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Developing effective interorganizational relationships between community corrections and community treatment providers

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ABSTRACT

Weak service coordination between community corrections and community treatment agencies is a significant barrier in the diffusion of pharmacotherapy for treating opioid and alcohol use disorders. This analysis draws on qualitative interviews ($n = 141$) collected in a multisite randomized trial to explore what probation/parole officers and treatment staff believe are the most critical influences on developing positive interorganizational relationships between their respective agencies. Officers and treatment staff highlighted factors at both the individual and organizational level, with issues related to communication surfacing as pivotal. Findings suggest that future interventions consider developing shared interagency goals with input at all staff levels.

KEYWORDS

Interorganizational relationships; parole; pharmacotherapy; probation; treatment

Introduction

Of the over 4.7 million individuals under community supervision in the United States at yearend 2013, at least 15% were opioid dependent (Herberman & Bonczar, 2014). Earlier studies have also found that alcohol dependence is pervasive among this population (Polcin & Greenfield, 2003). Although community correctional officers initiate the vast majority of criminal justice referrals to community treatment, the relationships between criminal justice agencies and community providers are often weak and referrals to effective pharmacotherapies for alcohol and opioid dependence are rare (Duffee & Carlson, 1996; Taxman, Cropsey, Young, & Wexler, 2007).

Clients under community supervision with substance use disorders very rarely receive direct care from probation or parole officers (PPOs); therefore, delivering these services requires referral to treatment providers (Duffee &

Carlson, 1996; Friedmann et al., 2013; Friedmann et al., 2012). Successful referrals for substance abuse treatment often require interagency coordination between community corrections and treatment providers with positive inter-organizational relationships (IORs). PPOs do not view themselves as having service delivery roles, and they generally believe that treatment is easily and openly available in the community if the client feels it is a beneficial service (Friedmann et al., 2012). Because community corrections organizations may have limited networks of treatment providers (Duffee & Carlson, 1996; Friedmann et al., 2012), they often have difficulty in identifying appropriate clients with alcohol or opioid use disorders and in referring them to treatment programs offering pharmacotherapy. Thus, linking clients to providers with pharmacotherapy is largely dependent upon effective collaboration among community corrections and treatment agencies (Friedmann et al., 2013).

Although most conceptual models of implementation have emphasized IORs as a major factor regarding the adoption of evidence-based practices, few studies have explored what organizational staff believe are the most critical influences on developing positive IORs between health and justice agencies (Friedmann, Taxman, & Henderson, 2007; Lehman, Fletcher, Wexler, & Melnick, 2009; McCarty & Chandler, 2009; Welsh, Knudsen, et al., 2015a; Welsh, Prendergast, et al., 2015b). Research in this area has important implications for developing positive IORs and facilitating adoption of pharmacotherapy (and more generally evidence-based practices) in justice settings. This article seeks to inform the literature on IORs between service agencies by identifying factors at the individual and organizational level that actors discuss as both facilitating and impeding successful collaboration.

CJDATS and MATICCE

CJDATS (Criminal Justice Drug Abuse Treatment Studies II) was a 5-year multisite collaborative research project funded by the National Institute on Drug Abuse (NIDA), examining implementation of evidence-based practices for treating drug abuse within criminal justice settings (Ducharme, Chandler, & Wiley, 2013). Nine research centers were selected by NIDA for inclusion in the collaborative, each working with their own criminal justice agency and community treatment provider.

One of the CJDATS studies, Medication-Assisted Treatment Implementation in Community Correctional Environments (MATICCE), focused primarily on improving linkages between community corrections agencies (i.e., probation or parole agencies) and community treatment providers as a means of strengthening the use of pharmacotherapy for treating alcohol- and opioid-dependent offenders (Friedmann et al., 2013).

Unlike implementation studies that promote the adoption of a specific clinical practice by a new or novel group of providers, or effectiveness trials

that develop innovative treatments, the MATICCE study utilized implementation strategies to link clients under community correctional supervision with community-based pharmacotherapy providers. Therefore, instead of asking correctional agencies to expand their expertise and organizational scope, the MATICCE study began with the underlying assumption that addressing two primary barriers—correctional staff knowledge and understanding of pharmacotherapy, and lack of IORs—would facilitate improved and sustainable coordination of care for appropriate clients. This analysis utilizes qualitative data from this larger parent study, to discover how corrections and treatment staff perceive IOR maintenance and development.

Interorganizational relationships

Several key factors have been identified for understanding IORs that develop between human service agencies such as community corrections and community treatment providers (Van de Ven & Ferry, 1980; Van de Ven & Walker, 1984). First, when an IOR develops between two agencies, resource dependence is generally a catalyst for its emergence. In the context of IORs, resource dependence refers to the extent to which one agency (e.g., community corrections) needs something from another agency (e.g., delivery of treatment services) in order to complete its organizational purpose (e.g., ensure probationers are compliant with the conditions of their community supervision). When resource dependence emerges, interagency coordination is often required to negotiate how the organizations involved will participate in exchanges (e.g., referrals, information, funding, etc.).

