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TEMPEST IN A TC

Changing Treatment Providers for In-Prison Therapeutic Communities

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Corrections officials frequently use private contractors to operate in-prison, therapeutic community (TC) treatment programs. However, the recurrent competitive bidding process inherent in state agencies contracting for services sometimes results in a treatment-provider change. Few studies have focused on whether this change leads to better or worse treatment motivation and engagement for clients and how it might be evaluated. Using data collected during the larger Criminal Justice Drug Abuse Treatment Studies Performance Indicators for Corrections study, quantitative assessments of client functioning were made at two points in time. Changing to new treatment providers in three in-prison TC treatment facilities caused significant disruptions, leading to decreased client–counselor rapport and peer support as well as lower levels of treatment readiness, participation, and satisfaction of clients. Qualitative client and staff interviews provided further insight relevant for correctional administrators and treatment providers who may be considering similar changes. General recommendations for provider transition planning are offered.

Keywords: client–counselor rapport; engagement; motivation; provider change; therapeutic community

Research supports the therapeutic community (TC) as an effective treatment model for substance-involved offenders (Butzin, Martin, & Inciardi, 2005; Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Melnick, & Cao, 2004). As TC programming has become increasingly popular and is made available to larger and more diverse populations of substance-involved offenders, however, modifications also have been made to the treatment model for adapting to the needs of different clients

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(De Leon, 1997, 2000). Furthermore, as funding for offender treatment services continues to be limited, further adjustments have been made in the TC model to reduce expenses (Melnick & De Leon, 1999). These modifications, which often include shorter program lengths and manual-based programming, can place constraints on the delivery of the essential TC elements and potentially create a situation in which the core element, the “community as method,” fails to function.

When a program contract (e.g., in a correctional setting) is taken over by a new treatment provider, major modifications may be made to the program structure and the staff. Changes from peer group therapy to didactic sessions and hiring of new, inexperienced, or fewer counselors can directly impact the TC community. Linhorst, Knight, Johnston, and Trickey (2001) demonstrated that salary cuts resulted in increased staff turnover, which in turn resulted in the hiring of persons untrained in the TC approach and inexperienced in working with prisoners. The overall effect was a disruption in the level of trust and community between staff and inmates. In addition, staff turnover has been found to interfere with treatment, as fewer inmates may receive care and caseloads increase because of personnel shortages (Garland, 2002). Thus, a disruption in the continuity of care occurs when counselors leave and clients need to develop relationships with new counselors.

The importance of client–counselor relationships and the strength of the therapeutic connection have been emphasized in research focused on treatment process and engagement. Bell, Montoya, and Atkinson (1997) indicated that counselor trust and dependency is a process requiring a great level of ongoing energy and attention by the counselor and is critical in the development of a facilitative therapeutic relationship. Clients in TCs that are transitioning to a new treatment provider, however, may experience low levels of rapport with staff because they have not had adequate time to build good communications with newly assigned, rotating counselors or those with whom they lack one-on-one contact. A study by Broome, Knight, Hiller, and Simpson (1996) found that treatment ratings of counselor competence by TC clients predicted posttreatment outcomes and that low ratings of peer support by clients predicted negative outcomes. Indeed, it is necessary for clients to establish strong relationships with both peers and counselors for positive therapeutic change to occur in TC settings (Melnick & De Leon, 1999).

Simpson (2004) has provided a framework for organizing and assessing program attributes (including staff, organization climate, and resources) as well as client characteristics (e.g., readiness for treatment, problem severity level) that influence the treatment process. It delineates what happens to clients in treatment and emphasizes the need for them to become engaged in the program and establish therapeutic relationships with counselors and peers early in their treatment episode. These early changes, in turn, lead to additional steps in the recovery process whereby clients change specific behaviors (like drug use) and experience a number of psychosocial changes—including improved relationships, psychological functioning, and prosocial attitudes. With sufficient retention (i.e., length of stay) in the program, the likelihood of an individual becoming engaged and entering recovery improves significantly, as do the chances of sustaining recovery after return to the community.

