Development and Implementation of START NOW within a Correctional System

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Abstract

START NOW is a manualized mental health intervention which primarily employs a cognitive behavioral approach to treat incarcerated individuals with behavioral disorders. This paper describes the process of development and statewide implementation of an evidence-informed mental health program within a department of correction which can provide guidance for systems with similar objectives. Processes the team employed to address unique barriers confronted within the correctional environment and lessons learned and recommendations regarding program coordination, the value of statewide communication, the utilization of coaches in enhancing the process, and the need for flexibility in correctional program development and implementation are discussed.

*Keywords:* cognitive behavioral therapy, skills training, intervention, corrections, START NOW
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Development and Implementation of START NOW within a Correctional System

The need for mental health treatment among the incarcerated is great (Thigpen, 2007; Trestman, Ford, Zhang, & Wiesbrock, 2007), with three times more mentally ill people in prison and jails than in hospitals (Torrey, 2010). At the same time, treatment resources within correctional settings are often quite limited (Katel, 2011). There is a need for effective and economical therapies to treat incarcerated individuals with significant mental health issues. This paper describes the development and integration of START NOW, an evidence-informed model of mental health treatment, into a large correctional system, including the challenges related to the development, implementation, and early evaluation of START NOW (Shelton & Wakai, 2011). The specific strategies this health care system employed to meet those challenges provide guidance for other groups working to integrate structured treatments within correctional systems.

Literature Review

START NOW: Theoretical Perspectives

START NOW is an integrative evidence-informed model of treatment developed from a National Institute of Justice-funded study (2002-IJ-CX-K009) that tested a version of Dialectical Behavior Therapy, i.e., DBT, (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) adapted for correctional settings. Dialectical Behavior Therapy (DBT) was originally developed to treat people diagnosed with Borderline Personality Disorder, targeting associated impulsive and self-destructive behaviors (Linehan et al., 1991). While various correctional facilities implemented versions of DBT (Berzins & Trestman, 2004; McCann, Ball, & Ivanoff, 2000) it was found that maintaining such programs can be cost-prohibitive in correctional systems (Shelton, Sampl, Kesten, Zhang, & Trestman, 2009). In a study of DBT, modified for implementation in a correctional environment (Shelton et al., 2009), the first phase of treatment provided skills
training groups alone, without concurrent individual therapy. Post-group, participants showed reduced aggression and disciplinary infractions, and improved mood and coping skills.

Cognitive Behavior Therapy (CBT) involves learning and practicing new skills both within and between therapy sessions (McDonald & Morgan, 2013). CBT has emerged as the “predominant psychological method of treating not only mental illness, but a broad spectrum of socially problematic behaviors including substance abuse, criminal conduct, and depression” (Thigpen, 2007). Several meta analyses have been conducted illustrating the value of cognitive-behavioral therapy as an effective tool in reducing criminal behavior and recidivism (Pearson, Lipton, Cleland, & Yee, 2002) as much as 20-30 percent compared to control groups (Wilson, Bouffard, & Mackenzie, 2005). Additionally, Vaske, Galyean, and Cullen (2011) summarized numerous studies indicating that CBT is effective because offenders tend to have the types of neurocognitive deficits which are positively impacted by CBT.

Motivational Interviewing (MI) is a client-centered approach designed to address ambivalence and elicit motivation for change (Miller & Rollnick, 2002). CBT and MI have been combined in other effective treatment interventions (Dennis et al., 2004; Diamond et al., 2002; Steinberg et al., 2005) and research has broadly supported the use of MI with offenders (Davis, Baer, Saxon, & Kivlahan, 2003; Harper & Hardy, 2000; Anstiss, Polaschek, & Wilson, 2011; Stein, et al., 2006b; Clark, Walters, Gingerich, & Meltzer, 2006).