A second key factor for understanding IORs, consensus or conflict, builds between agencies as this coordination is developed (Van de Ven & Ferry, 1980). Once resource dependence exists, a greater frequency in communication emerges, and the organizations begin to negotiate specific methods for conducting exchanges of resources. As this occurs, inconsistencies in relational assumptions and expectations can develop. These issues can either be addressed at the organizational level, or an agency may move toward less resource dependence and greater autonomy (Van de Ven & Ferry, 1980; Van de Ven & Walker, 1984).

The effectiveness of these newly developed IORs is often perceived by the individuals in the agencies as the degree to which parties involved carry out their commitments to one another, and the extent to which they believe the IOR to be worthwhile, productive, and satisfying (Van de Ven & Ferry, 1980). IOR scholars have developed two levels of interagency awareness related to the perception of relationship effectiveness: agency level awareness and personal acquaintance (Van de Ven & Ferry, 1980; Van de Ven & Walker, 1984). In a dyadic relationship, agency awareness is understood by how familiar members of one agency are with the services and goals of the other

agency, and vice versa. Personal acquaintance, on the other hand, is understood by how long and how well the individuals in each agency know one another on a personal basis (Van de Ven & Ferry, 1980; Van de Ven & Walker, 1984).

In addition to these individual level components contributing to the development and maintenance of interorganizational relationships, are organizational factors such as culture, actor dispositions, and types and frequency of internal communications (Ritter & Gemunden, 2003a). In these dynamics, individuals working within an organization are actors whom represent the organization on its behalf while interacting with other agencies (Ritter & Gemunden, 2003a). When these agencies come together to interact, the actors representing the organizations are generating and assigning value to their collaborative efforts based on how each agency can profit (Ritter & Gemunden, 2003b). However, during this time of value creation, organizations experience a period of environmental uncertainty where they may be unsure whether the alternate agency will fulfill their obligations, or how new processes and practices will be instated (Premkumar, Ramamurthy, & Saunders, 2005). Therefore, Gulati and Sytch (2007) suggest that creating joint dependence, or shared goals and investments, between organizations can increase performance and improve this facet of IOR and agency collaboration.

Because the MATICCE study was developed to address issues that exist at the organizational level by implementing a process improvement strategy, understanding the intersection of each of these key concepts (i.e., joint resource dependence, consensus and conflict, interagency awareness, and environmental uncertainty) reflected in the literature on IOR development is imperative. This analysis also aims to extend the original scope of the MATICCE analysis and discover how personal acquaintance influences IOR development in the context of organizational change.

Methods

Data collection

Semistructured interviews were conducted by researchers with previous qualitative interviewing experience at each of the nine participating research centers (see Appendix). Research centers were located around the country and many were affiliated with local community justice and treatment partners who were in close geographical proximity to the research center. Interviews were conducted at two time points, baseline (i.e., before the start of the implementation intervention) and follow-up (i.e., after the completion of the intervention), during 2011–2012. Baseline interviews were designed to probe participants' knowledge of, and attitudes toward, interorganizational relationships, communication patterns between agencies, and the perceptions of barriers and facilitators to probationer access to medication-assisted treatments

(MATs). Follow-up interviews were designed to capture potential change over time in participants' views of these areas, but because the purpose of this analysis was to understand IOR rather than the influence of the intervention (Friedmann et al., 2015; Welsh, Knudsen, et al., 2015a), all of the interviews were coded and analyzed together to explore what participants believed to be the most critical influences were in developing IORs. All baseline and follow-up interviews lasted approximately 30 min. Research centers were given discretion about the location of the interviews, but most were completed at the affiliated research center offices or on-site at the participating agency. All procedures pertaining to human subjects were reviewed and approved by each research center's Institutional Review Board and criminal justice organization, and all participants were provided written informed consent.

Participants

A total of 118 PPOs from 20 parole and probation offices in nine different states completed a semistructured qualitative interview, and were primarily sampled based on convenience and availability due to officers' busy schedules and large caseloads. Additionally, 23 treatment staff who were directly involved in the change team intervention implemented by the larger parent study were also interviewed for a total qualitative sample of 141 ($N = 141$). The PPO sample was mostly female, White, and non-Hispanic. The mean age of the PPO sample was 46 years, with an average of 13 years of professional community corrections experience. The treatment provider sample was predominantly female, White, and non-Hispanic. The mean age of treatment providers was 52 years, with an average of 16 years professional treatment experience. (See [Table 1](#))

Data analysis

Qualitative interviews were audio recorded and transcribed within each research center. To protect participant confidentiality, the names of respondents, agencies, and any other potentially identifying information were redacted from the transcripts before cross-site collaboration occurred. These de-identified transcripts were then uploaded into the qualitative analysis software Atlas.ti (v. 6.2) for coding. All qualitative transcripts were initially

Table 1. Sample characteristics of PPOs ($n = 118$) and treatment providers ($n = 23$).

