categories. Ten previous participants from each of the categories were targeted to conduct the rating. This number represented 50% of the original number of participants. This "n" of 30 was identified as being a representative sample to reflect the opinions of the larger number interviewed in Phase I.

Recruitment and interviews were conducted by one of the interviewers used in the initial data collection process. In the initial recruitment process, participants were informed that they might be asked to participate in the second phase of the study;

thus, this request to participate again should not have been a total surprise.

Prospective participants were identified only as a number from the Administrative, Clinical and Non-Clinical categories, not by name. The interviewer's objective was to identify anyone from those three categories who had participated before. This was not difficult since the interviewer knew who participated previously. This information was not revealed to the researcher. Participants were first asked if they were willing to participate in this phase of the study. If they agreed, they were handed a form that contained the factors and the rating scale. Instructions were given on the purpose and intent of the form, and they were asked to rate the factors from most important to least important according to the scale provided. The form contained two sets of factors: factors that related to treatment program development and factors that related to treatment program implementation. No participants refused to participate. The form was left with each participant and later retrieved. This phase of data collection was accomplished without any difficulty.

The Rating Scale

A Likert-type rating scale was used because it allowed the researcher to determine the opinion of the participants on the importance of each factor on program development and implementation. Participants were asked to place a value ranging from 1 through 5 on each of the statements that reflected a factor affecting treatment program development or, similarly, treatment program implementation. These statements were derived from the list of all factors identified in the first phase of data

collection. The number 1 represented a value of least importance and the number 5 represented a value of most importance.

The Likert rating scale was used because it allows the subject to make a definitive choice on the value attributed to each statement. The response choices of least important to the most important were simple to interpret and simple to apply. A sample of the tool is presented in Appendix E.

CHAPTER V

FINDINGS

This chapter builds on Chapter IV where the methodology was presented. Chapter IV presented a description of how the study participants were obtained, and how the factors important in treatment program development and implementation were determined. Findings of the study presented in this chapter are divided into two parts. Part one presents a description of the participants and nonparticipants. The second part presents findings from participants' responses to the 12 research questions, including: (a) the ranking of factors that impact treatment program development, (b) the ranking of factors that impact treatment program implementation, and (c) common themes.

Description of Participants and Nonparticipants

This section of the findings is divided into two parts: (a) a description of the participants, and (b) a description of potential participants who refused to participate in the study.

Description of the Participants

The participants represented seven different disciplines or mental health care provider groups (physicians, psychologists, social workers, activity therapists, registered nurses, licensed practical nurses, and forensic security aides) in three major

categories (Administrative, Clinical, and Non-Clinical). With the exception of the forensic security aides and activity therapists, the participants had a license to practice on file at the setting. Physicians, psychologists, and social workers were prepared at the Master's level or above. The educational preparation of the registered nurses, activity therapists, and forensic security aides varied from a high school diploma to a 4-year college degree.

Of the targeted sample of 90 potential participants, 61 individuals were interviewed. This represented 68% of the potential sample. Fifty-six percent (56%) of the targeted number of forensic security aides participated in the study, followed by 35% of the licensed practical nurses. More than half (60%) of the participants came from the Department of Nursing, and more than half of those (63%) were in the Non-Clinical category of forensic security aides and licensed practical nurses. Licensed practical nurses were placed in this category as they are primarily responsible for medication administration in this setting and have an infrequent direct or active role in programming. Table 3 depicts the percent of the targeted sample that participated in the sample, and Table 4 depicts a breakdown of the number of participants interviewed from each clinical discipline by category (Administration, Clinical, and Non-Clinical).

Description of Potential Participants Who Refused

There was a variation between categories related to the number of potential participants who refused to participate in the study. None of the participants in the

Administrative category refused to participate in the study. Most refusals to participate in the study occurred among staff in the Non-Clinical category. They comprised approximately 89% of all the refusals. Forty-four percent of all attempts in the Non-Clinical category were refusals. Two primary reasons were given for refusing to participate in the study: (a) lack of interest by the Non-Clinical staff in the study,

Table 3
**Number and Percentage of the Targeted Sample Interviewed
by Discipline and Category**

Clinical Disciplines	Targeted Sample Size	Number Interviewed	Percentage of Targeted Sample
Psychiatry			
Administrative	2	2	100%
Clinical	4	4	100%
Psychology			
Administrative	2	2	100%
Clinical	4	4	100%
Social Work			
Administrative	1	1	100%
Clinical	4	4	100%
Activity Therapy			
Administrative	1	1	100%
Clinical	5	5	100%
Nursing			
Administrative	6	6	100%
Clinical	12	8	67%
Non-Clinical			
LPNs	17	6	35%
FSAs (AM)	16	9	56%
FSAs (PM)	16	9	56%
Totals	90	61	68%

Table 4
Number and Percentage of Participants Interviewed by Category

Category	Number of Participants Interviewed	Percentage of Participants Total Participants
Administrative	12	20%
Clinical	25	41%
Non-Clinical	24	39%
Totals	61	100%

and (b) the timing or inconvenience associated with participating in the interview process. Many of the inconveniences associated with participating in the study were already discussed in the Methodology chapter.

Presentation of the Findings

Presentation of the findings in this part is divided into three sections. The first section presents findings related to factors that affect treatment *program development*. Section two presents findings about factors that impact treatment *program implementation*. The third section presents *common themes* about program development and program implementation.

Program Development

Factors Affecting Treatment Program Development

Factors identified by participants that impact treatment program development reflected a wide range of perspectives from “*knowledge base (lack of)*,” to “*patient needs*” to “*number of staff*,” to “*money*.” Tables 5 through 9 provide an overview of the range of factors identified by the different disciplines and categories (Administrative, Clinical, and Non-Clinical).

Table 5

Factors Affecting Treatment Program Development by Administrative and Clinical Psychiatrists

Psychiatry Administration	Clinical Psychiatrists
A [workable] idea	Knowledge base (lack of)
Economic factors	Resistance of staff
Resources	Resources/Funds
Political environment	Educational level (lack of)
Regulatory factors	Motivational level
Flexibility of people	Cohesiveness of the group
Origination [of the idea]	Training
Consensus formulation	Resistance of staff
A good idea for a program	
Operating the plan	
Seeing how to implement a plan	

Table 6

**Factors Affecting Treatment Program Development
by Administrative and Clinical Psychologists**

Psychology Administration	Clinical Psychology Staff
Good staff	Patient needs
Funds	Resources related to time/space
Needs assessment	Treatment team
Training	Willingness and support of staff related to: <ul style="list-style-type: none"> • Level of patient challenge/problems • Level of security
Respect for observation by others	Management support
Experience of staff	Volume of admissions
Staff knowledge/education	Money/resources
Respect for the patient	Staff attitude
Quality of the program	Staff availability
	Skill level of staff
	Space
	Staff interest
	Enthusiasm
	Understanding
	Willingness of staff
	Staff attitude
	Consistency of philosophy
	Adequate staffing, especially RNs
	Patient interest and willingness to participate
	Assessment of patient needs
	Scheduling
	Cooperation of patient population
	Correct medication for the patient
	Resistance from staff

Table 7

**Factors Affecting Treatment Program Development
by Administrative and Clinical Social Workers**

Social Worker Administration	Clinical Social Workers
Staffing- number of staff	Behavior of patients
Funding	Condition of patients
Training of staff	Resources
Expertise of staff	Treatment options
	Time to do programming
	Staffing levels
	Physical setting
	Scheduling of programs
	Credentialing of staff

Table 8

**Factors Affecting Treatment Program Development
by Administrative and Clinical Activity Therapists**

Activity Therapy Administration	Clinical Activity Therapists
Human Resources	Money
Creative Ideas	Leadership
Time to develop programming	Team togetherness
Materials/supplies	The environment/unit milieu
	Age of patient
	Sex of patient
	Social background
	Past experiences of staff
	Interest of patient
	Needs assessment
	Acuity of patient
	Guidelines of Supervisor/Administration

Table 9

**Factors Affecting Treatment Program Development by Nursing Administration,
Clinical, and Non-Clinical Nursing Staff**

Nursing Administration	Clinical Nursing Staff	Non-Clinical Nursing Staff
Needs of the patient	Support of supervisor	A plan
Type of patient	Encouragement and sharing of ideas	The treatment team
Administrative support	Communication with the team	Clear communication
Staff support	Staff prejudices	Attitude of staff/ personalities
Staff commitment	Lack of initiative by patients and staff	Medication of the patient
Staff relationship with patient	Resources (lack of)	Staff initiative
Interdisciplinary involvement	Funding	Consistency
Role of the nurse	A good treatment team	Milieu of the unit/ environment
Nurse as educator	Patient diagnosis	Patient behavior
Staffing levels on the unit	Stabilization of the patient	Consistent staff
Activities on the unit	Patient needs	Sufficient staff

Rating of All Factors Affecting Program Development by All Participants

Factors having the most significant impact on treatment program development were determined by the participants' rating of these factors. The total of 30 participants used a Likert-type rating scale to apply a score of 1 through 5 to each

particular factor. These 30 respondents represented a random sample of the 61 original participants. Ten participants were selected from each category (Administration, Clinical, Non-Clinical). The scores for each question were ranked from highest to lowest and the median score determined. The median score or middle point in the distribution of the scores provided an indication of the perception of the preponderance of respondents on the importance of each factor to treatment program development and to treatment program implementation. Factors with higher median scores were determined to be more important than factors with lower median scores.