A neurocognitive rehabilitation approach is also important in this population, as studies have reflected that a significant number of incarcerated individuals have had traumatic brain injury (Williams et al., 2010), and standard therapies may fail if these impairments are not taken into account (Fishbein et al., 2009). Consequences of TBI may include reduced verbal capacity and shortened attention.
Cognitive behavior therapy, motivational interviewing, and neurocognitive rehabilitation are all key theoretical underpinnings of START NOW. MI complements the overall CBT approach of START NOW: MI can develop offenders’ motivation to change their maladaptive behaviors (Chambers, Eccleston, Day, Ward, & Howells, 2008; Howells & Day, 2006) and CBT provides the tools to effectively carry out this change. START NOW is also designed to take into account limitations such as those related to TBI and other neurocognitive deficits.

Considerations for Development and Implementation

The development and implementation of an evidence-informed mental health treatment intervention in a large correctional system presents many unique challenges. There is no “single roadmap” for implementing evidenced-based practice (Domurad & Carey, 2010). However, Domurad and Carey suggested that organizations share multiple commonalities in their initial steps towards implementation, including the engagement of leadership, involvement of line staff, use of an empirically-based risk/needs assessment tool, training, focusing more intensive interventions for their higher risk offenders, and quality assurance. In research related to the implementation of effective drug treatment programs in correctional settings, barriers identified included client identification, assessment, and referral; recruitment and training of treatment staff; redeployment of correctional staff; over reliance on institutional versus therapeutic sanctions; aftercare; and coercion (Farabee et al., 1999).

Program evaluators, including Harris and Smith (1996) and Petersilia (1998), assert that the method in which a program is implemented is at least as crucial as the actual program itself. Farabee et al. expressed additional concerns, stating,

the extent to which these model programs are being faithfully replicated is not clear.

What is clear is that the rapid and poorly planned implementation of correctional
treatment programs places these programs at risk of being less effective than the programs after which they were modeled. (1999, p. 160)

In a study by Martin, Inciardi, Scarpitti, and Nielsen (1997), a case management program for drug involved parolees was used to illustrate that poorer than anticipated outcomes were obtained due to inappropriate implementation of the program, thereby emphasizing the need for effective program fidelity monitoring during the process. Prendergast and Wexler (2004) stated that a commitment to making evaluation an integral component of program implementation in an effort to ensure that identified goals are met and program quality is maintained or improved, was more important than whether or not the evaluation was conducted by agency staff or outside experts.

Farabee et al. (1999) provided suggestions on how to address potential barriers; however, they emphasized that the actual solutions to those challenges are likely unique to the system in which they are found. They also suggested that the actual identification of potential problems is more important than the actual suggested solutions themselves.

Development and Implementation of START NOW

Program Development

Given the relevant literature and the common resource limitations within correctional mental health care, a work group was formed to develop a cost effective manual-guided group therapy for offenders with behavioral and emotional disorders. A panel of clinicians and researchers with expertise in correctional mental health treatments (see Acknowledgements) was consulted to identify critical coping skills for rehabilitation, institutional adjustment and facilitating lower levels of recidivism. Dr. Diana Fishbein, a cognitive neuroscientist focused on cognitive issues among inmates (Fishbein et al., 2009), was consulted at numerous points in the
development process to tailor the intervention, taking into account neurocognitive research findings. The resulting intervention utilizes group therapy as the primary treatment approach to allow offenders to provide support and feedback to each other, and to increase the cost-efficiency of treatment (Wilson et al., 2005).

Following the review of relevant literature and consultation with advisory panel members, a detailed facilitator’s manual was developed that included: the theoretical and research background of the intervention; the specific parameters of treatment; comprehensive session-by-session implementation instructions; and fidelity monitoring procedures. A companion gender-specific participant workbook was also created, incorporating examples relevant to incarcerated individuals, and including all of the needed participant handouts and practice exercises. The participant workbook was written at a fifth grade reading level and included many iconic images throughout to enhance understanding and retention, with repetition of key concepts and real-life practice of skills emphasized throughout the intervention.

*Initial Implementation Efforts*

START NOW was initially piloted at a maximum security facility for men with serious mental health disorders. Twelve mental health and correctional staff members (counselors and clinical treatment officers) were initially trained. The support of custody and mental health facility leadership was enlisted by providing an overview of the intervention and its potential benefits regarding safety and security. One of the lead clinical developers of START NOW (S.S.) provided monthly on-site consultation meetings to the facilitators to provide support with both clinical and pragmatic issues of implementation. She also observed each of the groups once per START NOW cycle, rating the groups for fidelity of implementation, and providing corresponding feedback. The initial clinical opinion of group facilitators suggested that those
inmates receiving START NOW benefited from the intervention. Subsequently, efforts to introduce the program system wide ensued. A total of seventy staff members were trained, representing a variety of professional disciplines from eleven correctional facilities.