Variables	Probation or parole officer n (%)	Treatment provider n (%)
White	84 (71)	20 (88)
Non-Hispanic	95 (80)	22 (94)
Female	65 (55)	17 (76)
Average years experience	13	16
Average age	46	52

coded using a universal coding scheme developed by qualitative researchers from all of the nine research centers, through an iterative consensus process within a cross-research center workgroup. Through this process, qualitative researchers were able to develop a standardized codebook that contained a list of primary and secondary codes, definitions, and examples that was agreed upon by all qualitative analysts in the cross-research center workgroup. Working directly from this codebook, one researcher from each research center coded the baseline and follow-up transcripts, and in research centers where more than one analyst coded their respective transcripts, reliability checks were performed to ensure fidelity of coding, which is a marker of rigor in qualitative research (Tracy, 2013).

The analysis for this article utilized text segments within five existing cross-research center codes developed in the workgroup: (a) current IOR (respondent's knowledge and perceptions of inter-organizational relationships between corrections and pharmacotherapy in the community, as they currently exist); (b) perceptions of other agency (respondent's opinions on collaborating agencies); (c) perceptions of MAT (respondent's personal perceptions and attitudes regarding pharmacotherapy); (d) role perception (respondent's perception of their roles and responsibilities in the organization, other's roles, or how the respondent's role and the roles of others interact); and (e) IOR enhancement (suggestions given for improving the linkages between CC and treatment providers, and specifically how to increase or improve the referral process). These five existing cross-research center codes were primarily used as a mechanism of data reduction in order to isolate specific areas of the qualitative interviews that pertained to IOR issues.

While this initial, or primary, level of coding was approached deductively, including similar pre-existing expectations as those used to generate the semi-structured interview guide, the secondary level of coding allowed the authors an opportunity to inductively generate a coding scheme from the data. The first author, after quotations associated with the primary codes were read and rigorously analyzed, created an inductive subcoding scheme based on themes and concepts that emerged from the respondent narratives related to factors that participants deemed critical for IOR development. These subcodes were then applied to all of the isolated text segments.

Results

Throughout the qualitative data, communication was the most salient factor in the development of both positive and negative IORs between community corrections and community treatment providers. While both PPOs and treatment staff noted that the quantity and quality of communication acted as both an indicator of their current IOR, as well as a driving factor of how their relationship would develop in the future, PPOs tended to place a stronger

emphasis on the importance of using direct communication (when information is exchanged directly between officers and treatment staff) as a mechanism of information exchange. When communication between the agencies at the individual officer and treatment staff level was described as poor, respondents tended to describe perceptions of the other agency in negative terms, as a whole, by generalizing their experiences from their interactions with one or two individuals to the entire agency. This generalization was amplified when indirect lines of communication developed (when information is exchanged between officers and treatment staff through another party), either by inconvenience or through an intermediary agency (e.g., a specialized treatment referral agency). Treatment providers, while agreeing that communication between the agencies for the purpose of information exchange was important, tended to place a greater emphasis on communication as a tool for collaboration in achieving both agency missions of public safety and public health.

Direct communication

On a routine basis, PPOs and treatment staff most commonly communicated directly with one another by phone or fax to discuss pertinent updates for PPOs' clients who were enrolled in a local pharmacotherapy program. PPOs generally reported satisfaction with these methods of communication—when treatment progress for supervised clients was provided in a timely and efficient manner. More productive relationships between the agencies were associated with regular communication and an understanding of respective processes. For example, several PPOs described visiting treatment providers in order to understand their programs, saying that as a result, “We have the good open communication with them in relation to our clients... including sharing reports and important information.” Others described “great relationships” with outside referral agencies where there was communication and problem solving between agencies. As one PPO respondent noted:

Yes, I mean it is positive for the clients ... it is positive for us as [community corrections] officers ... it helps us to manage our caseloads better ... it is not easier but it does make our job easier to know that someone is in treatment and knowing that someone comes to your office on a Thursday afternoon and needs some type of treatment and we can make a phone call and that person will get some help then and there ... not next week ... it is helpful when you have a provider that is there and willing to work with you. I think if everyone is on the same page then it works well.

