

Using Evaluation to Improve Program Implementation

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Michael Prendergast, Ph.D.
Director, Criminal Justice Research Group
UCLA Integrated Substance Abuse Programs

Introduction

Evaluation is an essential part of funding and implementing programs for treating drug and alcohol problems. People want to know, particularly those who fund the programs and those who operate them: Are the programs effective? Do they produce the outcomes that are expected? Too often, however, evaluations of alcohol and drug abuse treatment programs present outcomes of the programs long after such findings will help the programs to improve and long after legislators and policy makers need the information in order to make funding decisions about the programs. But properly funded and conducted, evaluations can provide agencies and provider organizations with reliable and timely information on the operation of programs. This information can be useful in ensuring, among other things, that:

- the objectives of the program are being met,
- the program elements are well-thought out and based on evidenced-based principles and practices,
- the treatment model is being faithfully implemented,
- client needs are being identified and services being provided to meet those needs,
- reasons for early drop out or poor retention are noted,
- staff and client perceptions of program operation are taken into account,
- gaps in service delivery are identified, and

- managers are aware of problems in staffing patterns and staff development.

In short, for program and policy purposes, evaluation of the processes of treatment and its short-term impacts is at least as important as evaluation of the outcomes of treatment.

Over the past decade, the UCLA Integrated Substance Abuse Programs (ISAP) has conducted a number of program evaluations for various state agencies that have attempted to examine process (as opposed to outcome) measures of program performance. In particular, for the past five years, we have been evaluating the California Department of Correction's growing system of treatment for prisoners and parolees. We are evaluating 17 prison-based programs in 12 prisons and have collected data on over 11,000 inmates who have participated in prison treatment and on nearly 4,000 parolees who have participated in community treatment. The evaluations are monitored by CDC's Office of Substance Abuse Programs.

Evaluation Goals

The evaluations are being conducted under three separate contracts, but the main questions addressed in the studies are similar.

1. How well were the prison treatment programs components planned, developed, and implemented?
2. What problems have been encountered and how have they been addressed?
3. To what extent do the programs' activities and services achieve stated goals and objectives?
4. What impact do the programs have on the behavior of participants during treatment (e.g., disciplinary actions, drug test results)?
5. What problems have occurred in referring program graduates to community treatment?

6. What are the outcomes of participants in the programs following release to parole with respect to rearrest, reincarceration, drug use, and social adjustment?
7. What are the costs and cost-benefits of the programs?

Data Collection and Reporting

What are the sources of our information about the programs?

- We periodically visit each prison treatment program to talk with program staff and observe program activities.
- We attend the steering committee meetings of those prison treatment programs that have such a committee.
- We review program documents (program descriptions, curriculum materials, reports, etc.).
- We conduct focus groups with treatment and custody staff and with program participants.
- We receive data on the characteristics of new admissions to the programs and on when and why participants are discharged from the programs.
- We collect disciplinary and appeals statistics on program participants and on general population inmates.
- We collect information from selected prison on the impact of lockdowns on programming activities.
- We receive data on whether prison treatment participants enter community-based treatment and how long they stay.
- We attend as many committee and subcommittee meetings associated with the initiative as possible.

How are the result communicated?

- We prepare quarterly, annual, and special reports. After the reports are reviewed and approved by CDC's Office of Substance Abuse Programs, they are distributed to CDC staff and the treatment providers. (Examples of these reports have been provided to Commission staff.) The content of these reports vary, but topics that have been included are
 - data comparing disciplinary actions and appeals between the treatment facilities and the general population facilities,
 - results of random urine testing,
 - program completion status (discharge, graduate, referral to aftercare); reasons for program discharge,
 - descriptions, successes, and problems at specific programs,
 - major issues concerning program implementation that we have observed,
 - summary of focus group discussions.
- We also issue data reports that inform the providers and CDC about
 - characteristics of the participants in each of the programs (demographics, primary drug, drug/alcohol dependence, criminal history, etc.),
 - the average length of stay in programs,
 - the percentage who enter community-based treatment and the percentage who enter each type of treatment modality,
 - the average length of stay in community treatment.
- At the quarterly meetings of OSAP's Policy Advisory Committee, we report on the status of the evaluations and on major issues in implementation.

- We discuss data and our observations of program activities informally with CDC staff and with the providers.
- We present selected findings from the evaluations at researcher and practitioner conferences.
- We publish findings in academic journals (several of these have been forwarded to Commission staff).