Shelton and Wakai (2011) conducted a process evaluation of early START NOW implementation at two maximum security correctional facilities (the facility for male offenders with significant mental health issues, and the only state facility for female offenders). Utilizing a convenience sample of 26 inmates (18 male, 8 female), they reported encouraging findings. On the participant satisfaction survey, 85% of participants reported that they were very satisfied with their START NOW participation; retention statistics showed 85% of inmates completed more than half of the 32 START NOW sessions, with 31% completing all of the sessions. Compared to rates prior to START NOW participation, there were reductions in the post treatment rates of disciplinary infractions, number of days in segregated housing, and number of days in the inpatient mental health unit.

In a study by Kersten, Cislo, Lynch, Shea, and Trestman (2015), 846 inmates (totaling 953 program participation events) who participated in the START NOW program from 2010 through 2013 had a 5% decrease in the incident rate of disciplinary reports received with each additional session attended. The study also controlled for overall security risk scores, psychiatric diagnosis and comorbidity, and sociodemographic factors. Program participation was robust to all groups with those inmates having the highest overall security risk scores benefiting the most.

Further analysis of this study focused on the number of inpatient psychiatric days in relation to the number of START NOW sessions completed (Cislo & Trestman, 2016). Consistent with the findings referenced above, with each session completed there was a 5%
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decrease in subsequent inpatient hospital days. Caution in interpreting these results was recommended because of the relatively limited, yet sufficient, sample size of inpatient psychiatric hospitalizations and because the effects of other programming received in addition to the START NOW intervention could not be accounted for; however, these encouraging findings strongly suggested the benefit of START NOW and the continued need to test this intervention.

_Custody and Administrative Engagement_

One of the essential elements in integrating a state-wide program within a correctional system is the engagement of Custody and Administration. Administrative and Custody support played an integral role not only in the operational aspects of obtaining space, access to inmates, etc. but also in terms of resource commitment and sustainability. Otherwise, the perceived cost (disruption to facility activities, reallocation of resources, and investment of time and money to train custodial and health service personnel in the model) may be perceived to outweigh potential benefits of implementation. Marginal acceptance without buy-in has the potential to undermine the implementation process through delay, apathy, or institutional barriers.

_Program Coordination_

A crucial factor for successful implementation of a new treatment program is program coordination. As the START NOW program developed and expanded, it was determined that a coordinator was needed to facilitate interdisciplinary collaboration through regular meetings and communication, identify and address roadblocks to implementation, track and report the extent of program implementation within the system (e.g., tracking which staff members were trained, the number of current participants, and collection of relevant outcome indicators), and insure that all data necessary for outcome evaluation was collected.

_Needs Analysis_
The Coordinator required a clear understanding of the program, its goals, and, where present, the issues or barriers hindering those goals from being met. To develop this understanding START NOW-trained staff from each of the initial facilities was interviewed individually as were groups of staff to obtain feedback on program implementation. A standard set of questions was posed during this process. These questions addressed fidelity monitoring, supervision, the referral process, whether the current groups were open or closed, data entry, the management of offenders referred to or currently receiving START NOW treatment upon transfer to other facilities, the knowledge and use of a newly developed agency website partially dedicated to START NOW and the collection of data, inmate satisfaction surveys, continuous quality improvement, custody involvement, and training. At the end of the interview process, staff was asked for additional feedback regarding the program that might help improve the program itself or its implementation. Finally, group facilitators were asked if they thought that the program was effective in changing inmate behavior.

**Corrective Action Plan**

Results of the interview process were collected and a detailed report of the findings at each facility served as a tool in guiding implementation. A corrective action plan (CAP) was developed that outlined all issues identified during the process. These issues were broken down into categories, including: Group Enrollment, Group Process, Custody, Training, Research/Information Technology (IT), and Evaluation. Each category had several areas for follow-up or modification.