In a similar vein, many PPOs reiterated how collapses in both quantity and quality of communication between their agency and the treatment provider also negatively impacted IORs. Some corrections staff focused on negative experiences with individual treatment agencies, and described

treatment providers as being slow to respond with information or keeping poor records:

Ok, I guess a negative, unfortunately, would be that [treatment agency] has always been the main program that we've used so a lot of time had difficulty being able to get information as far as other substances that the offender was using, so they may have been getting their daily methadone which we could confirm but then I would find out too late or down the road too far that they were then testing positive for another substance such as cocaine, which seemed to be pretty regular, and the response was always "We're trying to tweak the levels of methadone," but my response was, "I need to know what else he's using, because we have a safety issue at hand," so if we're out there using cocaine while on methadone, that's not acceptable.

In response, treatment providers mentioned feeling as though they spent more time trying to get in touch with PPOs to provide the updated progress of clients under community supervision, than PPOs did trying to contact treatment staff:

I think we do more trying to get in touch with them than they do with us ... they don't really get involved too much. Most of them, there's a few of them that are more involved in their clients lives but if they can't find somebody, you know they'll call over here, have you seen so and so lately you know or I've gotten e-mail once, do you know what ever became of so and so, oh yeah they were here last year. Oh, just trying to find him now you know.

Given that updated progress reports were requested by the PPO, treatment providers noted feeling frustrated that they were asked to initiate communication between the two agencies. One treatment staff member mentioned this issue coming up during an intervention meeting: "They wanted us to be the ones to send the progress report form. Why do we have to be the ones to do it? So kind of like, who's responsible I guess."

One PPO referenced treatment staff turnover as a contributing factor for their receipt of poor quality information. When information received from treatment agencies was untimely or was of insufficient quality, officers' sense of IOR decreased because they were unable to adequately monitor their probationers:

Their turnover is really affecting them. We're supposed to be informed about [client] issues on the same day. ... It's hard making contact to find out information. ... Regular communication makes a major difference because we need to know when they miss a group, we need to know when they start using again. We need to know immediately. (PPO)

Communication appeared to be central factor for the respondents in this study, who often used a personal measure of quality and quantity of communication as a proxy for the quality of the organizational relationship, itself. In the PPO excerpt next, the respondent began discussing interorganizational communication, unsolicited, when asked a direct question by the interviewer

about the quality of relationships with other agencies. This respondent came to the conclusion that their relationship with the treatment provider was good because the level of communication was sufficient:

I would say we have a good relationship but I think it was maybe a year and a half ago now myself, our drug court judge, my director, we all went and actually did a site visit and then I had gone back a few months later and given a presentation on our program as well. So yeah, I mean we have the good open communication with them in relation to our clients. (PPO)

Indirect communication

Indirect methods of communication and information gathering (e.g., hearsay gathered through clients or other staff, intermediary assessment or referral agencies, etc.) appeared to be problematic for PPOs and treatment staff in establishing positive IORs. For PPOs, a general sense of uncertainty surrounding the policies and procedures treatment agencies used in providing pharmacotherapy created barriers to improving IORs, especially when officers believed the programs were “relaxed” or not “aware” of probationers’ continued substance use. These perceived attributes made it more difficult for PPOs to successfully monitor their clients in pharmacotherapy programs, thus decreasing their perceived IOR with the provider.

Other PPOs complained about a provider’s lack of accommodation and flexibility for clients, stating, “We’re not happy with them. ... Nothing good to say about them. Their reports are always screwed up. They don’t do a good job.” Still others discussed distant relationships with providers who maintained “distasteful,” or “inhumane” practices such as “discharging people, primarily for financial reasons” or those who operated “dosing stations,” (i.e., providers who gave methadone take-homes without supervision, groups, therapy, etc.):

Those people get on my nerves. They don’t have any groups. They just send these people out into the world with these take homes. You can never reach anybody. You never know if they’re really going there or not. ... That’s not a program. You’re essentially a dispensary. (PPO)

As another PPO noted:

I didn’t really like [the treatment program] too much because it seemed like I really couldn’t monitor [treatment progress] too well. The clinic was very informative on some things, but some things they really weren’t. It could have been the place I was working with, I don’t know. It was just really difficult to monitor. (PPO)

Although this PPO noted that not all pharmacotherapy programs presented problems for continued monitoring of probationers, those that did present such challenges had a clear impact on the PPOs ability to adequately monitor their caseload. This PPO quote also highlights the importance of communication in

monitoring probationers on pharmacotherapy, given that the quality of pharmacotherapy related care could impact PPOs' perceptions of exchanging quality and timely communication, which has already been established as integral to PPOs being able to perform their duties. Unfortunately, although PPOs were able to directly assess how well, and expediently, treatment personnel exchanged information on probationers, they were only indirectly able to assess the quality of pharmacotherapy-related care. Given the instrumental role that perceived quality of pharmacotherapy care can have in shaping PPOs' perception of the treatment agency, as a whole, and thus, how PPOs perceived the strength of IORs, it is important to note that much of what PPOs knew about the quality of pharmacotherapy care being provided came indirectly through their interactions with probationers in those very MAT programs. When asked about whether their opinion of pharmacotherapy programs was shaped by the probationers on their caseload, this PPO responded:

