What is the plan for CJ-DATS?

Criminal Justice Drug Abuse Treatment Studies (CJ-DATS)

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Summary

This report provides an overview of needs and objectives envisioned by the Texas Research Center and its team of Criminal Justice Collaborators (CJCs) participating in the national Criminal Justice Drug Abuse Treatment Studies (CJ-DATS). The project has been funded as a multi-center collaboration with the National Institute on Drug Abuse (NIDA). The present report is intended to help communicate major project needs and collective objectives to CJ leaders and program supervisors within and across CJC teams, as well as consolidate them within a broader context that guides the CJ-DATS planning and decision-making process.

The goals of the CJ-DATS Texas Center and collaborators are summarized within a conceptual framework to help systematize the research and evaluation tasks that focus on "innovation implementation." In addition, specific objectives of the CJCs are described, which also are translated into abbreviated operational plans containing (1) research questions to be addressed within formal multi-site evaluations, and (2) overviews of several client and program staff assessments already being collected by some CJCs for answering these questions.

What is the plan for CJ-DATS?

What is the CJ-DATS mission?

Research undertaken in Phase 2 of CJ-DATS is expected to extend previous research and *create a foundation for improving the quality of treatment services* for drug-involved offenders. In particular, it is expected to yield organizational- and systems-level studies on *implementing and sustaining* research-supported interventions across a continuum of care. As exemplified in a large multi-agency Program Announcement (PAR-07-086) by NIH for funding **Dissemination and Implementation Research in Health**, a comprehensive view of innovation implementation has been developing. It states "Dissemination and implementation have both been used to represent the complete process of bringing 'evidence' into practice, originally defined as 'diffusion.' While using the terms dissemination and implementation to cover such a wide area can be very helpful in facilitating discussion, it does not allow for the division of this very complex diffusion process into smaller, more easily addressed research questions that can develop a robust knowledge base." It goes on to note "Implementation is the use of strategies to adopt and integrate evidence-based health interventions and change practice patterns within specific settings."

Implementing research-based treatment practices in typical CJ settings faces a variety of clinical, administrative, organizational, and policy barriers. Furthermore, if the implementation solutions are expedient rather than systemic, the innovation may not be sustainable, regardless of its clinical effectiveness or cost-effectiveness. An essential component of implementation research is **organizational change,** discussed in the literature that focuses on quality improvement, implementation and technology transfer, management science, and inter-organizational relationships or cross-agency collaboration.

The processes to implement new treatment services may require changes in clinical or administrative infrastructure and practices that in some respects parallel individual behavioral change processes.

Examples of potential **clinical changes** include innovations for (1) reviewing and revising screening/assessment and intervention protocols; (2) providing adaptive programming to address specific client risks and needs (e.g., readiness and motivation, mental health); (3) adopting/updating transitional criteria for advancing across continuum-of-care stages; (4) using incentives for raising staff adherence to defined practice standards; and (5) re-engineering rewards and sanctions to reinforce offender compliance.

Examples of **administrative changes** might include procedures for (1) adjusting treatment admission rates and retention thresholds; (2) adjusting criteria for placing high-risk offenders in special treatment tracks; (3) developing informational infrastructure to acknowledge and support quality improvements in services; (4) improving inter-agency linkages between drug treatment programs and corrections departments by improving information sharing and transition of care responsibilities; and (5) using performance criteria for defining treatment completion and determining post-release treatment needs.

Why is it so important to focus on "implementation process"?

Simpson and Flynn (2007) and Fixsen et al. (2005) stress the point that adoption and implementation of innovation is a *process*, not an isolated *event*. Some of the stages that treatment programs move through to accomplish this process are comparable to those observed in relation to client changes during treatment (Simpson, 2004). Both involve an integrated process that relies on readiness to change, training on how to

do it, and engagement in its implementation. Like the clients they serve, treatment programs themselves must be ready and committed to change before engaging in staff training for innovations and successfully implementing them. Linking together components of the change process over time is a major challenge in conducting translational research in health services delivery systems.