When considered within this framework, of course, it is expected that provider changes resulting in staff and program changes might influence client treatment motivation and engagement. Although unintended, switching treatment provider organizations in response to budget-related contracting pressures in particular can have unintended negative consequences. For example, counselors sometimes leave following a provider change. As a result, the therapeutic

bonds they have with their clients are severed, leading to changes in client–counselor rapport, client participation in and satisfaction with the program, and feelings of peer support among TC clients. Fiscal pressures also can lead to larger counselor caseloads, which tend to increase group size, reduce individualized contact, and make it more difficult for therapeutic bonds to develop between clients and counselors. With reduced rapport, clients will likely withdraw from the treatment process, limiting self-disclosure during counseling sessions. Decreased willingness of clients to self-disclose, in turn, inhibits peer trust and reduces client–counselor communications.

Garner, Knight, Flynn, Morey, and Simpson (2007 [this issue]) provide psychometric evidence for relevant client-functioning assessment tools that measure this process in offender populations. This study used these tools in a natural history design to examine changes within a TC program when a new treatment provider was introduced. That is, cross-sectional assessments of client functioning and treatment engagement administered as part of a related study (described below) was followed by a change in treatment providers for some of the participating programs. By re-administering the client assessments after the change in provider was implemented, accompanied by semistructured interviews with staff, several features of the program-change process were examined in relation to its impact on client functioning.

METHOD

A subset of the data collected as part of the Performance Indicators for Corrections (PIC) study, described by Simpson and Knight (2007 [this issue]) and Garner et al. (2007), were used. The PIC study is part of the national Criminal Justice Drug Abuse Treatment Studies (CJ-DATS), a collaborative project funded by the National Institute on Drug Abuse. It focuses primarily on psychometric properties and validation of self-administered offender assessments completed at 26 facilities associated with five CJ-DATS Research Centers located across the United States. The Texas Christian University (TCU) Criminal Justice Client Evaluation of Self and Treatment (CJ CEST; Garner et al., 2007) and the National Development and Research Institutes, Inc. Client Assessment Inventory (Sacks, McKendrick, & Kressel, (2007 [this issue]) were included. Analyses presented in the current article are limited to data from the CJ CEST because it includes scales related directly to Simpson's (2004) treatment process model being used as a logistical framework.

PROGRAM DESCRIPTIONS

Three in-prison TC programs from the larger sample of 26 programs participating in the PIC study later became subject to treatment and staff operational changes when a new treatment-provider organization assumed management of their operations. In each case, the new provider displaced the existing provider that had been delivering TC treatment in these programs for more than a decade. In an effort to evaluate the impact of this transition on clients over time, a second cross-sectional administration of the CJ CEST was repeated about 1 year later in these programs. One program was located in a correctional facility in the southwestern region of the United States, and two were located in smaller but similar correctional facilities in the mid-Atlantic region. Clients in these programs from both regions had been mandated to substance abuse treatment by criminal justice officials, either classified through the state-level department of corrections or direct referral by a judge.

After completing these in-prison TCs, clients in the mid-Atlantic facilities also participated in 6-month, work-release aftercare programs that incorporate TC treatment elements to provide a continuum of rehabilitation and community reentry. Both men and women were eligible to participate, and these programs admitted clients referred directly from courts along with those who completed in-prison TC. During the first 3 months of this aftercare phase, clients' needs are assessed, they participate in therapy groups, they are assigned job responsibilities within the TC community, and they prepare for reentry. During the last 3 months, clients are allowed to leave during the day to work at pre-assigned jobs, but they return to the program facilities for evenings and weekends. The same treatment provider that managed the in-prison TCs described above operated three of these programs and, therefore, offered an opportunity to collect comparable client-functioning assessments in alternate settings.

PARTICIPANTS

In-prison TC programs. Using procedures approved by the Institutional Review Boards at universities overseeing implementation of the PIC study, written consent and protected health-information authorizations were obtained from individuals who agreed to participate (the overall refusal rate was less than 10%). One-hour assessments were conducted in small-group settings of about 25 clients at a time. The first administration of the CJ CEST was conducted in mid-2004 (Time 1), when the provider changes were being funded and implemented, and again in mid-2005 (Time 2), about 9 to 12 months later. The referral process for placing clients into these programs did not change during this period.