I would say a lot. I would base a lot of what I think about the program based on the people [probationers and parolees] who are first handedly experiencing what the program offers. So I would say [I base] my views a lot on the attitude and the characteristics of my clients [probationers and parolees]. They either love the program because it's a really cheap fix or a high, or they are tired of it and say it doesn't help them [probationers and parolees] either. So my attitudes based a lot on the feedback I do get from them [probationers and parolees]. (PPO)

Additional PPOs acknowledged rumors that circulated regarding pharmacotherapy programs, and the general lack of information about these programs in their offices. One PPO admitted: "Honestly, I've never been to the place. I don't have that information except what they [clients] tell us that they do over there." This is an important consideration when trying to determine meaningful processes that shape IORs for community corrections and treatment agencies. Probationer experience with a pharmacotherapy program can be shaped by many different subjective factors as a client of a community service and, given how influential PPO perceptions of pharmacotherapy and pharmacotherapy programs can be on determining IORs, direct participation between PPOs and treatment personnel seems to dramatically enhance positive IORs.

Treatment providers echoed PPOs' concerns about indirect lines of communication and information exchange by noting that the ideal arrangement was for PPOs to physically visit the treatment sites, on occasion, to understand how the clinic operates and see clinic policies in action. At one treatment site, providers made it clear that their preference was to have PPOs present during the initial intake meeting with treatment staff, but that it was often inconvenient and difficult to implement. When asked about the relationship between treatment staff and PPOs, one provider noted:

From what I hear, overall it's pretty good. We do have some problems because we like to have the probation officer actually come in and meet with the therapist and

the client for the first, you know the intake session which, that is sometimes hard to coordinate. But overall, I haven't heard many complaints about it. I think [the amount of communication] depends on the probation officer and how much ... how they want to be involved. (Treatment staff)

The desire for a physical or telephonic presence of a client's PPO went beyond the initial intake meeting at some clinics, with one treatment supervisor suggesting to treatment staff that they bring the client into their office and call the PPO directly. This supervisor believed that hosting a conference call between all relevant parties was the best and most efficient way to avoid some of the problems associated with communicating indirectly through a client:

If the client is not coming to group and you're getting manipulated and the stories and all, like the BS that comes with it, let's just bring them into the office get the PO on the phone, put him on a speaker and let's have them all discuss what's going on, what your recommendations are and come up with a solution. Because with three people involved, the counselor, the PO and the client you have the triangle ... to try to stop the manipulation and everybody knows what's going on and all the cards are on a table and a lot of the games stop. (Treatment staff)

In another example of the problems that develop with indirect communication, several treatment personnel mentioned that they believed the use of external treatment referral agencies in their jurisdictions resulted in inefficient communication between community corrections and treatment agencies because treatment referral agency personnel limited the direct correspondence between officers and treatment staff once a referral had been initiated. One treatment provider was able to compare the existing relationship with community corrections now that a treatment referral agency had been introduced in the jurisdiction, with the relationship that existed prior to this occurring. This treatment provider mentioned that:

Years ago we didn't have [treatment referral agency] and so I have a point of comparison that clients would come to us directly and it was much smoother ... and when we had it that way, not that we still can't have a positive relationship with [community corrections] we can, but I think we had a better relationship with [community corrections] because it was more direct. (Treatment staff)

When communication was slowed because of an intermediary agency, officers became frustrated and generally preferred to work with a treatment provider with whom they could communicate directly, thus increasing the strength and positive perception of IORs with the latter agency. Inefficient mechanisms of communication were directly related to PPO ability to do their job, and many officers used these concepts synonymously. The more efficient particular policies and processes were, the better able officers felt in their ability to carry out their duties.

Organizational-level dynamics

Negative interactions at the individual-level were primarily noted by PPOs as being used to formulate negative perceptions toward the alternate agency, as a whole. These negative perceptions of the agency, as a whole, translate into much weaker professional working relationships, and thus less positive perceptions of IOR. Beyond individual-level mechanisms of communication used by PPOs and treatment staff, organizational-level dynamics existed between the agencies that respondents associated with the development of positive IORs.