Rank Ordering of Factors Affecting Treatment Program Development by Category

Table 10 shows the median scores of each factor for treatment program development and the median score for each factor in the Administration, Clinical, and Non-Clinical categories. Data from this table show that among all categories of respondents, *“staffing levels on the unit to do programming”* was the factor ranked as having the most significance on treatment program development. This factor received the highest possible median score of 5. Fifty-six percent (56%) of all respondents gave this factor a score of 5. Eighty-eight percent (88%) of all the respondents gave this factor a score of 4 or higher. This would indicate that the majority of respondents were in close agreement that this factor has the most significant impact on treatment program development. *“Political factors”* was ranked as having the least impact on treatment program development with an overall median score of 2.0.

Table 10

**Median Scores of Factors for Program Development by All Categories:
Administrative, Clinical, and Non-Clinical**

Factors	All Categories	Administrative	Clinical	Non- Clinical
Cohesiveness/cooperation among treatment team	4.0	4.0	4.0	5.0
Knowledge/expertise of staff	4.0	4.5	4.0	4.5
A good program idea/creative idea to design	4.0	4.0	4.0	3.5
Leadership/supervisory support	4.0	5.0	4.0	3.0
Political factors	2.0	2.5	2.5	1.0
Education/training of staff	4.0	4.0	4.0	4.5
Funds/money/materials/supplies	4.0	3.5	4.0	4.0
Programs designed to meet patient needs	4.0	4.5	4.5	4.0
Patient attitude/behavior/interest in programming	4.0	4.0	3.0	4.0
Patient instability/acuity	3.5	3.0	4.0	3.5
Time within a schedule to do programming	4.0	4.0	4.0	3.5
Milieu on the unit/safety of patient/safety of staff	4.0	4.5	4.0	4.5
Staff attitude/enthusiasm/prejudices	4.0	4.0	4.5	4.0
Cooperation of staff to achieve a treatment goal	4.0	4.5	4.0	4.0
Respect for others: expertise, input	4.0	3.5	5.0	4.0
Staffing levels on the unit to do programming	5.0	4.5	4.5	5.0
Flexibility to design and plan programming	4.0	4.0	4.0	3.0

A review of Administration, Clinical, and Non-Clinical categories with respect to the above findings show the Non-Clinical category to be in agreement that *“staffing levels on the unit to do programming”* was the most significant factor as evident by a median score of 5, the highest possible score. The Administration and Clinical categories had median scores of 4.5, which showed close agreement that this factor was significant.

Administration category. The Administration category ranked *“leadership and supervisory support”* as the most important factor with 60% of the participants in this category giving this factor a score of 5. Four other factors had median scores of 4.5, indicating agreement that these had a significant influence on treatment program development. These factors were:

Knowledge and expertise of staff,

Programs designed to meet patient needs,

Milieu on the unit/safety of patients/safety of staff, and

Cooperation of staff to achieve a treatment goal.

In comparing the perception of respondents in this category to those in other categories, it was found that respondents in the Clinical and Non-Clinical categories agreed with the respondents in the Administration category that *“leadership and supervisory support”* was the most important factor affecting treatment program development. There was agreement, however, between the Administration category and the Non-Clinical category that *“milieu on the unit/safety of patient/safety of staff”* had a significant impact on treatment program development. There was also

agreement among the respondents in all three categories that “*staffing levels on the unit to do programming*” was significant.

The factor ranked by the Administration category as of least significance was “*political factors*.” This factor had a median score of 2.5. Ninety percent of the respondents in this category gave this factor a score of 3 or less, thereby indicating general agreement.

Clinical category. The Clinical category ranked “*respect for others: expertise, input,*” as the most important factor with a median score of 5.0. Sixty percent (60%) of the respondents in this category gave this factor a score of 5. Three other factors received a score of 4.5 indicating they were also of significance to the respondents in this category. These included:

Programs designed to meet patient needs,

Staff attitude/enthusiasm/prejudices, and

Staffing levels on the unit to do programming.

In comparing the perception of respondents in this category to those in other categories, the data showed that respondents in the Administration and Non-Clinical category did not agree that “*respect for others: expertise, input*” was a significant factor.

In regard to the other three factors identified, the Administration category agreed with the clinical category that “*programs designed to meet patient needs*” was important. They also gave this factor a median score of 4.5. “*Staff attitude/enthusiasm/prejudice*” was perceived by all categories to be important to

treatment program development. Again, all categories agreed that *“staffing levels on the unit to do programming”* was important. This factor received a median score of 4.5 by respondents in the Clinical category, while the other two categories gave it a median score of 5 given by respondents in the other two categories.

“Political factors” was identified by the Clinical category as being the factor having the least significance in treatment program development. This perception is consistent with the perception of respondents in other categories. The median score for this factor was 2.5 with 70% of the respondents in this category giving this factor a score of 3 or less.

Non-Clinical category. Respondents in the Non-Clinical category ranked two factors as having the most significant impact on treatment program development:

“staffing levels on the unit to do programming” and *“cohesiveness /cooperation among treatment team.”* Both of these factors received a median score of 5. Seventy percent (70%) of the respondents gave *“staffing levels to do programming”* a median score of 5, and 60% of the respondents gave the factor *“cohesiveness/cooperation among the treatment team”* a score of 5. Three other factors had median scores of 4.5. They were:

Knowledge and expertise of staff,

Education /training of staff, and

Milieu on the unit/safety of patients/safety of staff.

In comparing the perception of respondents in this category with those in other categories, the findings show that neither respondents in the Administration or

Clinical categories agreed that *“cohesiveness/cooperation among treatment team”* was the most significant factor. However, there was agreement that *“staffing level on the unit to do programming”* was an important factor. There was general agreement among all categories that *“knowledge and expertise of staff,” “education/training of staff,”* and *“milieu on the unit/safety of patients/safety of staff”* were important factors in treatment program development. All three of these factors had median scores of 4.0 or higher among all categories. *“Political factors”* was identified by the respondents in this category as having the least significance on treatment program development with 60% of the respondents in this category giving this factor a score of 1.

Differences in Role Perception by Category

Perception of one's role in treatment program development reflected a range of involvement and differences in perception by discipline and category. These differences are illustrated below through responses made by the participants to the interview questions.

1. Administration Category:

I have the trained staff needed to develop treatment programs. [I] assure resources are available.

My role is to determine organizational concerns, provide resources, and see how programs fit into the overall scheme and mission of the hospital.

I assist in development and training, and make sure my department works effectively with other departments.

I see myself as a core person to help develop the program.

I am assigned to review their progress [related to] the Treatment Team goals.

2. Clinical Category:

A. Psychiatry

I am the Team Leader.

I meet with the team and discuss problems.

B. Psychology

I attend treatment team meetings with individual members to share observations and data.

I see myself as part of the [Treatment] Team and program development.

C. Social Work

I see myself as a person who is able to assess the needs of the patient and then assist to develop group programs.

I attend Treatment Team meetings and plan programs through discussion with staff.

D. Activity Therapy

I work as a therapist. I am part of the [Treatment] Team.

I am in a supervisory position. I offer ideas, suggestions, give guidance, critique, and oversee implementation.

E. Nursing (Registered Nurse)

I am a member of our Treatment Team. The patient's needs are assessed and discussed, and programming is planned, implemented, and monitored.

I am assigned to review their progress [related] to the Treatment Team goals.

My role is [to assure that] programming is scheduled and the content is relevant to the patient population.

3. *Non-Clinical Category:*

A. Licensed Practical Nurse

I am not really involved.

We give inputs on patients.

B. Forensic Security Aide

We are not involved in development of programs.

We report observations to the Treatment Team.

I have input into the Treatment Team, and observe patients.

Ideas from staff are passed to the RN supervisor to be shared with the Treatment Team.

Relationships Between Factors Affecting Treatment Program Development

A review of the interviews revealed relationships between factors and groups of factors that, when linked together, established a consequence or impact on treatment program development. Relationships readily observed included:

1. When there is "cohesiveness/cooperation among treatment team members" and staff have "knowledge and expertise," treatment program development is enhanced, resulting in "treatment programs designed to meet patient needs," and "the cooperation of staff to meet treatment goals."

2. "Adequate staffing levels [affect the] milieu and safety of the unit" thus providing an environment in which staff and patients can participate in treatment program implementation.

3. Supervisory and leadership support or lack thereof affects one's "flexibility to design and plan programming," and "staff interest and enthusiasm," which in turn affects patient/prisoners' attitudes, behavior, and interest.

4. Patient/prisoner stability and acuity level impact the milieu of the unit, and the safety of patients/prisoners and staff thus impact treatment program development and implementation.