All clients in the three in-prison TC programs for male offenders were eligible to participate in the study. The mid-Atlantic programs obtained 163 client assessments at Time 1 and 180 at Time 2; mean age of this respondent tool was 32 years, and 56% were African American, 31% White, and 10% Hispanic (3% were "other"). In the Southwest program, the first and second assessments included 417 and 437 clients, respectively; mean age of respondents was 40 years, and 40% were African American, 28% White, and 30% Hispanic. These clients represented 87% of the eligible sample in the mid-Atlantic programs and 97% in the Southwest.

Aftercare programs. Clients in the three aftercare programs located in the mid-Atlantic region also were assessed at Times 1 and 2; mean age of respondents was 33 years, and 47% were African American, 44% were White, and 3% were Hispanic. Clients participating in this study represented approximately two thirds of those who were enrolled in the three aftercare programs during the time of the assessments.

MEASURES

The CJ CEST contains 14 scales representing four domains of measurement, including Treatment Motivation and Readiness (Desire for Help, Treatment Readiness, Treatment Needs, and Pressures), Psychological Functioning (Self-Esteem, Depression, Anxiety, and Decision Making), Social Functioning (Hostility and Risk Taking), and Treatment Engagement (Treatment Participation, Treatment Satisfaction, Counseling Rapport, Peer Support, and Social Support). These scales include 5 to 13 items each and use a 5-point,

Likert-type response scale ranging from 1 (*disagree strongly*) to 5 (*agree strongly*). Scores for each scale are calculated by summing responses to its set of items, dividing the sum by the number of items included (yielding an average), and multiplying by 10 to rescale the final scores so they range from 10 to 50. As described in more detail by Garner et al. (2007), these scales demonstrate favorable measurement properties, including good internal consistency, reliability, and predictive validity.

Five of these scales were considered particularly relevant for the purpose of the present study. They include Treatment Readiness (from the motivation domain), which examines client willingness to participate in treatment and perceptions of the possibilities for recovery. The remaining four scales are from the treatment engagement domain. Treatment Participation measures the level of active participation of the clients in the program. Treatment Satisfaction reflects client perceptions of the efficiency, convenience, organization, and flexibility of the program. Counselor Rapport focuses on how the client views his relationships with his counselor. Peer Support examines the relationships of the respondent with other clients.

Qualitative data also were collected in the form of semistructured interviews with program staff at each of the three in-prison TC programs during the time between the first and second administrations of the CJ CEST. Additional process evaluations were implemented at the two mid-Atlantic sites that involved passive and noninvasive observations of program operations and participants by research staff. Therapy groups and other group activities also were observed, including informal interviews consisting of nondirected questions that were conducted on an open schedule by research staff with both clients and clinical staff.

DATA ANALYSIS

Because different clients participated in the first and second assessments, it was not possible to examine matched client-level changes in CJ CEST scale scores. Instead, Time 1 and Time 2 group means were compared using two-tailed *t* tests for independent samples.

RESULTS

The CJ CEST assessments were examined in three steps. First, scale-score means from Time 1 were computed for the total sample from all three TC programs, as represented in Table 1, and compared with norms (including percentile profiles) available from the TCU developers of the CJ CEST (see <http://www.ibr.tcu.edu/resources/rc-factsheets.html>). The TCU norms are based on archived assessments from almost 2,300 males previously studied in correctional settings, and these comparisons showed that all scales fall inside the middle third (33rd to 67th percentiles) of the TCU score distributions. These comparisons showed that mean scores on all CJ CEST scales—representing motivation, psychosocial functioning, and program engagement—collected from participants in the present study were in the middle range (and very near the grand means) of scores typically observed for male offenders in correctional treatment programs.

In the second analytical step, Time 1 and Time 2 scores for the CJ CEST were compared. As summarized in Table 1, none of the psychological or social functioning scores changed significantly over time. However, all of the five treatment-motivation and engagement scales