Based on their review of over 700 articles dealing with implementation research drawn from broad cross-disciplinary selection process, Fixsen et al. (2005) offer the following conclusions. First, implementation evidence points mainly to what does NOT work, emphasizing the failure of simple forms of dissemination and didactic training. Second, future progress will require a long-term "multilevel" approach that takes into account intervention components, staff skills, training processes, and policies.

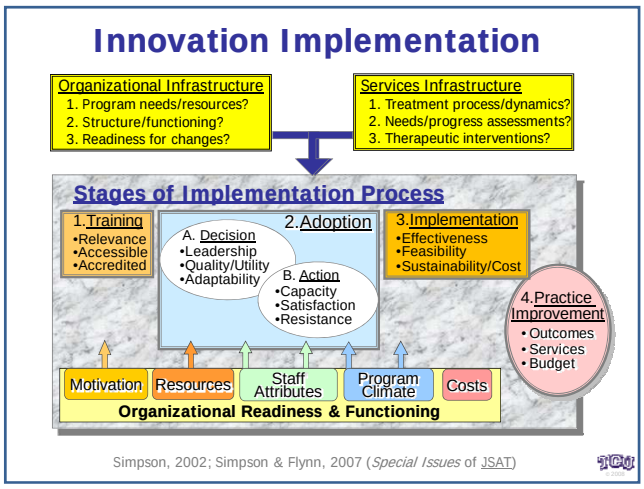

Figure 1. Four key stages of the TCU Program Change Model: 1) Training, 2) Adoption 3) Implementation, and 4) Practice Improvement

Third, there is a deficiency in evidence regarding the influences of organizational factors and systems on the implementation process. Fourth, a large gap exists in the research literature concerning interaction effects involving implementation stages and components, effectiveness, and sustainability.

The TCU Program Change Model (Simpson, 2002; Simpson & Flynn, 2007; see Fig. 1) postulates that 4 key stages are involved—that is, training, adoption, implementation, and practice. Factors that *influence* each of these stages are separated into those related to the *innovation* per se, versus those that are related to the general *organizational context* into which the innovation is being incorporated.

The growing conceptual commitment by CJCs to using an "adaptive treatment" approach that depends on effective integration of client assessments with treatment services planning and delivery underscores the need for implementation studies. Because some CJ treatment programs seem to adopt change and progress more rapidly than others, it is important to examine the factors that influence this process. For programs that recognize needs for a specialized "treatment engagement module" for inmates who fail to engage in mainstream or primary treatment, this is especially important.

For a services innovation, evidence suggests training must be relevant to the needs as perceived by staff and be delivered with competence. Adoption represents a decision by program leadership (preferably with staff participation) to try it out, based on expectations about potential use and benefits.

The implementation phase is the broader "field test" of its effectiveness, feasibility, and sustainability. If the innovation passes this test, it likely becomes incorporated into regular practice. However, organizational functioning (measured as collective perceptions from staff) also influences discrete stages of this process. It includes information on program motivation and readiness for change, resource allocations, staff attributes, and organizational climate.

How can "implementation process" be studied and potentially improved?

As part of our research studies at TCU, the process of innovation adoption has been investigated using longitudinal records collected from a statewide network of almost 60 treatment programs over a

2-year period (Simpson, Joe, & Rowan-Szal, 2007). Program-level measures of innovation adoption were defined by averaged counselor ratings of program training needs and readiness, organizational functioning, quality of a workshop training conference, and adoption indicators at follow-up.

Findings showed that staff attitudes about training needs and past experiences are predictive of their subsequent ratings of training quality and progress in adopting innovations a year later.

Organizational climate (clarity of mission, cohesion, openness to change) also was related to innovation adoption. In programs that lack an open atmosphere for adopting new ideas it was found that counselor trial usage was generally poor. Most important was evidence that innovation adoption based on training for improving treatment engagement was significantly related to client self-reports of improved treatment participation and rapport recorded several months later.

What do CJ collaborators say about their "needs and objectives" for CJ-DATS?