5. The availability of financial resources (funds and resources) affect: staffing levels on the unit; materials and supplies to conduct treatment programs; and education and training opportunities for staff which in turn affect the safety of patients/prisoners and staff, patient/prisoner attitudes, and treatment program development.

The following is a synopsis of responses made by participants to the question, "Are any of these factors related to one another?" Participant responses included that they:

go hand in hand

are all related

are all entwined

are all connected

all work together

are a little related

are all equal

all relate to each other.

This preponderance of similar responses validated that participants perceived a strong relationship among many of the factors.

Program Implementation

Factors Affecting Treatment Program Implementation

Factors identified by participants that affect treatment program implementation reflected a wide range of perspectives from “*piloting a program*,” to “*a cooperative team*,” to “*assessment and evaluation of the patient*,” to “*staffing levels*” and “*interested staff*.” Tables 11 through 15 provide an overview of the range of treatment program implementation factors identified by the different disciplines and categories (Administrative, Clinical, and Non-Clinical).

Rank Ordering of Factors Affecting Treatment Program Implementation by All Participants

Table 16 shows the median score of each factor associated with treatment program implementation for all categories combined and for the separate categories of Administration, Clinical, and Non-Clinical. A discussion of the factors each category perceived as important is provided below.

Table 11

**Factors Affecting Treatment Program Implementation
by Administrative and Clinical Psychiatrists**

Psychiatry Administration	Clinical Psychiatrists
Piloting of a program	Lack of knowledge by staff
Lack of a process for implementation	Cohesiveness of treatment team
A process of implementation	Money
Location or space to do programming	Approval of the plan
Scheduling problems	Time to do programming
Logistic problems	Flexibility in implementation
Special training needs of staff	Staff involvement
Adequate training of staff	Sharing of ideas

Table 12

**Factors Affecting Treatment Program Implementation
by Administrative and Clinical Psychologists**

Psychology Administration	Clinical Psychologists
Approval of a plan	A cooperative team
Team work	Time availability
Education of staff	Consistency of staff
Staffing patterns	Logistics
Credentials of staff	Respect of patients
Available space	Flexibility
Available time	Experience and training of staff
Staff involvement	Personal motivation
Sharing of ideas	Available resources
	Time factor to do programming
	Space to do programming
	Number of clinicians
	Staff knowledge of the plan

Table 13

**Factors Affecting Treatment Program Implementation
by Administrative and Clinical Social Workers**

Social Work Administration	Clinical Social Workers
Staffing numbers	Assessment and evaluation of the patient
Training of staff	Staff resources
Resources	Time structure
Materials and supplies	A good functioning team
	Scheduling
	Coordination with others
	Security
	Cooperation with the treatment team
	Staff availability
	Support of administration
	Available space for therapy
	Ability to find agreement with treatment team

Table 14

**Factors Affecting Treatment Program Implementation
by Administrative and Clinical Activity Therapists**

Activity Therapy Administration	Clinical Activity Therapists
Human Resources	Staffing levels
Money	Patient motivation
Space	Security on the unit
Autonomy	Staff working together
Milieu support	Money
Security	Highly motivated staff
Safety requirements (mobilization and emergency count)	Leadership
	Staff attitude
	The patient's behavioral problem(s)
	Resistance from staff
	Team togetherness
	Security attitudes, security measures

Table 15

**Factors Affecting Treatment Program Implementation by Nursing Administration,
Clinical, and Non-Clinical Nursing Staff**

Nursing Administration	Clinical Nursing Staff	Non-Clinical Nursing Staff
Space	Consistency on the unit	Interested staff
Staff skills and interest	Respect of staff	Education tools to run groups
Supplies	A schedule the patient understands	Education of staff
Unit operations	Stability of patients	Staff willingness to participate
Number of registered nurses	Time to run groups	Patient motivation
Education of staff	Materials	Staff biases
Cooperation with the treatment team	Interest of patients	Staff motivation
	Security restrictions	Patient's stability & medication
	Cooperation among Disciplines	Experience of staff
	Staff willingness	Enough help/staff
	Patient cooperation and motivation	Space to have groups
	Freedom to think, watch and observe	Supplies, materials for group
	The RNs influence	Cooperation of the patient
	Treatment team support	Attitude of the patient
	Education/training of staff	Level of education of patient
	Staffing levels	Patient's willingness and motivation to help themselves
	Unit activity	
	The environment	
	Needs of the patient	
	Treatment team support	

Table 16

**Median Scores of Factors for Treatment Program Implementation by
All Categories: Administrative, Clinical, and Non-Clinical**

Factors	All Categories	Administrativ e	Clinical	Non- Clinical
Treatment team working together/good functioning team	5.0	5.0	4.0	5.0
Education/training/experience/skill of staff	4.0	4.0	4.0	4.5
Approval of a plan	4.0	4.0	4.0	3.5
Support	4.0	4.5	4.0	4.5
Flexibility/autonomy to do ones job	4.0	4.0	4.0	4.5
Security/management of the patient	4.0	4.0	4.0	5.0
Funds/money/resources/materials/supplies	4.0	3.5	4.5	3.5
Assessment/evaluation of the patient	4.0	4.5	4.0	4.0
Patient attitude/behavior /motivation	3.5	3.0	3.5	4.0
Patient diagnosis/acuity/stability of patients	4.0	3.0	4.0	4.0
Time/schedule/availability of space to do programming	4.0	4.0	4.0	3.5
Security measures/-count, emergencies	4.0	4.0	3.0	4.5
Staff willingness/motivation/interest/resistance	4.0	4.0	4.0	5.0
Cooperation of staff to achieve a treatment goal	4.0	4.0	4.0	5.0
Coordination with others	4.0	4.0	4.0	4.0
Human resources; number of staff, number of clinicians	4.0	4.0	4.0	4.0

All categories of participants. The factor perceived as having the most significance in treatment program implementation was the “*treatment team working together/a good functioning team.*” The median score for this factor was 5. Fifty-three percent (53%) of all respondents gave this factor a score of 5. There was a clear distinction of the median score on this factor from the median score on all other factors. A comparison of the response across the three categories to the identified factor shows that 60% of the respondents in the Administration category gave this factor a score of 5, while 40% in the Clinical category and 60% in the Non-Clinical category assigned this factor a score of 5. As can be observed, the Administration category and the Non-Clinical category had the greatest influence on the decision regarding this factor as the most significant. These results are depicted in Table 16 above.

Administration category. Findings show that respondents in this category perceived “*treatment team working together/ a good function team*” as the most significant factor affecting treatment program implementation. The median score for this factor was a 5. Two other factors had median scores of 4.5 indicating respondents considered that these factors were also significant. They included:

Support, and

Assessment/evaluation of the patient.

In comparing the perception of respondents in other categories to that of the Administration category, on this factor the findings show general agreement, particularly between the Administration and Non-Clinical categories. Both of these

categories had median scores of 5 on this factor. There was less agreement from the Clinical category as is reflected by a median score of 4. There was also agreement among all categories that *“support”* and *“assessment/evaluation”* were important factors, as evidenced by a median score of 4.

The low 3.0 median scores on two factors identified them as having the least significance in treatment program implementation. These were:

Patient attitude/behavior/motivation, and

Patient diagnosis/acuity/stability of the patient.

Respondents in the Clinical category agreed that *“patient attitude/behavior/motivation”* was of least importance assigning it a score of 3.5, but disagreed that *“patient diagnosis/acuity/motivation”* was of least importance. The latter factor received a median score of 4.

Clinical category. Findings show the most significant factor ranked by this group to be *“funds/money/resources/materials and supplies”* with a median score of 4.5. Fifty percent (50%) of the respondents in this category gave this factor a score of 4.5, and 80% of the respondents gave this factor a score of 4 or higher indicating significant agreement among the respondents.

In comparing the perception of respondents in other categories with the above, data showed that they did not perceive *“funds/money/resources/materials/supplies”* as the most important factor. Both persons in the Administration and Non-Clinical categories gave this factor a median score of 3.5.

Within the Clinical category there was close agreement on the significance of the factors. Fourteen of the 16 factors or 88% had a median score of 4. Based on median scores, most of the factors (14 of 16) were regarded as having a significant influence on treatment program implementation.

The factor ranked as having least significance was “*security measures/count/emergencies*” with a median score of 3. Sixty percent (60%) of the respondents gave this factor a score of 3. This finding was not unexpected since respondents in this classification are the ones least likely to be involved and affected by security measures and emergencies. Respondents in other categories rated this factor of higher significance as reflected by median scores of 4 and 4.5.

Non-Clinical category. Respondents in this classification also ranked “*treatment team working together/a good functioning team*” as the most significant factor affecting treatment program implementation. However, they also identified three other factors as being significant rating these with a median score of 5. These were:

security/management of the patient,
staff willingness/motivation/interest/resistance, and
cooperation of staff to achieve a treatment goal.

In each case, 60% of the respondents gave each of these factors a score of 5. However, respondents in the Administration and Clinical categories gave this factor a median score of 4.

The Non-Clinical category ranked four other factors with a score of 4.5.

These were:

education/training/experience/skill of the staff,

flexibility/autonomy to do ones job,

support, and

security measures/count/emergencies.