Treatment providers tended to be more outspoken about aspects of organizational-level communication and collaboration, (e.g., sense of a shared interagency mission, resource dependence, community corrections' power and authority over clients, etc.), and factors that tended to facilitate or impede developing IORs at this level. Because the job of a PPO is to supervise clients in the community, according to a set of guidelines or orders passed down from the courts, PPOs tended to need purposeful, individual-level communication with treatment staff to retain information about one of their clients with a substance use disorder. This level of communication satisfied the need their job required, and generally made supervising clients with substance use disorders easier. In this light, PPOs tended to be less concerned with influential dynamics at the organizational level. As one treatment provider noted:

I know some POs that really get frustrated with dealing with their addicted population of clients. And so, they would rather send them to the counselors and the treatment providers to deal with that bunch of folks and are glad to work with us, because it does make their job easier. (Treatment staff)

Treatment providers, on the other hand, do not require information from community corrections in order to treat a client on their caseload with a substance use disorder. Treatment providers most often noted that their job was to “establish a therapeutic relationship” with clients in order to help them achieve their goals for treatment. If a client also happened to be on community supervision, treatment staff would account for that in their treatment plan, and encourage clients to follow all of the conditions of their supervision and sign a release of information form that would allow their PPO and relevant treatment staff to discuss their progress openly. However, given the authority PPOs maintain over their clients, and treatment providers' general focus on therapy engagement, one treatment staff member noted being placed in difficult situations between the client and the PPO when trying to push the issue of signing a release of information:

I think the probation officers need to force the issue [of the release of information form], they have more leverage than we do ... I mean we can't make the clients sign or release form ... I can understand they need [information] for the judge. ... But, I

can't give you something that I can't give you, no matter what you say ... they want us to like tattle tale on them, we can't do that, we have to have a therapeutic relationship with the client in order to be able to provide treatment, and they don't get that. They want you to, you know oh the client on zero tolerance so I want you to call me as soon as, no, we're not going to do that. So I mean I think that's hard to get across, "cause they're coming from a different, they're coming from where they're relationship with the client is you know, punitive and that they are just have authority over what's going to this person. As far as, they get put in jail or extend their probation, or release them early all that kind of stuff. So, I think it's just a different situation and I think it's gonna be hard to blend the two." (Treatment staff)

Blending the perceptions of two different relationships or situations was a common organizational-level barrier that both PPOs and treatment staff noted. Respondents often drew a line between community corrections' mission of public safety and treatment providers' mission of public health, with one treatment staff member noting, "I just think we're always gonna be on opposite sides." Treatment providers believed that PPOs "are not very tolerant to relapse" and other therapeutic processes associated with working with substance use disorder clients, making it difficult to work together because treatment personnel "understand that that's part of the recovery process usually." Another treatment provider noted: "Criminal justice is very different and I've learned that in working with them is that you know we come with very different goals in mind a lot of times and different understanding of how to get to those goals."

On the other hand, PPOs most often suggested that their role was far more extensive than community supervision, with one corrections officer describing their role as "more a case management and probation" job because of all the different aspects they were required to address with any particular client. Another officer mentioned:

I think it's ... we always say around here, we wear a different hat, and we do. We're everything, like, we're parents because when you're chasing these people around and you're trying to get them to go to treatment and you're nearly begging them, you feel like a parent. And then, we're social workers, because I'm trying to find you treatment programs and I'm trying to put you in job placement and I'm trying to find out what's going on with your family and what's up with your health. (PPO)

While many PPOs agreed that all of these elements were critical to performing their job, they also indicated the difficulty, and in some cases the inability, in facilitating all of the needs of their clients and connecting them to each of the community services they required. Several officers regarded their role as existing between two sometimes-conflicting missions—helping their clients while also keeping the community safe. As one PPO summarized:

And, my ultimate goal for all of us, well, I guess I shouldn't say that, my ultimate goal is public safety, and the rehabilitation of the offenders, and as long as I am not compromising public safety, then my next goal is [rehabilitation]. (PPO)

Discussion

Ultimately, communication emerged as a pivotal concept and tool in developing positive IORs between community corrections and community treatment providers. In this analysis, communication that occurred at the individual level can be categorized into two forms, direct and indirect. Direct, individual level communication was integral for the day-to-day exchange of information between agencies, but both officers and treatment staff noted various breakdowns at this level that caused negative perceptions of IORs to develop. Similarly, communication that occurred indirectly at the individual level also caused a disruption to information exchange that frustrated staff at both agencies. PPOs tended to discuss issues of IOR development and maintenance at this level more so than treatment staff. At the organizational level, treatment staff tended to be more likely to describe issues surrounding agency power dynamics over clients and incompatible agency missions as influencing how IORs would exist between the agencies.