TABLE 1: Changes From Time 1 to Time 2 on CJ CEST Scales

| CJ CEST Scale | In-Prison TC Sample | | | | Aftercare Sample | | | |
|-------------------------|---------------------|-------------|--------|-----------|------------------|-------------|--------|-----------|
| | Time 1 | Time 2 | t Test | p Level | Time 1 | Time 2 | t Test | p Level |
| | | | | | | | | |
| Desire for Help | 40.4 (7.1) | 39.0 (7.2)* | 3.29 | p < .001 | 35.2 (7.1) | 36.2 (7.3) | -1.39 | p < .17 |
| Treatment Readiness | 34.1 (8.4) | 32.3 (8.5)* | 3.89 | p < .0001 | 27.0 (8.0) | 29.1 (7.8)* | -2.48 | p < .02 |
| Treatment Needs | 32.6 (7.9) | 32.8 (7.7) | -0.34 | p < .74 | 30.5 (7.9) | 31.1 (8.2) | -0.66 | p < .51 |
| Self-Esteem | 38.2 (6.6) | 38.7 (6.6) | -1.05 | p < .30 | 38.9 (7.9) | 39.5 (7.0) | -0.80 | p < .42 |
| Depression | 22.5 (6.6) | 22.9 (7.0) | -0.82 | p < .41 | 24.5 (8.1) | 23.6 (7.4) | 1.22 | p < .23 |
| Anxiety | 26.4 (7.7) | 26.0 (7.6) | 0.89 | p < .38 | 26.6 (8.2) | 25.9 (8.3) | 0.90 | p < .37 |
| Decision Making | 38.0 (5.1) | 38.4 (5.1) | -1.30 | p < .20 | 37.9 (6.5) | 38.1 (5.9) | -0.51 | p < .62 |
| Hostility | 24.2 (7.9) | 24.5 (8.1) | -0.58 | p < .57 | 24.9 (8.2) | 24.8 (8.2) | 0.08 | p < .94 |
| Risk Taking | 29.5 (6.8) | 29.0 (7.0) | 1.43 | p < .16 | 27.8 (7.4) | 28.9 (7.2) | -1.57 | p < .12 |
| Treatment Participation | 41.6 (5.8) | 40.8 (5.8)* | 2.16 | p < .04 | 39.5 (6.3) | 40.9 (5.6)* | -2.33 | p < .02 |
| Treatment Satisfaction | 34.5 (8.0) | 31.5 (8.6)* | 6.29 | p < .0001 | 26.4 (7.7) | 30.4 (8.1)* | -4.89 | p < .0001 |
| Counseling Rapport | 38.4 (7.7) | 37.2 (8.2)* | 2.56 | p < .02 | 34.9 (9.8) | 36.9 (8.5)* | -2.35 | p < .02 |
| Peer Support | 35.2 (7.9) | 33.0 (9.0)* | 4.34 | p < .0001 | 30.6 (8.2) | 32.3 (8.9)* | -2.01 | p < .05 |
| Social Support | 41.0 (5.6) | 40.7 (6.1) | 0.91 | p < .37 | 40.3 (5.8) | 40.7 (5.8) | -0.69 | p < .93 |
| N | 576 | 619 | | | 197 | 205 | | |

Note. CJ CEST = Criminal Justice Client Evaluation of Self and Treatment; TC = therapeutic community. Boldfaced numbers indicate findings that are statistically significant differences.

listed as primary indicators for this study showed significant ($p = .05$) decreases over time. In addition, an omnibus test of time differences for this collective set of five measures was significant, $F(5, 1179) = 8.71, p < .0001$. This indicates that although psychosocial-functioning attributes measured for clients in the three in-prison TC programs for males did not change appreciably over time, the treatment-process scales detected a significant deterioration in therapeutic atmosphere. It also is noteworthy that the distinctiveness of these change patterns from Time 1 to Time 2 (i.e., the psychosocial versus treatment-process variables) argues against an alternate interpretation that these results can be explained merely by systematic changes in admission-cohort characteristics over time.

In the third analytical step, simultaneous time-related changes in the CJ CEST scales were examined in the three work-release aftercare treatment programs that were part of the same provider continuum of care located in the mid-Atlantic region. It should be emphasized that these aftercare programs differed in many ways from in-prison TC programs. For instance, they varied in terms of therapeutic dynamics and purpose (especially involving job training) and gender composition (i.e., 26% of aftercare clients were females, whereas the in-prison TCs included males only). Although these and other reasons limit direct comparisons between these sets of programs, Table 1 shows that the pattern of negative changes observed in the in-prison TCs did not apply to the aftercare programs. In fact, statistically significant improvements were reported over time in Treatment Readiness and Treatment Satisfaction scores for offenders in the aftercare programs (along with an increase in "Risk Taking" as well). Furthermore, an omnibus test of the set of all five Treatment Engagement scales showed a significant improvement from Time 1 to Time 2, $F(5, 560) = 4.78, p < .0003$. This suggests that treatment dynamics in intensive TC settings are different from aftercare or reentry programs with less (or at least different) therapeutic focus and intensity.