A closer look at the median scores given by the respondents showed a high level of agreement on the significance of multiple factors in treatment program

implementations. This agreement is reflected in the median scores of the factors.

Specifically, 81% the factors had scores of 4 or more.

Three factors were ranked as having the least significance in program implementation with median score of 3.5. These were:

approval of a plan,

funds/money/resources/materials/supplies, and

time/schedule/availability of space to do programming.

In summary, the factor identified as being the most significant in program development was “*staffing levels on the unit to do programming,*” while “*political factors*” was identified as being of least importance. “*Treatment team working together/good functioning team*” was identified as most significant in impacting treatment program implementation, while “*patient attitude/behavior/motivation*” was identified as being of least importance.

Perceptions Regarding the Treatment Team

A review of the transcribed responses from the taped interviews conveyed a similar perception among respondents on the dominant role of the treatment team in program development. The following participant responses to the interview questions illustrate this finding:

The entire treatment team needs to buy in to some degree that what you are doing is important and effective, and they are part of it.

A good treatment team and how it functions is important.

The treatment team support is a factor because we all have to be on the same page in recognizing the needs of the patient.

We, the treatment team, try to find the best individual treatment program for the patient to suit his needs.

You need to have a team that is organized.

The treatment team and the individual disciplines need to come to an agreement for patient programming.

The treatment team working together and how they relate to the staff.

Other Perceptions

One factor that did not appear in the ranking of factors, but which was expressed clearly in the interview response, related to what the majority of participants stated in answer to the question, *"If you could spend \$100,000 in one area of treatment program development, what factor would that be?"* Most respondents identified the *"education and training of staff"* as that factor. This finding is illustrated by the following responses of participants:

I would get more staff education, perhaps seminars.

I would hire more highly competent staff.

The most trained staff the better.

Some more formal staff development.

My training, the things I have learned during the years help me.

Education is important. It is the opinion of some non-clinical people that it has no effective value.

Change the perception of staff to look at the needs of the patient.

People need to be educated on why certain programs are important for this population.

This is a tough setting to work in. Complacency or burnout is something that needs to be dealt with.

Factors participants ranked as important to treatment program implementation differed from those cited as affecting treatment program development. For treatment program implementation, the most important factors addressed the functional and treatment side of operations or programming versus the theoretical or conceptual aspects that were focused on under program development. For example, under implementation, participants cited factors such as:

treatment team working together,

educated staff in sufficient numbers staff willing to participate in implementation,

time and space availability to conduct programming,

funds to secure materials and supplies for use when implementing treatment programs, and

staff willingness.

In contrast, under treatment program development participants cited factors such as:

a good idea for a program,

economic factors,

respect for others,

working together as a team, and

a good program design.

Also included as an important factor in treatment program implementation, but not mentioned under program development, were the various aspects of *security* that affect program implementation such as:

security management of patient/prisoners,

security measures including patient/prisoners counts,

other emergency security measures, and

severity of the patient/prisoner's illness and instability.

These factors create a security risk for both the staff and patients at this setting. These results indicate that because implementation has a different focus, a different set of factors needs to be considered when implementing a treatment program.

***Differences in Role Perception Related to Program Implementation
by Category***

The participants' perceptions about their role in treatment program implementation reflected whether they were in an administrative, clinical or non-clinical staff position. The following responses of participants are illustrative of this finding.

1. Administration:

I see myself as the one who goes and tells the staff exactly what the treatment plan for the patient involves, and what we (the team) have in mind. I then assign people to do specific treatment programs.

Educating and working with staff on the programs they are responsible for.

I assist in developing and training and measuring how my Department works with other Departments.

2. Clinical Category

A. Psychiatry

We sit down with each other when they [the patient/prisoner] come to the unit, and we look at some of the programs they have encountered in the prison setting and what their major goals are, and we all [the treatment team] have equal input into where we go with this.

I would see that the program gets implemented according to the program statement.

B. Psychology

I make sure that the people who implement the plan understand it.

I run group therapy on the unit.

C. Social Work

I make assignments for groups.

I get directly involved. I help run groups.

I am given a great deal of liberty in terms of being able to develop and implement groups—individual therapy.

D. Activity Therapy

I develop a lot of unit programming for the patients/prisoners that are on the acute admissions unit.

I can develop any programs I want and implement them.

I work closely with other therapists in groups.

I run 2-4 groups per day. I am very active.

E. Nursing

I am one of the people who actually sits down and draws up the plan of treatment after it has been discussed.

I run groups.

3. Non-Clinical Category**A. Licensed Practical Nurse**

We talk to the supervisors and nurses about patients.

By following the patients/prisoner's Plan of Care and documenting on the patient, and communicating with the treatment team.

I assist in getting patients involved.

I teach about medication on a one-to-one basis.

Sometimes I do medication teaching or try to teach about diseases they might have.

I run groups and assist in groups.

B. Forensic Security Aide

I run treatment groups, brainstorm about new treatment programs, and assist patients with their treatment goals.

I talk to supervisors and nurses.

I run a creative arts group.

I offer groups, and listen to problems.

We do simple groups that are not too long.

I have input with the treatment team, and observe patients.

I run groups and find materials pertinent to groups.

I run a sports group every week and other groups.

I am the one who motivate them [patients/prisoners] to go to groups.

I help the patients/prisoners by being a friendly ear, and making sure they remain safe.

We do simple groups that are not too long.

I offer groups but sometimes just listen to problems that are on their minds.

I see myself as one who carries it [treatment programs] out and reports how it is working.

Each discipline reported implementation as a process that is active and dynamic in nature with a diverse range of inputs from various disciplines. The perceived scope of involvement was reported to be broad. The role and participation perceived by each discipline was reported as distinct while the focus of the objective was similar.

Common Themes

Themes that emerged during the study differed with respect to both program development and program implementation. These findings are presented below.

Program Development

Themes from the findings about program development depict a cohesive harmonious planning group. Participants reflected this theme in terms such as:

the treatment team

an active process of input

interchange

action focused in a specific direction and targeted to a specific agent or recipient (the patient).

Action, as a concept, incorporates the blending of the intangibles such as ideas, attitudes, education and training, and cooperation. These actions lead to the formulation of a plan, a treatment plan that has a specific expectation and can be implemented in a variety of ways. Treatment program development was perceived to assist in interpreting and designing methods of implementation. The findings of this study reveal that the central theme of treatment program development was *a blend of key factors*.

Program Implementation

Themes that emerged from findings about program implementation reflected more action-oriented processes than action steps. These processes incorporated the how, when, and where of the developmental phase to arrive at a specific outcome. Tangibles such as funds, materials and supplies, staffing numbers, trained staff, and stable patients were reported by participants as having a direct impact on this process. Participants viewed actions as circular and connectable with one set of factors having the potential to affect another set of factors, and all factors affecting each other positively or negatively. The participants reported that program implementation requires more of a linking of factors than a blending of factors. The findings of this study determined that the central theme of program implementation was a *linking process*.

The linking process calls for the program planner to identify the appropriate links in the implementation process to assure that implementation occurs. For example, in the program development phase the need for patients/prisoners with a diagnosis of Schizophrenia to understand their mental illness was identified. The treatment team suggested that a Schizophrenic Anonymous group would be one way of addressing that need. To achieve the outcome of a Schizophrenia treatment group, the program planner(s) must begin to connect the applicable and appropriate resource links. This linking process may include factors such as:

1. What program or material resources on Schizophrenics Anonymous are available or can be made available?

2. How should the program be designed and relate factors such as the number of sessions, length of sessions, and content of each session?
3. Are funds available to purchase these programs or materials?
4. Who among the staff is knowledgeable, experienced, and interested in conducting such a treatment group?
5. What subset of the population should participate?
6. What space is available?

The linking process therefore calls for the planner to be conscious that certain factors such as those identified in this chapter can affect implementation. An analysis of those factors may be necessary in order to properly link those factors that are essential to any particular treatment program outcome.

CHAPTER VI

SUMMARY AND CONCLUSIONS

This chapter is divided into five parts: summary, conclusions, limitations, recommendations, and suggestions for future research. The summary presents an overview of the study and the main findings. Conclusions drawn from the study are listed and discussed. Limitations of the study are briefly identified followed by recommendations on what should be considered when developing and implementing treatment programs. Lastly, suggestions for future research are addressed.

Summary

This qualitative study was conducted in a mental health hospital that provides treatment to mentally ill prisoners. The purpose of the study was to examine treatment program development in a correctional mental health facility so as to identify the factors that influence how programs are developed and implemented. It also sought to determine which factors have the greatest effect on treatment program development and implementation. The information will hopefully be used to improve how treatment programs are developed and implemented in settings with mental health programs for mentally ill felons.