Given the extent of the concerns identified through the needs analysis and the logistics of enforcing these statewide, a Steering Committee was established to include the Executive Director, mental health leadership, a training representative, an information technology
specialist, continuous quality improvement and program evaluation staff, and the START NOW Coordinator.

The CAP was introduced and subsequently reviewed at each Steering Committee meeting. Facility feedback was also reviewed and information was adopted, modified, or respectfully declined as a means of enhancing programmatic and implementation success. The essential component of this process was that a direct line of communication had been established by which feedback was received effectively and considered between facility-level and administrative staff.

One year after the CAP went into effect, 25 of the 29 (86%) issues identified had been resolved. As a result of the enhanced communication and support during this initiative, the team was able to tackle issues such as the identification and follow-up of material and equipment needs, alternative approaches to program-specific challenges that develop, time management concerns, staff resistance, the promotion of collaboration through training initiatives, etc. Overall, the needs analysis and CAP process provided the structure necessary to facilitate informed discussion and establish a framework from which to modify the implementation process, expand the program system wide, and to proceed in a more standardized manner.

Training and Coaching

As a result of the needs analysis and CAP, the need to establish a more efficient manner of communication between the Steering Committee and facility-specific staff was identified and a system was developed to support the training and ongoing clinical work of mental health staff. Dean Fixsen, PhD (Co-director of the National Implementation Research Network) emphasized in consultation the importance of utilizing a coaching model in the effective implementation of evidence-based interventions. Training, in the absence of coaching, is insufficient for successful
clinical implementation (Fixsen et al., 2005). For example, after the initial training of 70 staff members in START NOW, less than half of them facilitated the intervention.

In the spring of 2010, START NOW Coaches were identified, employing the model that “coaching” is “the art of facilitating the performance, learning and the development of another” (Downey, 2003). These START NOW coaches guided the training and fidelity process. In addition, START NOW facility-based clinicians were recruited as trainers, who voluntarily attended a START NOW “Train the Trainer” program in June 2010. Each trainer was asked to take on the role of local expert and coordinator of communication pertaining to the implementation of START NOW at their facility(s). The START NOW Coaches provided a comprehensive training to the facility-based trainers, which included the requisite materials to train at the facility level (e.g., workbooks, practice exercises handouts, and dry erase boards).

As was noted in a process evaluation of a drug court system, communication challenges between management and direct care providers can impede successful program implementation (Wolf et al., 2003). In an effort to enhance communication between the central office and facility-based staff, START NOW coaches attended the Steering Committee meetings bringing concerns from the field, and sharing centralized developments with the trainers to communicate to the line staff within their respective functional unit. The START NOW trainers in turn attended a quarterly meeting facilitated by the START NOW coaches. At these meetings, they received additional information and training, updates from the Steering Committee meetings, shared their operational and clinical ideas and concerns about implementing START NOW, and supported each other’s efforts.

The START NOW trainers’ team also provided help with problem solving current or potential obstacles. For example, the trainers participated in meetings with custody and clinical
managers within their designated facilities to ensure that pragmatic details were addressed. Such
details included locating potential group rooms, ensuring that safety and security procedures
were met, and working out schedules for groups.

The Coach/Trainer model provided a bi-directional communication infrastructure in
which information flowed from the “top down” and from the “ground-up.” This bi-directional
communication was further enhanced at each quarterly Trainers meeting and at each Steering
Committee meeting by including a standing agenda item that asked the question: “What can the
Steering Committee do to further support the efforts of the trainers and facilitators?” Later, a
quarterly START NOW newsletter was developed to enhance communication, highlighting the
latest changes to the program and updates on its implementation system-wide.

In this situation, engaging the administrative support of healthcare leadership was
straight-forward, as the Executive Director of Health Services (RLT) initiated the project. The
support of leadership within the correctional system was enhanced through a series of
presentations about START NOW to Custody leadership, including the statewide administrators,
as well as to custody and healthcare leadership at specific facilities. START NOW was viewed
as a promising clinical model which was incrementally supported by staff of various disciplines.