QUALITATIVE OBSERVATIONS

Program observations and informal client and staff interviews in the in-prison TC programs provided useful information about perceptions involving the transition in treatment providers and how it impacted program processes and management. Because the observations made across sites were highly similar, the findings presented here represent an overall synopsis of staff changes, program changes, and effects on clients.

Staff changes. Once it became known that a new request for bids from potential treatment providers had been issued, treatment-program employees began to anticipate the possibility of change. Concerns about job security ensued, although layoffs would not turn out to be the major problem. Rather, the foremost issue was salary cuts and reduction of benefits that led to high levels of staff turnover. The turnover resulted in the loss of experienced staff members who were replaced by newly hired staff with limited or no prior experience in TCs or in prison-based treatment. Positions often were filled with counselor interns or entry-level persons having little counseling experience.

Because of the slow process of restaffing a program, existing staff believed that they had to work harder at their jobs. Client-to-staff ratios increased for most group meetings, as did the counselor-to-supervisor ratio because of a reduced number of clinical supervisors. Shorthanded staff struggled to meet performance measures, and new job requirements resulted in more paperwork for counseling and supervisory staff to document treatment

plans, treatment reviews, individual sessions, and continuum of care and discharge reports. More tenured staff had the responsibility of learning new work duties, helping to train new staff, and handling larger client caseloads caused by shortages. “We were working harder, not smarter, and getting poorer results,” commented one former long-term employee who had experienced and witnessed a decline in work-related enthusiasm among colleagues. In addition, counselors and their supervisors had to adjust to a new program philosophy, schedule, and treatment curriculum.

Program changes. Some of the most obvious changes noted by staff were related to new and different treatment components and philosophies. For example, one group that formerly consisted of 25 clients doubled in size, which dramatically altered group dynamics. For some clients, the ability to disclose personal information was reduced as the groups became larger and less personal. There was an estimated 20% increase in the client–staff ratio after the provider transition. One counselor explained that the new program was no longer about the goal of a lifetime of recovery but more focused on cognitive and behavioral modification. This counselor complained that the program “lost its heart and spirit.” A related concern was about the perceived loss of peer-to-peer accountability and individual accountability to the community. This was evidenced by placing less emphasis on community hierarchy and the elimination or reduction of peer and group confrontation.

It was noted that some program changes required staff to interact differently with clients, and clients to interact differently with their peers. Clients were no longer allowed to confront inappropriate behavior on the floor; instead, they had to route behavioral issues through a counselor. This limited peer accountability and ability to confront issues immediately. Even more significant from a TC perspective, clients were not reprimanded by peers for not confronting inappropriate behavior on the unit. One client put his impression of the result this way: “This is just jail with groups, man. Ain’t no real difference between here and [any other] unit.” Program staff (including highly ranked staff) voiced displeasure at new curriculum and called it “restrictive.” One counselor who had worked for both providers said, “They (the new provider) took away our best tool—them” (pointing to the clients).

Effects on clients. Clients who had been in the program under both old and new providers observed that after the new treatment providers arrived, they often attended larger groups in new formats with fewer and less experienced staff. A higher staff–client ratio meant that clients could remain more anonymous and more easily “buck the system,” or “get over” on the counselors. The uncertainty brought about by the changes led to client disengagement from treatment and lashing out emotionally and physically. Many “tuned out” from the program. They would follow all of the rules and participate in groups but make no effort to process their feelings.

At two of the programs, fighting among clients occurred, which was extremely rare under the old program. In one case, clients even threatened staff with physical violence. According to one previous staff member, clients who entered treatment during the transition time were not made a priority to staff, who were busy learning the new program, learning counseling in general, or keeping up with the record keeping required for licensure. This inattention was obvious to the clients, as evidenced by one client comment: “They (staff) don’t care about us. They come out and do a group and then go back to their office and do paperwork. And all these guys go right back to being dope fiends.”