This study was exploratory in nature. It used structured interviews to gain information from experienced staff on their perceptions of factors that affect

treatment program development and implementation. The targeted population consisted of staff from five clinical disciplines: Psychiatry, Psychology, Social Work, Activity Therapy, and Nursing. For data analysis purposes these disciplines were grouped into three main categories identified as: Administrative, Clinical, and Non-Clinical categories. This categorization allowed for larger data groups and provided anonymity to the participants, particularly for disciplines with small numbers of participants, such as Psychology and Social Work. There were 242 potential participants identified in the discipline classifications. The sample size of 90 was derived by sampling 50% of potential participants from each discipline, except for Nursing. Since the Nursing classification was significantly larger in size, sampling was restricted to 25% of potential participants.

Approval was received from hospital authorities to interview hospital staff at the facility, and the institution's process for the approval of research proposals was followed. Approval was also obtained from Western Michigan University's Human Subjects Institutional Review Board.

Structured interviews were the primary means of collecting the data. The interview questionnaire consisted of 17 questions related to program development and 17 questions related to program implementation. There were three parts to each questionnaire: Part I required the interviewer to document facts that were used to describe the sample. Part II used an open-ended format of questions to elicit a broad range of information on program development. Questions addressed the participants' involvement in program development, and explored the participants' perceptions of

factors that affect treatment program development. Part III explored the participants' thoughts on similarities and differences in viewpoints among the different classifications.

Because of this writer's administrative position at the institution and to assure that confidentiality of the participants was maintained, two nurses with previous experience at the institution were hired as research assistants to recruit participants and to conduct interviews. This writer did not recruit, interview, or have knowledge of those who were interviewed and what they said.

A Recruitment Script was used to recruit potential participants. It was designed to elicit the willingness and involvement of staff to participate in the study and to provide: (a) full disclosure of the participants' involvement, (b) a description of how confidentiality of information would be maintained, and (c) information on any potential risks to the participant for participating in the study.

The recruitment process consisted of identifying potential participants from a master list of names. The potential participant pool consisted of 1 out of every 2 participants in the Psychiatry, Psychology, Social Work, and Activity Therapy classifications, and 1 out of every 4 participants in the Nursing classification. Those individuals were contacted by telephone and in person, and they were asked if they were interested in participating in the study. If an individual did not wish to participate, then the next individual on the master list was called or contacted, and this process was repeated until the targeted number of participants was obtained.

Prior to agreeing to be interviewed, the research assistants obtained the participant's consent. This was done through a review of the Consent Form. The Consent Form addressed the Human Subjects Institutional Review Board's requirements for disclosing to the participant all aspects of the study, and required the participant's signature.

Interviews were conducted in a closed office to preserve the anonymity and confidentiality of the participant. The research assistant gave each participant a code number. These code numbers were arranged by discipline and by major category. No names were used. All interviews were taped and transcribed. Only transcripts with the participants' code numbers were forwarded to this writer.

The research assistants faced many challenges throughout the recruitment and data collection process. The primary problems were access problems. These included problems related to both access into the institution and access to potential participants who were on the units, particularly those in the Nursing classification. Participants in the Nursing classification were primarily engaged in providing treatment and unit operations. This affected the research assistants' ability to schedule interviews with any degree of predictability. Planned interviews were interrupted by such events as staff calling in sick, participants being reassigned to other units due to staff shortages, emergencies on the unit, and other unforeseen events.

To overcome some of these obstacles, the research assistants arranged on-unit appointments to facilitate data collection and to meet institutional operational needs. Sixty-one (61) individuals from the potential sample pool of 90 were interviewed. The

percentage distribution of total responses consisted of 25% in the Administration category, 29% in the Clinical category, and 41% in the Non-Clinical category.

Refusals to participate in the study were primarily in the Non-Clinical category and represented 86% of all refusals.

Data analysis occurred in two parts. Part I consisted of the reviewing and sorting of the transcribed interview responses. This resulted in a list of 17 factors that were identified as affecting treatment program development, and 16 factors that affected treatment program implementation. In Part II, the above factors were then rated after selecting a random sample of 30 participants from the total sample of participants. This subsample was used to reflect the opinions of the total group of participants. A Likert-type scale was used to rate the factors. This method of rating allowed a determination to be made as to the value placed on the importance of each factor on program development and program implementation. Participants placed a value of 1 through 5 on each statement that reflected a factor affecting treatment program development and affecting treatment program implementation. A median score was determined for each factor by ranking the scores for each factor. This median score reflected the perception of the majority of participants about the relevant importance of factors identified.

In the area of treatment program development, the results revealed that many of the factors affecting treatment program development were intertwined. The most important factor, represented by the highest median score, was *"staffing levels on the unit to do programming."* When comparisons were made between the Administrative,

Clinical, and Non-Clinical categories, the results revealed that there were differences between each category in what was perceived to be the most important factor. The Administrative category identified *"leadership /supervisory support"* as the most important factor. The Clinical category cited *"respect for others: expertise, input,"* while the Non-Clinical category identified *"staffing levels on the unit to do programming"* and *"cohesiveness/cooperation among the team"* as the most important. All of the subsample participants perceived the influence of *"political factors"* on treatment program development to be the least significant of all factors.

It should be noted that participants in both the Clinical category and Non-Clinical categories frequently cited the concept of the Treatment Team as an essential factor. Also, participants in the Non-Clinical category had a strong focus on the role of both the staff and the patient/prisoner in treatment program development.

In the area of treatment program implementation, the factors perceived to be important differed from those cited as affecting treatment program development. Findings revealed that the most important factor affecting treatment program implementation was the *"treatment team working together."* It was described by participants as *"a good functioning team."*

Common themes that emerged from the study differed with respect to both treatment program development and treatment program implementation. These findings are presented below.

Program Development

Themes from interviews about program development depicted a cohesive and harmonious planning concept. Participants referred to this theme in terms of *"the treatment team," "an active process of input," "interchange,"* and *"action focused in a specific direction and targeted to a specific agent or recipient"* (the patient/prisoner). Action, as a concept, incorporates the blending of the intangibles such as ideas, attitudes, education and training, and cooperation. These actions lead to the formulation of a plan, a treatment plan, that has a specific expectation and can be implemented in a variety of ways. Treatment program development participants reported assisting in interpreting and designing methods of implementation. The findings of this study revealed that the central theme related to treatment program development was *a blend of key factors*.

Program Implementation

Themes that emerged from interviews about program implementation reflected more action-oriented *processes* than action steps. These processes incorporated the how, when, and where of the developmental phase to arrive at a specific outcome. Tangibles such as funds, materials and supplies, staffing numbers, trained staff, and stable patients were reported by study participants to have a direct impact on this process. Participants viewed actions as circular and connectable with one set of factors having the potential to affect another set of factors, and all factors affecting each other positively or negatively. The participants reported that program

implementation requires more of a linking of factors than a blending of factors. The findings of this study determined that the central theme of program implementation was a *linking process*.

An effective linking process calls for the Program Planner to identify appropriate links in the implementation process to assure that implementation occurs. For example, in the program development phase of a treatment program, the need for patients/prisoners with a diagnosis of Schizophrenia to understand their mental illness is identified. The treatment team suggests that a Schizophrenics Anonymous group would be one way of addressing that need. To achieve the outcome of a treatment group for Schizophrenics, the Program Planner must begin to connect the applicable and appropriate resource links. This linking process may include factors such as:

- (a) what program or material resources on Schizophrenic Anonymous are available or can be made available; (b) how should the program be designed—for example, the number of sessions, length of sessions, and content of each session; (c) what funds are available to purchase these programs or materials; (d) who among the staff is knowledgeable, experienced, and interested in conducting such a treatment group; (d) what subset of the population should participate; and (e) what space is available.

Therefore, the linking process requires that the Program Planner be conscious that certain factors, such as those identified in this study, can affect implementation, and an analysis of those factors is necessary in order to properly link essential factors to any particular treatment program outcome.

Conclusions

The following conclusions are based on the findings in this study.

1. Factors that impact treatment program development and treatment program implementation are similar in description but have different applicability and at times overlap.

2. Many different factors affect treatment program development and implementation.

3. Factors are interrelated, inasmuch as they are connected and affect each other, and therefore cannot be viewed or treated in isolation from each other.

4. Factors identified as most important varied among the Administrative, Clinical, and Non-Clinical categories.

5. Safety and security concerns peculiar to the setting were reflected in many of the factors.

6. Knowledge of the factors affecting treatment program development and implementation impact planning for such services. Planning improves the effectiveness of processes that affect development and implementation if they are known, understood, shared, and applied.

Discussion

Conclusion 1: Factors that impact treatment program development and treatment program implementation were similar in description but had different applicability and at times they overlap.

The similarity in description potentially creates a perception that program development and program implementation are one continuous process affected by one set of factors. This is not necessarily the case. For example, *knowledge and expertise of staff* for treatment program development purposes (e.g., a conceptual base to develop a program) has a different meaning for treatment implementation purposes (e.g., skills grounded in knowledge to implement a treatment). One requires a level of professional and conceptual knowledge and experience in a field of practice, while the other requires skills, knowledge, and experience in how to make functional the knowledge and expertise to make implementation happen.

Implementation factors are those that relate to the ability of the Program Planners to actually put into place critical features (factors and standards). Often re-examination of the plan or design in place occurs as a result of implementation problems (Fixen & Blasé, 1993). It is important for planners to understand that the two processes have different foci and therefore the factors may have a different meaning and applicability. This holds true for other factors that may be similarly identified. The initial interpretation and application of factors must therefore be made with a thorough understanding of the context in which they apply.