Fidelity Monitoring

Fidelity monitoring is the most frequently used form of monitoring quality assurance in the
implementation of manual-guided clinical interventions. It serves as a mechanism to support the
delivery of reliable and internally valid care. Fidelity monitoring measures provide information
about the quality of care and aid in the continued adherence to a particular treatment approach
(Gearing et al., 2011). Studies have demonstrated that higher levels of treatment fidelity are
associated with better treatment outcomes. Establishing definitive fidelity criteria and measuring
adherence enables treatment to be more standardized, consistently researched and replicated (Mowbray, Holter, Teague, & Bybee, 2003).

To ensure adherence to the treatment design, fidelity monitoring is traditionally implemented from the onset of a manual-guided intervention and continued at various points throughout to prevent deviation from the protocol (Borrelli, 2011). The most common methods of assessing fidelity include the use of audiotaping, videotaping, maintaining a provider self-report checklist or a participant self-report questionnaire. Environmental factors largely impact which format is most suitable for a given population or intervention. In most correctional facilities, taping of sessions is generally not permitted secondary to concerns regarding security and potential litigation. Direct observation of therapy sessions is the method recommended for START NOW programs (Sampl, Trestman, & Krauss, 2013). The main advantage to this method is that it allows for immediate access to treatment effectiveness. It is a direct form of assessment and can allow for both objective as well as subjective content (Brunk, Chapman, & Schoenwald, 2014).

Fidelity components were derived from a meta-analysis of 24 studies. A Fidelity Monitoring Guide and quality assurance forms were subsequently generated to aid in the assessment of the components identified from the meta-analysis. This guide offers comprehensive information on rating the performance of facilitators on all of the 32 sessions of START NOW. On the form, raters are required to fill out the necessary information listed in the top portion. These include: “Date”, “Facilitator”, “Facility”, “Length of Group”, “Session Number” and “Rater”. The date refers to when the group was conducted. The ratings on the form are been divided into two major components: “Contents” and “Process”. The items in the “Contents” section vary according to the session conducted while the items in the “Process” section stay the same for all the sessions. Under “Contents”, the facilitators are rated according to how well they
cover the listed topics for each session. In the “Process” section, facilitators are rated according to how well they demonstrate the basic skills of conducting START NOW groups.

While a Fidelity Monitoring Guide and quality assurance forms were generated, the process of monitoring was challenging to complete for a number of reasons. Fidelity monitoring requires a high degree of organization and commitment to ensure each group and facilitator are observed once per unit, training is monitored, and travel across the state for a multitude of days and times during the course of the 32-session curriculum per facilitator. Logistical barriers prevented the fidelity monitoring from being completed with regularity, including communication, staff time, other job responsibilities, and travel. As a result, it was clear that the process of fidelity monitoring needed to be further developed to enhance the ability of staff to complete as outlined.

Motivation for Inmates

When beginning a new correctional treatment program, it helps to understand the motivators for participating inmates. START NOW participants were influenced to attend treatment by a number of intrinsic and extrinsic motivators. Some individuals appreciated the opportunity to meaningfully engage in group treatment. Other participants simply wanted to socialize with clinical staff and peers or gain out-of-cell time. For some individuals a group context provided an opportunity to incorporate some of the new skills into their behavioral repertoire and practice skills in the interim between sessions within the correctional setting. Inmate’s comments on anonymous “Participant Satisfaction Surveys” (to be discussed further in this paper) about their START NOW experience, illustrated that quite a few participants appreciated the opportunity to learn new skills:

- “Helped me prep for when I get released, and for my future. Helped me set goals, and to always move forward no matter the situation.”
• “Just learning more about choices and the fact I control my reactions concerning my feeling, etc.”
• “I found it helpful to learn how to appropriately communicate with others when in stressful situations and how to recognize and eliminate negative relationships.”

A mental health clinician facilitating START NOW stated on a “Facilitator Satisfaction Survey” that the best part of the group was “the open relaxed matrix the program provided for both facilitators and participants,” which speaks to the opportunity for positive interaction provided through START NOW participation.