Use of the Data

Has the information we have provided been helpful? It is difficult to determine whether the information we report back to CDC and the treatment providers has had a direct impact on the programs because CDC and the providers have multiple sources of information and because programs have their own maturation process that would occur whether we were evaluating them or not. Anecdotally, however, there are instances where program changes can at least partially be attributed to our feedback.

- At one program, we observed and reported persistent destabilization of the treatment milieu caused by a continuous influx of new, often involuntary and resistant, clients. The provider developed separate month-long “Induction Units” for new program admissions that markedly improved the program climate and better integrated new clients into the program.
- We noted high numbers of program clients who were being removed from the program due to inappropriate placements in the program. CDC classification staff modified their screening and assessment procedures, resulting in a reduction in the number of inappropriately placed clients.

- While the initial cross training between treatment staff and institutional staff was essential in getting the programs off the ground, its effects attenuated over time. We reported that continued working relationships between treatment and custody staff become strained by role conflicts and misunderstandings. Providers implemented weekly cross training sessions between treatment staff and institutional staff that improved the situation.
- In the summary of our focus groups, we reported that the programs placed a heavy emphasis on sanctions for violations of program rules and did little to offer incentives for active program participation. Nor did CDC have much to offer in the way of incentives for participation. CDC and provider staff set up a committee to develop an incentive system to enhance participation by clients in programming.

Again, it is hard to know how important the reporting of our process evaluation findings was in bringing about these changes. But it is likely that a problem reported by an external evaluator will be taken more seriously by CDC institutional staff or by the treatment providers than were it to come from within one or the other organizations.

Policy Implications

On the basis of our evaluations of California's prison treatment programs and our knowledge of prison treatment in other states, we can indicate a number of implications for policy and programming. Some of these are explained further in the annual evaluation reports that we have submitted to the Commission:

- Outcome evaluations should not begin until programs have reached maturity (further explained below).

- Because inmates mandated to treatment can disrupt programs and interfere with the treatment of those who want to be in treatment, special attention needs to be given to how to handle coerced participants. Especially for new programs, one suggestion would be to admit only voluntary clients for the first 6-12 months in order for a therapeutic climate to develop—one that will be able to more easily accommodate coerced clients.
- To be successful, treatment programs need support from institutional staff. By the same token, treatment staff need to understand the priorities and needs of correctional staff. As suggested above, ongoing crossing-training between correctional and provider staff is essential to fostering successful programs within a prison environment.
- Staff recruitment and staff development are important factors in successful prison treatment programs. Adequate salaries commensurate with working in a highly stressful work environment, thorough training upon hiring, and opportunities for ongoing professional development are among the steps that CDC and the treatment providers could take to establish an experienced and stable workforce.
- Since a single approach cannot address the variety of needs of inmates needing substance abuse treatment, a variety of treatment modalities and specialized treatment programs are needed to increase the chance of success for all treatment participants and to make efficient use of resources. CDC is moving in this direction (e.g., activating a cognitive skills program soon), and should be encouraged to continue doing so.

Final Comments

Programs should not be evaluated before they are ready. An outcome study of a new program, designed to determine its effectiveness, should not be conducted until the program has reached maturity. Although programs, depending on their complexity, their institutional setting, and the nature of their client population, mature at different rates, as a general rule, an outcome evaluation should not begin until a program has been in operation for at least a year and more likely two years. In funding outcome evaluations, particularly of new programs or pilot programs, it would help if the contracts could begin a year or two after the program contract in order to allow adequate time for a mature program to be evaluated.

Even if an outcome study is not being conducted during the maturation phase of a program, an external evaluator can assist the provider in developing a mature, stable program that is ready to be assessed as to its ability to produce positive outcomes. Working cooperatively, the provider and the evaluator can identify implementation problems, work toward possible solutions, ensure that program activities match program objectives, tailor the program to the (actual) client population, select appropriate assessment instrument and performance measures, set up management information systems and develop useful data reports, and develop policies and procedures for staff development. Such collaboration will not guarantee that the program is successful (however success is defined), but it will increase the likelihood of success, and if a program is not successful, it will be more likely that it is the treatment model that is defective rather than a failure of implementation. Process evaluations also help the evaluator to place the outcome findings in context, by knowing how the program changed over time and how those changes might have affected the outcomes.

We hope that this information will be of help to the Commission and we would welcome further opportunities to discuss our work or provide materials relevant to the Commission's continued study of the effectiveness of treatment for offenders.