Conclusion 2: Many different factors affect treatment program development and implementation. The range of possible factors is a product of the following:

1. The participants identifying the factors, their role, their interests, and the level of participation in the treatment program development and implementation process. The factors identified must therefore be utilized with this understanding of

the source from which the specific factors are derived. More than likely, each source portrays its own interests and motives.

2. The setting, or environment, in which treatment program development and implementation is occurring. The setting would include the population being served, the physical structure, and the institution's organizational culture. The factors identified are unique to the setting, and generalization to dissimilar settings cannot be made. However, one may be able to isolate certain universal core factors applicable to similar settings. For example, *milieu on the unit/safety of patients/safety of staff* may not be as important in a non-prison outpatient setting as in an inpatient prison setting.

3. Individual values, beliefs, and personal convictions of the participants. Embedded in the data collection process was the portrayal of the participants' perceptions. Personal preferences and bias automatically affect perception and the choices made. Planners must evaluate the extent to which individual preference and bias appear to dictate the factors identified, and screen these factors accordingly.

Conclusion 3: Factors are interrelated, meaning that "they are connected," affect each other, and therefore cannot be viewed in isolation from each other. A strong emphasis was placed by the participants on the need to think of factors affecting treatment program development and implementation as connected to a bigger picture rather than simply viewing them alone. The broader perspective allows for consideration of many factors at one time and their effect and relationship to each other.

Planners and program developers should formulate plans that connect factors together to assure that relationships among those factors occur. This would assist in the formulation of patterns that could have consistent application. An example of such a pattern would be: *education and experience* together generate skilled staff *interested and willing* to participate in treatment program development and implementation.

Conclusion 4: Factors identified as most important varied among the Administration, Clinical, and Non-Clinical categories. In the area of program development, participants in the Administrative category identified the most important factor to be *knowledge/expertise of staff*. Participants in the Clinical category identified *staff attitude/enthusiasm/prejudice*, while participants in the Non-Clinical category identified *staffing levels on each unit to do programs* as most important. Differences also occurred in the area of program implementation. These differences could result from many factors, such as the primary and differing focus and responsibilities within each category, and could vary with a change in the mix of participants. In addition, each category of participants may be unaware of what is important to other categories, and this could adversely affect overall treatment program effectiveness.

Planners and program developers need to be aware of what is important to groups within the planning process, and realize that participants in the process of treatment program development and implementation can be blind to each others'

priorities. Leaders have to assure that factors of importance and concern to each category are addressed in the planning and implementation process.

Conclusion 5: Safety and security concerns peculiar to the setting are reflected in many of the factors. Factors such as the *stability of the patients/prisoners/acuity, staffing levels, assessment and evaluation of patients/prisoners*, and possibly *education, training and skill of staff* affect unit safety. The factor of *safety and security*, although it was low in the ranking of importance, must be viewed for planning purposes as a factor that blends with and is integral to the other factors.

Conclusion 6: Factors affecting treatment program development and implementation impact planning for such services. These factors can provide information to planners on what should be considered important when developing and implementing treatment programs. Such factors may be unique to a setting or may have implications for similar settings.

Significance of Findings

Arbuthnot and Gordon (1988) identified a few critical factors affecting treatment program development and implementation that were supported by the findings from this study. They suggested that managers and administrators should have some understanding of the problems related to program development and implementation, and be aware of the success and effectiveness of behavioral treatment for the population they serve (p. 279). They emphasize the importance of identifying one person, as opposed to a team, who will fight to maintain interest, motivation,

enthusiasm, and accountability for the team's mission. These authors also made several recommendations that closely parallel the findings in this study. For example, they suggested that corroboration with the person designing the program and the agency staff affect the success of the programs. They also recommended changing the qualifications of staff involved to individuals with postsecondary education.

Studies done by Collins, Ellsworth, Casey, Hickey, and Hyer (1984), and Ellsworth et al. (1979) indicate that none of the following had any relationship to program effectiveness: staff/patient ratio, a high number of professional staff, or the presence of a qualified psychiatrist. However, the stability of shift assignments and stability of front-line staff were related to program effectiveness. Although the present study did not address program effectiveness specifically, it is the writer's experience and belief that factors affecting program development and implementation also affect program effectiveness. Finally, results from this study concur with findings by Ronald Greene (1988) that identified mutual respect and open communication as key elements in communication among mental health staff working together.

In conclusion, findings from this study give support to the proposition that effective treatment program development and implementation can occur if knowledge of those factors is known and understood. This knowledge is acquired through proactive efforts at isolating and defining as clearly as possible all factors that are perceived to have an impact on treatment program development and implementation. The benefits of a proactive approach allow for the inclusion of this knowledge and information into the planning process. With respect to the findings in this study, it

supports the assertion that the inclusion of qualified, knowledgeable, and experienced staff in the treatment program development process is a number one priority. This single factor had a direct effect on the planning process and the expected outcome, and also affected many other factors, thereby shaping the outcome of the treatment development process. Administrators must utilize this knowledge when hiring prospective employees.

In contrast, the most important factor affecting treatment program implementation was the concept of "a work in progress." The beginning and ending of the process were less defined, conveying more of a process that continuously links and loops factors into each other. Leadership must recognize the need to sustain linkages in order to promote a harmonious working relationship among factors to achieve program implementation. Such linkages must include adequate funding, materials, and resources; adequate space; a multidisciplinary cohesive working team; and sufficient staff. Further, of importance is the fact that the recipient of service, the consumer, must be linked to the process. Finally, policies must exist within organizations that take into account the findings of this study. The resulting knowledge gained about planning efforts as these should improve program development and implementation.

Limitations of the Study

The principal purpose of this research study was to identify the most important factors affecting treatment program development and implementation in a

psychiatric hospital that provides care to mentally ill prisoners. This was achieved. A sample of all disciplines involved in this process participated in the study and provided a wide variety of information on those factors. There were, however, some inherent limitations.

One of the primary limitations of the study concerns external validation. The research was conducted in one correctional mental health facility that had its own unique organizational culture and operational structures. Treatment program designs at this facility are also reflected in the institution's economic, political, and environmental factors. Therefore, the identification of factors affecting treatment program development and implementation in the setting for this study cannot be generalized to other correctional mental health facilities, or to other facilities that serve mentally ill prisoners.

Second, the research design did not lend itself to the advantages of a true qualitative study where the writer could, through an established relationship with the participants, explore information and leads that would provide enlightenment on a particular subject or point of interest. The writer's inability, due to an administrative position, to participate in the interview process resulted in lost opportunities to do a pure or true exploratory study and expand on the meanings of factors identified. Thus, by providing protection to the participants, the study design restricted interpretation of the findings by this writer.

Third, the number of participants representing the sample size in both phases of data collection (60 participants in Phase 1, and 25 participants in Phase 2) was not

large enough to allow for a broad interpretation of the data gathered. There was also a limited number of participants representing each of the categories within the total sample. The number of participants representing each discipline and category was small in spite of adjustments made to group disciplines into larger categories. This study was, in essence, an exploratory study.

Fourth, one threat to data accuracy was posed by the participants' interpretation of the concepts of treatment program development and treatment program implementation. Participants were often involved in program development and implementation due to their roles at the facility. That fact may account for the similarity of descriptions on the factors identified for both program development and program implementation.

Despite these limitations, however, the results are enlightening. The results of this study now provide a set of prioritized factors that will hopefully give direction to future treatment planning and implementation in this area.

Recommendations

In mental health settings that provide services to mentally ill prisoners, planning for the provision of treatment programs should be an active and continuous process. Planning should incorporate efforts targeted to achieve a particular goal, in this case, treatment program development and implementation. Although this goal may be one of many other goals, administrators, who may be the early planners,

should give equal weight to what is needed for both program development and implementation to be effective. To this end, the following recommendations are made:

1. Administrators, directors, and managers should have a clear theoretical framework of what needs to be achieved, that is, they should embrace Program Plan or design. This framework should be established early and be reframed as appropriate. Such a framework allows planning to occur within a context to achieve a desired outcome. The context should also reference the numbers of staff in specific categories, and the number of staff with specific pre-identified qualifications and experience within categories to implement the treatment framework identified. The context should also link how implementation is to occur and by whom.

2. Administrators, directors, and managers should target hiring to look for a fit between the applicant and the goals and expectations within the setting. Such targeting moves beyond the qualifications of the applicant to an assessment of the applicant's behavioral attributes. Findings from the study identified that staff's willingness, motivation, interest, and attitude are important factors affecting treatment program development and implementation. For example, in an attempt to assess motivation, an applicant may be asked the following question, "You are involved in a complicated project in which you have a specific part; how would you begin?"