Those participants who successfully completed each START NOW unit, in addition to the program as a whole, received a written certificate of completion. Group facilitators reported that many participants stated that earning a certificate was among their motivators for participation. Earning a certificate of participation provided both a sense of accomplishment and evidence of programming involvement in support of transitional supervision, re-entry furlough, or release to a halfway house. Participants earn certificates upon completion of each of the four clinical units and the program as a whole, conditioned upon attendance and participation. At the same time, participation in START NOW was voluntary and inmates had the option to decline the program if they did not believe it would meet their needs.

*Individual treatment for those in Special Management Units*

Each correctional system has a system for segregating inmates with the most disruptive or dangerous behaviors within segregated or restrictive housing units. These inmates are excellent candidates for change via the skills development of START NOW given the severity of their problem behaviors (Landenberger & Lipsey, 2005). Providing group mental health treatment for inmates housed in segregated housing presents multiple logistical challenges,
however, including the structure of the facility itself, staffing ratios, and safety concerns. For example, Administrative Segregation inmates are typically not allowed unrestricted contact with other inmates and require a 1:1 or 2:1 officer to inmate supervision ratio.

Due primarily to safety concerns and required staffing ratios, it was decided START NOW would be provided on an individual basis for these high-risk inmates. As in a group setting, the facilitator presented the START NOW sessions and concepts, but on an individual basis; then the inmate was asked to review and complete the exercises in their cells. Subsequently, completed exercises were reviewed by the facilitator with the inmate. When the inmate demonstrated understanding and mastery of the material, the next section of START NOW was provided. Staff continually reinforced START NOW skills with inmates during interventions for behavioral issues; many inmates successfully integrated the skills into their daily routine. The certificates of completion for START NOW were presented once the participant demonstrated consistent skill use.

The case of Mr. A., incarcerated for first degree murder, illustrated how START NOW may benefit this population. In his first ten years of incarceration, Mr. A. accumulated over 40 disciplinary infractions, including a dozen for fights and assaults, many of which were against staff. His behavior resulted in his classification to the Administrative Segregation (A.S.) unit of the State’s maximum security facility. He continued engaging in disruptive and maladaptive behaviors, including punching walls, cutting himself, and interfering with safety and security. Treatment attempts were ineffective. After three years of being unable to progress through the A.S. program, he accepted the opportunity to participate in START NOW on an individual basis. Upon completion, he successfully completed the A.S. Program and was subsequently transferred...
to a less restrictive setting. In the two years following his involvement with the START NOW programming, he engaged in no violent acts.

*Participant Satisfaction*

As part of Quality Assurance, a participant satisfaction questionnaire (refer to Table 1) was modified from an existing questionnaire (Joe, Broome, Rowan-Szal, & Simpson, 2002). Facilitators were asked to collect data from the satisfaction questionnaire upon completion of each of the four units. A total of 619 responses to unit-level satisfaction were collected from across the system. The first eight questions utilize a Likert format, with a rating of 1 representing the least satisfaction and 4 the greatest. Items were counter-balanced to reduce the impact of a response set bias. The results averaged in the “Satisfied” to “Very Satisfied” range (3.1 to 3.5), suggesting participants were quite satisfied with their participation.

Two additional open-ended questions were posed. The first of these (Question 9) requested comments on the activities or topics they most liked about the unit. Responses were categorized through qualitative analysis with the six most frequent responses provided here for review. Of the 619 participants, 581 responded to Question 9, and some offered more than one code-able response for a total of 741 responses. The six most frequent responses for Question 9 (total number of responses for each category) were coded as “All/Everything” (89), the “ABC’s” (the system for functional analysis of problem behaviors) (65), “General Coping Skills” (49), “Overall Group Process” (48), “Miscellaneous” (36), and “Setting and Achieving Goals” (26). These responses indicated that participating inmates were pleased overall. It is also encouraging that they recalled and cited specific coping skills learned from the groups, increasing the likelihood they will be employed in the future.
The final open-ended question (Question 10) asked participants what they might want to change to make the unit better. Of the 619 participants, 581 responded to this item, generating a total of 638 responses (participants could provide multiple responses for this item). The six most frequent responses for Question 10 were coded as “Nothing” (235), “Miscellaneous” (37), “Greater Session Length” (41), “Greater Number of Sessions” (23), “New or Changed Session Content” (21), and “More Hands On” (18). The most popular responses either suggested no changes to the program or requested greater exposure to the START NOW program indicating general satisfaction by participants.