The Texas Research Center at TCU has worked for several years with most of its CJCs to address a variety of concerns, but recently conducted a survey to help tabulate needs and objectives more clearly for each CJC. In general, the 7 major needs listed below emerged as priorities (specific responses are shown in the **Appendix** at the end of this report). On the basis of their experiences in providing substance abuse treatment for over 50,000 offenders, these collaborating systems are interested in —

- *1. Client assessments that inform care planning/delivery, stage progression, and client engagement/participation (i.e., program decision rules for treatment)*
- *2. Strategies that improve sequential client induction and adaptive programming*
- *3. Aggregated client assessments for staff feedback on 'program functioning/ effectiveness'*
- *4. Organizational 'readiness for change' assessment/feedback for client care planning*
- *5. Program-level performance evaluations for management tools (i.e., staff and client information)*
- *6. Innovation implementation stage-based evaluations for tracking progress in making change*
- *7. Identification of between-system barriers for reentry care and supervision responsibilities*

What kinds of information should be collected in participating CJC programs?

Previous studies by the TCU research center team have relied on a combination of client-level and staff-level assessments obtained within treatment programs. Several of these forms are already being adopted or in use by CJ collaborators.

The **Client Evaluation of Self and Treatment (CEST)** includes 14 scales self-administered by clients to measure motivation and readiness for treatment, psychological and social functioning, and treatment engagement (Joe et al., 2002; Garner et al., 2007). By combining client-level scores on these measures within treatment programs, a variety of useful comparisons can be made that reflect on program effectiveness. Special attention is usually focused on the three treatment engagement scales. Counseling rapport (13 items) reflects client perceptions of core areas of therapeutic relationship with treatment counselors such as mutual goals, trust, and respect. Treatment participation (12 items) summarizes client perceptions of their own involvement and active engagement in treatment sessions and services. Treatment satisfaction (7 items) indicates how well clients feel the treatment program is meeting their needs.

The **Criminal Thinking Scales (CTS)** is a supplement to the CEST and is designed to measure "criminal thinking" (Knight et al., 2006) The 6 CTS scales include Entitlement, Justification, Power Orientation, Cold Heartedness, Criminal Rationalization, and Personal Irresponsibility which represent concepts with special significance in treatment settings for correctional populations.

The **Organizational Readiness for Change (ORC)** assesses staff perceptions of organizational needs and functioning shown to be related to program change (Lehman et al., 2002). It includes 18 scales from 4 major domains—needs and pressures, resources, staff attributes, and climate. Needs and pressures (motivation for treatment) factors include program needs, training needs, and pressures for change, while program resources are evaluated in regard to office facilities, staffing, training, equipment, and Internet. Organizational dynamics include scales on staff attributes (growth, efficacy, influence, adaptability, and clinical orientation) and program climate (mission, cohesion, autonomy, communication, stress, and flexibility for change). The subset of organizational climate scales include clarity of program mission (5 items), staff cohesiveness (6 items), staff autonomy (5 items), communication (5 items), stress (4 items), and openness to change (5 items).

The **Workshop Evaluation (WEVAL)** form includes 2 parts and has been used to collect staff ratings on (1) satisfaction with innovation training, (2) resources available at programs, (3) desire for more training, and (4) perceived organizational support for using the training materials (Bartholomew et al., 2007). The first part focuses on staff responses to training in general immediately following its completion, and the second is workshop specific.

The **Workshop Assessment Follow-Up (WAFU)** is completed by workshop trainees several months later to address questions about innovation adoption (Bartholomew et al., 2007). It contains items on post-training satisfaction with and adoption of workshop materials, an 8-item inventory about barriers to use, and a section on booster training (if appropriate).

Several of these forms are being modified for use with Automated Data Capture (ADC) technology. More specifically, the CEST and CTS (as well as some newly created client risk assessments) have been prepared as 1-page optical scanning (Scantron) forms that can be scanned and scored for counselor feedback (see ADC Forms at www.ibr.tcu.edu).

What are some of the main research questions (and hypotheses) to address?