DISCUSSION

When a treatment provider changes, a tumultuous transition period can ensue. This might be intentional and appropriate for ineffective programs, but in established TCs, it evokes the metaphor “a tempest in a tea pot.” Findings from the present study suggest that careful planning is needed to cultivate or maintain therapeutic integrity of TC programs during transition periods, especially to limit the negative impact that these changes can have on the clients and staff of well-functioning programs. Devoting attention to stabilizing and retaining staff, maintaining treatment model integrity, and including client input as a part of the change process could ease the discontinuity and adjustment period that often occurs with the introduction of a new treatment provider.

Management changes in programs within correctional settings are inevitable because of the shifting financial and political landscapes in which they operate. However, research on correctional drug-treatment programs point out many barriers to establishing effective programs (Farabee et al., 1999). Changes in treatment providers can produce a financial gain initially for correctional systems, but short-term monetary gains should be weighed against the medium- and long-term costs associated with the impact that this change has on treatment process and outcomes. The effect of not having a well-trained and experienced staff can permeate an entire treatment program (Linhorst et al., 2001), and retaining effective staff with incentives may be difficult for a new provider that has made a bare-bones bid to win a contract.

Changes can be for the better—but not necessarily. Dysfunctional or ineffective programs stand a better chance of benefiting than do well-established and stable programs. Even though federal, state, or local authorities charged with overseeing this process must operate within budgetary constraints and related policy directives, they can (and should) adopt more systematic planning and implementation procedures. First, new providers should give careful attention to understanding the existing program atmosphere, needs, and effectiveness as perceived by staff and clients. Next, their plans should be responsive to this information, especially in regard to staff transitioning, program alterations (e.g., philosophy and procedures), and curriculum. In particular, the rationale (with evidence to support it) and objectives for changes should be made clear to correctional decision makers as well as to the program staff and clients. Third, the implementation plan (with clear timelines and benchmarks) for the transition process should be explained openly, including altered strategies for defining staff duties and training as well as assessing and managing clinical process and client activities.

As discussed by Simpson (2002) and Simpson and Flynn (in press), organizational functioning and integrity exert predictable influences on the effectiveness of treatment programs. Research shows that stages of program change—training, adoption, implementation, and practice—are subject to a combination of factors that reflect personal attitudes and perceptions of staff as well as the collective culture established within a program setting. These factors include measurable dimensions of program needs and openness to change, resources, staff attributes, and organizational climate (Lehman, Greener, & Simpson, 2002). When organizational functioning is assessed along with indicators of client-level functioning, such as the CJ CEST (as used in this study), a multilevel approach can be followed to help identify goals and barriers as well as to evaluate and monitor progress made toward change. Simpson and Dansereau (2007) explain how programs can apply this self-evaluation and monitoring strategy.

Some of the limitations faced in the current study should be noted. For example, because of the cross-sectional and anonymous manner in which data were collected, aggregated client scores were used to test for changes over time in client treatment-motivation and engagement levels. They were not the same clients, so it is possible that the significant differences observed could have resulted from cohort variations in sample composition. However, there were no procedural changes in program referrals during the study, and the full set of client-assessment results included subdomains of psychosocial attributes that remained stable from Time 1 to Time 2. A comparison group of non-TC aftercare programs also was examined, and they did not show deterioration of therapeutic engagement indicators. These findings argue against—but do not rule out—the “cohort variations” explanation for results. Nevertheless, more systematic longitudinal assessments of clients and the inclusion of stable comparison in-prison programs for which a provider change does not occur would offer a more definitive evaluation of how provider changes affect program staff and the clients who go through such a transition.

Although the focus of this study emphasizes the need for intentional planning and monitoring program functioning (both at the client and program levels) during critical periods of provider transitions, there is value in making performance monitoring a permanent feature of virtually all treatment programs. Even when a provider is retained, the impact of internal management changes, adoption of new innovations or treatment procedures, budget cuts, staff turnover, and so forth occur naturally over time and also can have an adverse impact on the quality of treatment. Having a routine assessment infrastructure in place would offer continuity (with “baseline” performance records) for evaluations of the impact that these changes may have on the treatment program.

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