Discussion

Although START NOW is an evidence-informed intervention and the initial outcome data continues to show promise, the continued and concurrent development and implementation of the program requires that the clinical recommendations are tempered pending further validation of its efficacy.

Even though many issues were identified and addressed while the START NOW program was piloted, many of the inherent challenges that developed were unforeseen until implementation, when the unique facility-specific, operational, or systemic factors became apparent. As Block (1999) found in a study involving the integration of scouting programs into prison systems, each program adapts to the available local community resources, which effects program operations. For example, the scouting program involved parenting classes, but some facilities were not able to incorporate them, were formal or informal, or were facility run or volunteer run. Thus, the need for flexibility within the system is an essential component to the implementation and program development process. START NOW was also modified to meet the challenges or operational differences unique and inherent to the correctional system or...
specific facilities in general, including open-ended vs closed groups, weekly or bi-weekly sessions, and an individual versus a group treatment modality.

To date, START NOW has been implemented in fourteen correctional facilities throughout the state. Centralized attendance and implementation data is collected, and a number of differences have been observed across facilities. Some differences, as noted previously, included the provision of START NOW individually as opposed to a group format in segregated housing units. In addition, the frequency of groups varied among facilities, with some providing START NOW twice weekly, as originally designed, and others providing it on a weekly basis. This variant was approved by the Steering Committee to take into account practical issues such as the availability of group room space and staffing.

In a statewide internal review, there were 27 ongoing START NOW groups, of which 17 were being conducted twice weekly and 10 once weekly. Interestingly, the trend at a number of facilities has been to begin providing START NOW once weekly, and then to shift to twice weekly. Initially, new facilitators were dubious about allocating time and finding space for groups, but over time identified benefits of more frequent sessions. As one facilitator expressed, “Meeting twice a week keeps more of a flow between sessions. They (participants) can complete units and earn certificates quicker.” An inspection of the pattern of group frequency reveals that twice weekly groups tends to be associated most often with jail settings and inmates with more intensive mental health and behavioral needs. It was clear to the Steering Committee that early identification of a designated program coordinator is beneficial to facilitating this process and to identify and address challenges that present themselves as early in the process as is feasible. It is also recommended that this coordinator develop and conduct a formalized needs analysis including on-site interviews and observations adapted to the specific program.
A system of effective communication between direct care providers and the program’s Steering Committee needs to be established early in the process as well and is critical in advancing the organizational goals. While communication within the agency itself was a strength, it is a limitation that Custody staff was not included in the Steering Committee membership as suggested by Welsh and Zajac (2004), who included key personnel from a university and state correctional agency in its Steering Committee in an effort to establish an effective partnership in assessing drug treatment. It is recommended that future efforts or systems include representation from the correctional agency within the Steering Committee to enhance the collaborative and implementation process.

The START NOW program development process illustrates that without a supportive network of coaching, training alone is insufficient for successful program implementation (Fixsen et al., 2005). Our experience demonstrated that the establishment of a network of coaches and unit-based trainers was not only necessary for establishing a START NOW clinical knowledge base, but also promoted positivity and staff morale for direct clinical providers of START NOW. The latter was an unforeseen positive consequence in the program’s development. Administrators of other new correctional based clinical programs can expect the need for top-down buy-in and substantial time and staff allocation to maintain a program-specific supportive network.

Over time, fidelity monitoring did not increase proportionate to the growth of the program as the number of staff assigned as fidelity monitors did not increase with the number of groups initiated. As stated earlier, logistical barriers also prevented the fidelity monitoring from being completed with regularity, including communication, staff time, other job responsibilities, and travel.
In addition, further review of the fidelity monitoring process identified areas where enhancements were necessary. First, there needs to be a clear grid identifying all START NOW facilitators and the details of the groups they each facilitate including day, time, and location. Furthermore, it is recommended that fidelity monitors ought to be identified and trained in the completion of the fidelity monitoring quality assurance forms and a clear organizational plan needs to be created to ensure the completion of ongoing fidelity monitoring. This plan will ensure each facilitator is observed once per unit during the course of the program. Following a direct observation of a START NOW group, the fidelity monitor will subsequently be required to provide feedback to the facilitator, underscoring any discrepancies or nonadherence to the protocol. Facilitators observed to deviate from the protocols will then be provided with additional training and supervision.