1. Are program needs and readiness for training related to responses to training and innovation implementation? Because a staff survey of program needs and training readiness can (and should) be used in part to help plan training events, it is expected that these ratings of program needs are related to staff reactions to the training and, ultimately, to innovation implementation. More specifically, it is reasonable to expect that ORC measures of previous satisfaction with training, program facilities and climate, program computer resources, and training barriers will be related to staff evaluations of training (based on WEVAL measures for training relevance, engagement, agency support, and workshop quality).

2. Is organizational functioning and feedback related to innovation adoption and implementation? It is expected that organizational climate measures (ORC) for programs are related to staff progress in subsequently adopting innovations (WAFU scales). That is, ORC climate scales (including clarity of mission, staff cohesion, communication, and openness to change) are expected to be predictive of staff perceptions about innovation benefits in terms of leading to better counseling skills and better rapport with clients (based on WAFU staff ratings of post-training satisfaction, trial use, better counseling skills, and better client rapport).

3. Are there organizational barriers (e.g., staff skills, attitudes, distrust, organizational mission or structure) that reduce effectiveness of reentry programming? There are differences between some CJ subsystems (such as those representing security versus treatment interests)

that can challenge the reentry process. It is expected that identifying and strategically addressing some of these core issues can help improve and sustain client engagement and retention in reentry services, as well as reduce recidivism rates.

4. Is program adoption of training materials related to client engagement? To the degree that program staff make progress in adopting an innovation (e.g., an enhanced induction strategy or medication protocol) and consider that it has improved the quality of their services (WAFU scales), it might also be associated with indicators of client functioning (CEST) and retention. This is a particularly reasonable expectation if the training innovation is designed for "improving therapeutic motivation, alliance, and engagement." Clients treated at programs with higher counselor ratings on innovation adoption indicators—including post-training satisfaction, trial use, and development of better skills—are expected to report higher ratings of rapport with their counselors and greater participation in treatment.

> ***A critical issue seems to revolve around the ability of clinical staff to use client assessments of need and progress in relation to care planning and strategic delivery of appropriate services.***

5. Are responses to innovation training and feedback on implementation affected by "moderator variables"? It is often important to consider the potential effects of "moderator variables" in observational studies of change in natural settings (James & Brett, 1984; Tucker & Roth, 2006). Namely, programs in which staff become more engaged in training and report greater benefits from adopting the innovation may have fewer barriers and more positive climate and available resources. In the program change process as described by Simpson and Flynn (2007), it is postulated that the stages of training, adoption decision, and adoption actions are subject to influences from staff and organizational attributes.

In order to examine these potential effects, the organizational climate scale for "openness to change" (from ORC) and the training score for indicating "relevance" of the innovation (from WEVAL) can be selected as independent variables because both are predictors of adoption actions at follow-up. After converting these predictor variable scores into dichotomous measures to define high versus low level programs on each measure, a 2-way analysis of variance can be conducted to test the question of whether program environment (openness to change) moderates the role of training opinions (relevance of the innovation) and implementation feedback to adoption actions at follow-up (WAFU).

What benefits are expected from the CJ-DATS project?

The conceptual model used to integrate this research on how programs adopt and implement innovations (Simpson, 2002; Simpson & Flynn, 2007) is likely to be refined and expanded for CJ settings by results of CJ-DATS. Its heuristic value includes benefits in explanatory value for helping treatment and reentry systems to understand the sometimes complicated process of how innovations become adopted and implemented, along with the factors that influence how well it is done and sustained.

Applying this information to formulate customized plans for improving treatment hopefully will follow. For example, evidence implies that programs should "plan and prepare" before beginning an innovation training and implementation initiative (Simpson, in press). If staff assessments reveal barriers or reservations, or if organizational functioning has deficiencies, then the program should first consider addressing its own infrastructure problems before introducing innovation initiatives (see Simpson & Dansereau, 2007). Issues that need to be addressed range from using new clinical tools for counseling enhancements to negotiating cross-system procedures that promote continuum-of-care goals.