IORs between community corrections and community treatment were examined in several publications from the parent study (Welsh, Knudsen, et al., 2015a; Welsh, Prendergast, et al., 2015b). In one analysis, quantitative outcomes showed positive development in both agency and personal awareness, and frequency of communication for community treatment participants, while there were no significant differences in any measure of IOR among PPOs (Welsh, Prendergast, et al., 2015b). Qualitative data for that analysis explain that community corrections and community treatment staff may have had differing expectations about how IORs would exist by the conclusion of the study, and therefore the quantitative data reflect treatment providers' belief that changes were made in all of the areas that were possible to address (Welsh, Prendergast, et al., 2015b). This aligns most closely with the existing literature that emphasizes environmental uncertainty and its intersection with performance and quality of collaboration (Gulati & Sytch, 2007). The lack of shared goals between the two agencies continued to permeate as a barrier to improving the perception of strong IORs and linkages.

The analysis in this article further expands on this understanding of IORs by contextualizing these differing expectations as existing in a dynamic network of what officers and treatment staff each believe to be the most important contributors to developing positive IORs. If PPOs believe that efficient and expedient information exchange at the individual level is the key component for a positive IOR with community treatment, then interventions should be focused on streamlining information sharing channels and processes. However, if community treatment providers believe that organizational dynamics involving power and authority, and incompatible organizational missions are the key components for a positive IOR with community corrections, then interventions designed only to streamline information

channels and processes would not meet their needs. This finding is supported by previous inquiries into IOR improvement between these agencies, which also found that community corrections staff believed that increased participation of treatment providers in the intervention would have resulted in even greater improvements (Welsh, Prendergast, et al., 2015b).

This analysis has several limitations. First, because it is a secondary data analysis from a parent study, sample sizes of community corrections and community treatment participants were not equal. Second, treatment provider qualitative interviews were conducted with staff members directly involved in the organizational-level intervention, which may have primed some of their comments to be geared toward factors at the organizational level. Third, data analysis was limited to the interview guide that was created for the parent study, and adjustments to the guide to probe further into participants' views of IORs were not possible. Finally, because the qualitative data was collected as part of a research cooperative, transcripts were redacted to protect participant confidentiality, which removed the researcher's ability to fully contextualize some of the data.

The CJDATS MATICCE study has generated several analyses to understand further the complex nature of developing and maintaining IORs between community justice and treatment agencies, which can be used to inform inter-organizational initiatives. The results of this analysis indicate that future interventions targeting IORs and linkages strongly consider the dynamic nature of communication as an integral factor for promoting change across agencies. Agencies may prioritize levels of communication differently, but direct lines of communication among staff members were important to both organizations in this study.

Future interventions should focus on identifying and improving a shared interagency goal. Such work should include input from staff at each agency who may have differing ideas about how a shared goal can be achieved. In addition to improving overall success of the intervention, this strategy might also have the latent effect of improving current IORs between agencies.

References

- Ducharme, L. J., Chandler, R. K., & Wiley, T. R. A. (2013). Implementing drug abuse treatment services in criminal justice settings: Introduction to the CJ-DATS study protocol series. *Health & Justice, 1*(1), 5. doi:10.1186/2194-7899-1-5
- Duffee, D. E., & Carlson, B. E. (1996). Competing value premises for the provision of drug treatment to probationers. *Crime & Delinquency, 42*(4), 574–592. doi:10.1177/0011128796042004005
- Friedmann, P. D., Ducharme, L. J., Welsh, W., Frisman, L., Knight, K., Kinlock, T., ... Pankow, J. (2013). A cluster randomized trial of an organizational linkage intervention for offenders with substance use disorders: Study protocol. *Health & Justice, 1*(1), 6. doi:10.1186/2194-7899-1-6