Although this paper identifies and describes solutions to the barriers faced in this process, consistent with the study completed by Farabee et al. (1999), perhaps the solutions themselves are not as important as the actual identification of those challenges. In that way, a correctional system can enter the initial stages of programmatic implementation with awareness of potential challenges and can proactively address them using solutions consistent with their respective system.

Conclusions

Development and provision of a structured mental health therapy intervention within correctional settings is not only feasible, but can be successful, as long as the environmental challenges are considered. Some of the key factors for promoting program success are noted in this paper and can be used by systems seeking guidance in implementation, including the need for flexibility in the implementation process to account for unique facility-specific or systemic
barriers. During this process, significant enhancements to the program were made as a result, including the option to provide the program individually instead of in a group format, open-ended versus closed groups, and facilitating groups weekly vs bi-weekly.

Custody staff engagement was enhanced through communication of program aims to administrators, and through inclusion of custody professionals in START NOW training workshops. In addition, a coaching model was established that served to provide a knowledge base with the unanticipated benefit of promoting staff morale and positivity.

Inmate investment was supported through relevant protocol content as well as certificates of completion. Over time the clinical protocol was refined to provide appropriate inclusion criteria for program participation and clinical guidelines for treating inmates at various levels of security.

The START NOW organization’s intent is to continue building the clinical infrastructure within the current system of care. This includes further developing the training, fidelity, and supervision components and integrating these into a standing Quality Assurance program. The START NOW program evaluation is currently in process, examining engagement and a range of clinical and behavioral outcome measures as they relate to function within the correctional setting and in support of successful transition to the community. Aspects of the participants (e.g., diagnosis and functional level) as well as additional comparative effectiveness studies are anticipated as well. It is hoped that careful assessments of patient characteristics, fidelity measures, financial impact and the pragmatics of implementation of START NOW will advance the field of evidence based practice in correctional mental health.
References


Table 1. START NOW Satisfaction Questionnaire

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<th>Question</th>
<th>Mean</th>
<th>SD</th>
</tr>
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<tbody>
<tr>
<td>Q1. How would you rate the quality of the START NOW unit you just completed? (1 = “poor”, through 4 = “excellent”)</td>
<td>3.36</td>
<td>0.71</td>
</tr>
<tr>
<td>Q2. Did you get the kind of help you wanted? (1 = “No, definitely not”, through 4 = “Yes, definitely”)</td>
<td>3.23</td>
<td>0.73</td>
</tr>
<tr>
<td>Q3. To what extent has this START NOW unit met your needs? (1 = “None of my needs have been met”, through 4 = “Almost all of my needs have been met”,”)</td>
<td>3.11</td>
<td>0.77</td>
</tr>
<tr>
<td>Q4. If a friend were in need of similar help, would you recommend that he/she participate in this START NOW unit? (1 = “No, definitely not”, through 4 = “Yes, definitely”)</td>
<td>3.48</td>
<td>0.78</td>
</tr>
<tr>
<td>Q5. How satisfied are you with the amount of help you have received? (1 = “Quite dissatisfied”, through 4 = “Very satisfied”)</td>
<td>3.37</td>
<td>0.75</td>
</tr>
<tr>
<td>Q6. Has this START NOW unit helped you deal more effectively with your problems? (1 = “No, it seemed to make things worse”, through 4 = “Yes, it helped a great deal”)</td>
<td>3.25</td>
<td>0.72</td>
</tr>
<tr>
<td>Q7. Has participation in this START NOW unit helped you cope with daily life in prison/jail? (1 = “No, it seemed to make things worse”, through 4 = “Yes, it helped a great deal”)</td>
<td>3.27</td>
<td>0.76</td>
</tr>
<tr>
<td>Q8. If you were to seek help again would you participate in this START NOW unit? (1 = “No, definitely not”, through 4 = “Yes, definitely”)</td>
<td>3.45</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Note. 619 responses to individual units; responses are accumulated across all four units as there were no differences.