3. Individuals charged with treatment program development and implementation should: (a) be knowledgeable about the contextual framework established by institutional leaders; (b) assure the early involvement of staff involved in treatment program development and implementation in planning processes;

(c) design a planning structure that reflects representation of all disciplines and or categories of staff in treatment program development and implementation; (d) recognize that development, implementation, and evaluation is a continuous process and the factors affecting each may be interrelated, may be the same, or may have a different meaning; (e) recognize that the motives and incentives of each participant and that one participant may not be aware of the interest and needs of the other; and (f) assure that communication remains open to facilitate an understanding and resolution of issues. This is essential to effective planning.

4. An active relationship should exist between the Program Planner and administrators, directors, and managers to assure that the support needed to achieve the treatment planning and implementation outcomes are met and sustained. For example, "*trained staff*" was identified as an important factor. The training of staff may need to be continuous and may need to be addressed in many ways. It may also require the coordination and the cooperation of other departments. Training may also require sustained funding to cover such aspects as overtime to cover staff's attendance at training. Funds will need to be reflected in the staffing and training budgets early in the process to achieve this and to avoid having to undo bad habits or change poor attitudes.

5. Administrators, directors, managers, and planners must think through the entire planning process beginning with the assessment of the need, followed by the development of the plan and the implementation of the plan. Evaluation of factors that

affect treatment program development and implementation must be done. Both formative and summative evaluation approaches must be built into this process.

6. Efforts must be made to identify areas of need for the allocation of resources—human, material, and financial—if effective program development and implementation are to be achieved. This study identified many factors, the management of which requires resources. Failure to allocate appropriate resources would leave program implementation floundering and make program development futile.

7. The planning process should use a research design to structure the development and implementation of treatment programs and the evaluation of treatment outcomes. This would lead to theoretical and conceptual building for model development and testing.

Suggestions for Future Research

1. Replicate the research method in this study using a larger sample size. In addition, the research method could incorporate institutions of various sizes, structure, and treatment approaches.

2. Determine whether the use of a structured planning approach to do treatment program development and implementation results in the desired treatment outcomes as compared to programs which do not use such an approach.

Appendix A
Recruitment Script

Recruitment Script:**1. Introduction**

- a. Hello ! ☺
- b. My name is (interviewer name):
- c. I am contacting you to invite you to participate in a research study.

You are being contacted because you are currently working in one of the facility's clinical departments. This research is part of Ruby Meriweather's doctoral course requirements at Western Michigan University's School of Public Affairs and Administration.

She is conducting a study on treatment program development and believes the input of clinical and non-clinical staff is crucial in understanding the factors that affect program development and implementation. You were selected at random from a master list of employees. I will be asking several individuals from each of the disciplines whether they would volunteer to participate in the study.

If you agree to participate, you will be asked to take part in an interview that will last approximately 30 minutes.

2. Screening Question to Determine Participant Eligibility

- a. In order to participate in this study you must have worked at this facility for over a year.
- b. How long have you worked at this facility? ____months ____years.

1. ____ Subject excluded from study – no further discussion/script.

Thank them for their time and interest.

2. ____ Subject included in study – proceed with discussion/script.

That's great ! ☺ Let me tell you more about the study

3. Purpose of the Study

- a. The purpose of the study is to identify what factors affect treatment program development and implementation.

- b. It is expected that this information will be helpful to other similar prison hospitals in developing and implementing effective treatment programs.

4. Selecting Persons to Participants in the Study

- a. Your name was selected in a random manner as mentioned earlier..

- b. This was done to assure that a group representative from each of the Disciplines involved in the treatment program participated in the study and had its viewpoints included.

5. Expectations of Participant

- a. You will be asked to answer a few questions about your opinions on what factors affect developing and implementing treatment programs. Your responses will be tape recorded and documented on a paper form. The taped interviews will be transcribed. Once the factors have been identified by all the participants, some of the participants will be

randomly selected and asked to participate in the second phase of the study. These participants will be sent a brief questionnaire and asked to rate the importance of factors identified earlier in Phase I

6. Confidentiality Protected

- a. Your decision on whether or not you choose to participate will remain confidential.
- b. The confidentiality of your responses will be assured as each of the responses and questionnaires will be given a code number.
- c. Only group data will be reported. – No individual participating in the study will be identified.
- d. The Master list containing participant names and their codes numbers, all interview notes and tapes will be kept in a locked file cabinet at Western Michigan University that is not accessible to Ms. Meriweather.

7. Risks and Benefits of Participating in the Study Project

- a. It is expected that you may benefit from having had an opportunity to discuss your viewpoints about what is most important in planning, developing and implementing effective treatment programs.

Your contribution may influence decisions regarding the development and implementation of treatment programs and indirectly benefit you if

findings from the study are utilized in decisions affecting program development and implementation.

b. The only risk to you participating in this study is the inconvenience of being interviewed on your lunch break or after work.

1. Your successful employment at this facility is not contingent or dependent upon your agreement or refusal to participate in this study.
2. You may withdraw from the study project at any time without jeopardizing your employment here, job assignment, job security or any other aspect related to your employment.

8. Do you have questions you would like to ask me?

9. I have a Consent Form that specifies everything you need to know about participating in the study. I ask that you review it before acknowledging your interest in participating. If you are willing to participate in the study you may sign the consent form, if not, then do not sign.

If yes, can I schedule you to conduct the interview?

Appendix B
Consent to Participate in Research

**WESTERN MICHIGAN UNIVERSITY, SCHOOL OF PUBLIC AFFAIRS
AND ADMINISTRATION**

**Factors Affecting Treatment Program Development in a Mental Health Facility
Serving Prisoners**

Principal Investigator, Peter Kobrak, Ph.D.

Student Investigator, Ruby Meriweather, RN, MPH, MBA

You are invited to participate in a research study. You have been selected to participate because you are currently working in one of the facility's clinical departments. This research is part of Ruby Meriweather's doctoral course requirements at Western Michigan University.

The purpose of this study is to learn what factors affect treatment program development and implementation. Staff in all disciplines of this facility will be interviewed about their thoughts on these factors. There are two phases to this study: 1) interviews with participants; and 2) analyzing the importance of the factors identified in developing and implementing effective treatment programs.

If you volunteer to participate, you will be asked to take part in an interview. You may choose not to participate and withdraw from the study or stop participating at any time without prejudice, penalty or any risk to your employment or status with Huron Valley Center.

Phase I

If you agree to participate, you will meet with either Marie Mc Dade or Catherine Nkuta in a private office during your lunch period (or after work) on a day and time that will be scheduled. You will be asked to answer a series of questions about issues relating to program development and implementation. Your responses will be taped recorded and documented on paper form. The interview will last approximately 30 minutes. The taped interview will be transcribed by Marie McDade or Catherine Nkuta, but your name and other potentially identifying information will be omitted or disguised. You may, if you wish, listen to the tape and request that some of your comments not be transcribed. Once the transcription is completed, the tapes will be erased. Ruby Meriweather will only have access to the transcriptions with all identifiers removed. This arrangement will help assure the confidentiality of your responses.

Phase II

Some participants will be invited to participate in the second phase of this study. If you are selected, you will be sent a brief questionnaire and asked to rate the importance of factors identified in Phase I. This questionnaire will be completely anonymous so do not put your name on it. If you choose not to participate in Phase II simply discard the questionnaire. Returning the questionnaire means that you consent to have the answers you supply used as research data. The only risk to you from participating in this study is the inconvenience of being interviewed on your lunch break or after work. There will be no negative consequences for not

participating or for withdrawing from the study. If you feel any risk to your employment from being in the study you may contact The Director of the hospital at ext. 3186, or utilize the process provided by Union Contracts or Civil Service for filing any concerns.

Measures will be taken to protect your privacy and the confidentiality of the answers you provide. Only aggregate data will be reported in the study. Answers from members of groups or disciplines with fewer than five members, will not be reported as coming from a specific group. All data will be stored in a locked cabinet in the Principal Investigator's office at Western Michigan University for at least three years after the end of the study, and then destroyed.

You may benefit from participating in this study by having the opportunity to discuss your ideas about what affects treatment program development and implementation.

Your contribution to this project may indirectly benefit you if these findings are applied to the planning of treatment programs at this facility. This study may also be helpful to others treatment facilities.

If you have any questions or concerns about this study, you may contact either Peter Kobrak at 267-387-8942 or Ruby Meriweather at 734-434-9639. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293, or the Vice President for Research at 269-387-8298 if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of

the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old.

Your signature below indicates that you have read and /or had explained to you the purpose and requirements of the study, and that you agree to participate.

To assure confidentiality you also agree that you will not share with your peers or others that you will be participating in the study or the content of the interview.