- Friedmann, P. D., Hoskinson, R., Gordon, M., Schwartz, R., Kinlock, T., Knight, K., ... Frisman, L. K. (2012). Medication-assisted treatment in criminal justice agencies affiliated with the criminal justice-drug abuse treatment studies (CJ-DATS): Availability, barriers, and intentions. *Substance Abuse*, 33(1), 9–18. doi:10.1080/08897077.2011.611460
- Friedmann, P. D., Taxman, F. S., & Henderson, C. E. (2007). Evidence-based treatment practices for drug-involved adults in the criminal justice system. *Journal of Substance Abuse Treatment*, 32(3), 267–277. doi:10.1016/j.jsat.2006.12.020
- Friedmann, P. D., Wilson, D., Knudsen, H. K., Ducharme, L. J., Welsh, W. N., Frisman, L., ... Vocci, F. J. (2015). Effect of an organizational linkage intervention on staff perceptions of medication-assisted treatment and referral intentions in community corrections. *Journal of Substance Abuse Treatment*, 50, 50–58. doi:10.1016/j.jsat.2014.10.001
- Gulati, R., & Sytch, M. (2007). Dependence asymmetry and joint dependence in interorganizational relationships: Effects of embeddedness on a manufacturer's performance in procurement relationships. *Administrative Science Quarterly*, 52(1), 32–69.
- Herberman, E. J., & Bonczar, T. P. (2014). Probation and parole in the United States, 2013. *Bureau of Justice Statistics*. Retrieved from <http://www.bjs.gov/content/pub/pdf/ppus13.pdf>
- Lehman, W. E., Fletcher, B. W., Wexler, H. K., & Melnick, G. (2009). Organizational factors and collaboration and integration activities in criminal justice and drug abuse treatment agencies. *Drug Alcohol Dependence*, 103, S65–S72. doi:10.1016/j.drugalcdep.2009.01.004
- McCarty, D., & Chandler, R. K. (2009). Understanding the importance of organizational and system variables on addiction treatment services within criminal justice settings. *Drug Alcohol Depend*, 103, S91–S93. doi:10.1016/j.drugalcdep.2009.03.001
- Polcin, D. L., & Greenfield, T. K. (2003). Factors associated with probation officers' use of criminal justice coercion to mandate alcohol treatment. *The American Journal of Drug and Alcohol Abuse*, 29(3), 647–670. doi:10.1081/ada-120023463
- Premkumar, G., Ramamurthy, K., & Saunders, C. S. (2005). Information processing view of organizations: An exploratory examination of fit in the context of interorganizational relationships. *Journal of Management Information Systems*, 22(1), 257–294.
- Ritter, T., & Gemunden, H. G. (2003a). Interorganizational relationships and networks: An overview. *Journal of Business Research*, 56, 691–697.
- Ritter, T., & Gemunden, H. G. (2003b). Network competence: Its impact on innovation success and its antecedents. *Journal of Business Research*, 56(9), 745–755.
- Taxman, F. S., Cropsey, K. L., Young, D. W., & Wexler, H. (2007). Screening, assessment, and referral practices in adult correctional settings: A national perspective. *Criminal Justice and Behavior*, 34(9), 1216–1234. doi:10.1177/0093854807304431
- Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Hoboken, NJ: Wiley-Blackwell.
- Van de Ven, A. H., & Ferry, D. L. (1980). The interorganizational field. In A. H. Van de Ven, & D. L. Ferry (Eds.), *Measuring and assessing organizations*, (pp. 296–346). New York, NY: John Wiley and Sons.
- Van de Ven, A. H., & Walker, G. (1984). The dynamics of interorganizational coordination. *Administrative Science Quarterly*, 29(4), 598–621. doi:10.2307/2392941
- Welsh, W. N., Knudsen, H. K., Knight, K., Ducharme, L., Pankow, J., Urbine, T., ... Friedmann, P. D. (2015a). Effects of an organizational linkage intervention on interorganizational service coordination between probation/parole agencies and community treatment providers. *Administration and Policy in Mental Health and Mental Health Services Research*, 43, 105–121. doi:10.1007/s10488-014-0623-8
- Welsh, W. N., Prendergast, M., Knight, K., Knudsen, H., Monico, L., Gray, J., ... Friedmann, P. D. (2015b). Correlates of interorganizational service coordination in community corrections. *Criminal Justice and Behavior*, 43, 483–505. doi:10.1177/0093854815607306

Appendix

Interview guides

Probation or parole officer interview guide (baseline):

1. What do you, personally, think about MAT such as methadone or naltrexone?
2. In general, how would you describe your organization's current views towards MAT for opiate problems?
3. Please describe the current relationship between your agency and MAT providers in the community.
4. What needs to happen to create an official relationship between your organization and the MAT providers in your community?

Probation or parole officer interview guide (follow-up):

1. What do you, personally, think about MAT such as methadone or naltrexone now?
2. In general, how would you describe your organization's current views towards MAT for opiate and/or alcohol problems?
3. Please describe the current relationship between your agency and MAT providers in the community.
4. What do you think would be most useful/effective for furthering or creating a relationship between your organization and the drug treatment providers in your community at this time?

Treatment provider interview guide (baseline):

1. What do you personally think about MAT such as methadone or naltrexone?
2. In general, how would you characterize the general attitudes regarding the use of MAT at your organization?
3. What is your understanding of the current referral process between your agency and [treatment provider, TASC, or parole/probation]?
4. Please describe the current relationship between your agency and [MAT providers, TASC, or community corrections agencies].
5. In what ways do you think the PEC process can enhance the relationship between your organization and [MAT providers, community corrections agencies, or TASC]?

Treatment provider interview guide (follow-up):

1. Are you currently performing the same job as when you completed your last interview for the project?
2. What do you, personally, think about MAT such as methadone or naltrexone now?

3. In general, how would you describe your organization's current views towards MAT for opiate and/or alcohol problems?
4. Please describe the current relationship between your agency and other agencies participating in the PEC.