In conclusion, CJ collaborator teams have stated they need more than an assortment of "isolated innovations" for offenders in treatment. **Most express a need for linking offender/client assessments dynamically to targeted treatment strategies in a manner that allows progress to be monitored, documented empirically, and "clinically managed" over time.** This represents a complex formulation of clinical tools (i.e., assessments and interventions), integrated applications based on user-friendly feedback of client needs and progress, and a supportive program structure. Regardless of program size or focus, experiences so far suggest this requires (1) staff preparation and leadership support, (2) structural alignments and role assignments, (3) training with customized adjustments to settings, and (4) follow-up monitoring and feedback on implementation progress. It will require the best efforts from all CJ-DATS investigators and CJ service collaborators to address these challenges.

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Appendix: CJ-DATS Texas Research Center Collaborator "Needs Survey"

X – NOT interested or needed (or not applicable to your settings)
A – Adoption needed/planned ("--" indicates uncertainty at this time)
U – Using already (if "assistance/more help" is needed, marked as "**Ua**")

A. Client Needs/Risks Tools	IL	TX	AZ	IN	NE	NM	VA	BOP	CEC	GF	PH	WC
1. Drug use severity screen	Ua	U	U	U	A	Ua	X	X	Ua	A	Ua	U
2. Background (crime/family) risks	A	A	X	U	A	A	X	U	Ua	A	Ua	U
3. Health (mental/physical) risks	A	A	X	U	A	U	X	U	U	A	Ua	U
4. Criminal thinking/orientation	A	U	A	U	U	A	U	U	Ua	U	Ua	U
B. Client Functioning/Engagement Tools												
1. Motivation & readiness for treatment	Ua	U	U	U	U	A	U	U	Ua	U	Ua	U
2. Psychosocial functioning	Ua	U	X	U	U	A	U	U	Ua	U	Ua	U
3. Treatment engagement indicators	Ua	U	X	U	U	A	U	U	Ua	U	Ua	U
4. Other cognitive processing domains	Ua	U	X	U	U	A	--	U	Ua	U	A	U
C. Organizational (Facility) Evaluation Tools												
1. Program needs/readiness for change	A	A	X	--	A	--	--	A	A	A	U	X
2. Resources & staff attributes	A	A	X	--	A	--	--	A	A	X	U	X
3. Organizational climate/barriers	A	A	X	--	A	--	--	A	A	A	U	X
4. Cross-system perceptions/barriers	A	A	X	--	A	--	--	A	A	A	Ua	X
D. Assessment Structure/Formatting												
1. Brief forms (e.g., 1-page TCU Scantrons)	Ua	U	X	X	A	A	X	X	U	U	Ua	U
2. Feedback of scores to counselors	Ua	Ua	X	U	A	A	A	X	Ua	Ua	Ua	A
3. Computerized administrations	Ua	A	X	U	A	A	A	X	U	Ua	A	U
E. Intervention Enhancements/Components												
1. Orientation/motivation strategy	Ua	Ua	X	U	U	A	U	U	Ua	U	A	A
2. TCU mapping-based counseling	A	A	X	U	A	--	X	X	Ua	A	A	--
3. Other cognitive/behavioral strategy	A	U	X	U	A	--	X	X	--	U	A	A
4. Life/social skills & decision-making	Ua	U	X	U	U	Ua	X	X	Ua	U	A	A
5. HIV/hepatitis risk reduction	Ua	Ua	X	U	A	Ua	X	X	Ua	A	A	--
6. Transition planning & reentry prep	Ua	Ua	X	U	A	Ua	A	X	Ua	U	A	A
7. Reentry supervision/transition	Ua	U	X	U	A	A	A	X	A	U	A	A
F. Systems Development/Procedures												
1. Treatment planning/monitoring	Ua	Ua	X	U	A	Ua	A	X	Ua	Ua	A	A
2. Client phase-advancement criteria	Ua	Ua	X	U	A	Ua	A	X	Ua	Ua	A	A
Total offenders in treatment (thousands)	4	10	2	4	1	1	2	13	10	18	2	1