Participant Signature

Date

Signature of Person Obtaining Consent

Date

Appendix C
The Structured Interview Instrument

The Structured interview Instrument

PART I. DEMOGRAPHIC DATA

Code:-----

Job classification:-----

Type:

Clinical----- Non clinical----- Administrative-----

Shift:

AM, PM

Unit primarily assigned:

Acute----- Subacute----- Medical----- Female-----

Number of years worked in a Correctional Mental Health agency-----

Part II. Program Development

1. In what ways do you participate in developing treatment programs?
Explain.
2. What do you do or have to do in treatment program development?
Comment-
3. In this kind of a setting, how do you see yourself involved in program development ? Comment-
4. What makes it possible for you to do what you think needs to be done in patient program development?
5. List all the factors that affect treatment program development. Out of that list, what is most important?
explain----- describe-----give examples-----

6. Of the factors you listed, are any of these more important in program development than the others?
 - a) which (one)s ?
 - b) explain your answer
 - c) give some examples
7. Are any of these factors related to one another?
 - a) If yes, in what ways(s) are they related to one another?
 - b) What are your reasons for not including the other factors?
8. Do your ideas about program development differ from that what others think?
Which discipline(s) agree with you on this? Explain your answer.
9. If you could make a recommendation to President of the United States or to someone who has power and authority re: treatment program development, what recommendations would you make?
10. What barriers need to be overcome to assure that effective treatment programs are developed?
11. What can be done to improve program development in a prison setting?
12. If you could create a treatment program, what would that consist of?
13. If you had a budget of \$100,000 dollars to develop treatment programs, how and where would you spend those dollars?
14. If you wanted to make a point about something important related to program development, what would you do?
15. What contributes most to your being able to do what you think needs to be done regarding program development?

16. In developing effective treatment programs, is there a common theme?

What might that be?

17. Is there anything else you want to share with me?

Part III. Program Implementation

1. In what way (s) do you participate in treatment program implementation now?

Explain:

2. What do you do or have to do in treatment program implementation?

Comment:

3. In this setting, how do you see yourself involved in treatment program implementation? Comment:

4. What makes it possible for you to do what you think needs to be done in program implementation? Explain:

5. List all the factors that affect treatment program implementation. Out of that list, what is most important ? Explain----- describe-----

6. Of the factors you have listed, are any of these more important in program implementation than the other?

a) which one or ones?

b) explain your answer

c) give examples

7. Are any of these factors related to one another?

a) If yes, in what way(s) are they related to one another?

b) What are your reasons for not including the other factors?

8. If you could make a recommendation to someone with power and authority re: program implementation, what would your recommendation be?
Comment:
9. What barriers need to be overcome to assure the effective implementation of treatment programs? Comment:
10. What can be done to improve program implementation in a prison setting?
11. If you had a budget of \$100,000 dollars to implement treatment programs, how and where would you spend those dollars?
12. Do your ideas about treatment implementation differ from what others think?
Which disciplines agree with you on this? Explain your answer.
13. If you want to make a point about something important relating to treatment program implementation, what would that point be?
14. What contributes most to your being able to do what you think needs to be done regarding program implementation?
15. In implementing effective treatment programs, is there a common theme?
What might that be?
16. Is diversity important in program development?
 - a) Explain your answer.
 - b) Give me a couple of examples.
17. Is there anything else you want to share with me?

END OF SURVEY INSTRUMENT

Appendix D
Master List Code Form

MASTER LIST CODE FORM

Department	Name	Classification	Code Number	Date Interview Completed	Date Rank Order Completed
Psychiatry	-----	Administrative	APS001		
			APS002		
		Clinical	CPS003		
			CPS004		
			CPS005		
			CPS006		
Psychology		Administrative	APY007		
			APY008		
		Clinical	CPY009		
			CPY010		
			CPY011		
			CPY012		
Social Work		Administrative	ASW013		
		Clinical	CSW014		
			CSW015		
			CSW016		
			CSW017		
Activity Therapy		Administrative	AAT018		
		Clinical	CAT019		
			CAT020		
			CAT021		
			CAT022		
			CAT023		
			CAT024		
			CAT025		
Nursing		Administrative	ANU026		
			ANU027		
			ANU028		
			ANU029		
			ANU030		
			ANU031		

Department	Name	Classification	Code Number	Date Interview Completed	Date Rank Order Completed
Nursing	-----	Clinical RN	CNU032		
			CNU033		
			CNU034		
			CNU035		
			CNU036		
			CNU037		
			CNU038		
			CNU039		
			CNU040		
			CNU041		
			CNU042		
			CPN043		
			CNU044		
			CNU045		
			CNU046		
			CNU047		
		Clinical LPN	CPN048		
			CPN049		
			CPN050		
			CPN051		
			CPN052		
			CPN053		
			CPN054		
			CPN055		
			CPN056		
			CPN057		
			CPN058		
			CPN059		
			CPN060		
			CPN061		
			CPN062		
			CPN063		
			CPN064		
			CPN065		
			CPN066		
		Non-Clinical AM Shift	NCA067		
			NCA068		
			NCA069		
			NCA070		

Department	Name	Classification	CODE NUMBER	Date Interview Completed	Date Rank Order Completed
Nursing	-----	Non-Clinical AM Shift	NCA071		
			NCA072		
			NCA073		
			NCA074		
			NCA075		
			NCA076		
			NCA077		
			NCA078		
			NCA079		
			NCA080		
			NCA081		
			NCA082		
			NCA083		
			NCA084		
		Non-Clinical PM Shift	NCA085		
			NCA086		
			NCA087		
			NCA088		
			NCA089		
			NCA090		
			NCA007		
			NCA091		
			NCA092		
			NCA093		
			NCA094		
			NCA095		
			NCA096		
			NCA097		
			NCA098		
			NCA099		
			NCA100		
			NCA102		

Appendix E
Research Project—Likert Rating Scale

Code #-----

Research Project –Part II Factors Affecting Treatment Program Development & Implementation

From the interviews conducted earlier, the following factors have been identified to be the most important factors affecting treatment program development at this facility. The data analysis identified 17 factors as being important to program development. A sample of you are being asked now to rank these factors based on your perception of their importance in affecting program development on a scale of 1–5, with 5 being the most important. Please take a few minutes to rank the following:

Scale: 1=least important 2=somewhat important 3=important 4=very important 5=most important

1. Cohesiveness/cooperation among treatment team	1	2	3	4	5
2. Knowledge/expertise of staff	1	2	3	4	5
3. A good program idea/creative idea to design	1	2	3	4	5
4. Leadership/supervisory support	1	2	3	4	5
5. Political factors	1	2	3	4	5
6. Education/training of staff	1	2	3	4	5
7. Funds/Money/materials/supplies	1	2	3	4	5
8. Programs designed to meet patient needs	1	2	3	4	5
9. Patient attitude/behavior/interest in programming	1	2	3	4	5
10. Patient instability/acuity	1	2	3	4	5
11. Time within a schedule to do programming	1	2	3	4	5
12. Milieu on the unit/ safety of patient/safety of staff	1	2	3	4	5
13. Staff attitude/enthusiasm/prejudices	1	2	3	4	5
14. Cooperation of staff to achieve a treatment goal	1	2	3	4	5
15. Respect for others: expertise, input	1	2	3	4	5
16. Staffing levels on the unit to do programming	1	2	3	4	5
17. Flexibility to design and plan programming	1	2	3	4	5

Comments _____

Code #-----

Research Project –Part II
Factors Affecting Treatment Program Development & Implementation
Ruby Meriweather

From the interviews conducted earlier, the following factors have been identified to be the most important factors affecting treatment program implementation at this facility. The data analysis identified 16 factors as being important to program development. A sample of you are being asked now to rank these factors based on your perception of their importance in affecting program development on a scale of 1 –5, with 5 being the most important. Please rank the following:

Scale: 1=least important 2=somewhat important 3=important 4=very important 5=most important

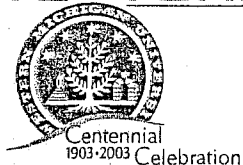
1. Treatment-team working together/ good functioning team	1	2	3	4	5
2. Education /training/experience /skill of staff	1	2	3	4	5
3. Approval of a plan	1	2	3	4	5
4. Support	1	2	3	4	5
5. Flexibility/autonomy to do ones job	1	2	3	4	5
6. Security-management of the patient/patient/tools	1	2	3	4	5
7. Funds/money/ resources/materials/supplies	1	2	3	4	5
8. Assessment/ evaluation of the patient	1	2	3	4	5
9. Patient attitude/ behavior/motivation	1	2	3	4	5
10. Patient diagnosis/acuity /stability of the patient	1	2	3	4	5
11. Time /schedule/availability of space to do programming	1	2	3	4	5
12. Security measures-count, emergencies	1	2	3	4	5
13. Staff willingness/motivation/interest/resistance	1	2	3	4	5
14. Cooperation of staff to achieve a treatment goal	1	2	3	4	5
15. Coordination with others	1	2	3	4	5
16. Human resources: number of staff, # of clinicians	1	2	3	4	5

Comments _____

Appendix F

Human Subjects Institutional Review Board Approval Letter

WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: January 30, 2003

To: Peter Kobrak, Principal Investigator
Ruby Meriweather, Student Investigator for dissertation

From: Mary Lagerwey, Chair

A handwritten signature in cursive script, appearing to read "Mary Lagerwey".

Re: HSIRB Project Number: 01-12-11

This letter will serve as confirmation that the changes (new interviewers) to your research project "Factors Affecting Treatment Program Development in a Mental Health Facility Serving Prisoners" requested in your memo dated January 28, 2003 have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: January 6, 2004

Walwood Hall, Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276

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