

Technology Transfer of Evidence-based Practice in Substance Abuse Treatment in Community Corrections Settings

A WHITE PAPER

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EXECUTIVE SUMMARY

The question of “what works” in corrections captivated the attention of policymakers, practitioners and researchers for nearly two decades as the United States struggled with building a corrections enterprise that punished offenders, held offenders accountable, and protected the community. The “what works” approach emphasized that scientific findings can inform policy and practice to advance the attainment of corrections goals in a cost effective and public safety framework. By having science provide objective information about effective practices that change offender behavior, policy makers and practitioners can use data on effectiveness, costs, and benefits to make informed decisions. The “what works” phenomenon, now more commonly referred to as evidence-based practices, offered this consensus-building approach to reduce the more reactive and crisis-driven decision-making that often characterizes policy in the criminal justice system.

Building evidence is relatively easy. Since the “what works” approach was introduced in the late 1980s (Andrews, et al., 1990), the methodology and techniques evolved with the advent of statistical tools to augment meta-analysis or systemic review processes. Systematic reviews are now fairly common, including those supported by the Campbell collaboration (www.campbellcollaboration.org), journals that are devoted to dissemination of experimental and systemic findings (e.g., *Journal of Experimental Criminology*), consensus and systematic reviews that are devoted to identifying best and evidence-based practices, national repositories of information about evidence-based drug treatment and prevention, and state legislatures that now require the use of evidence-based practices in their legislation (e.g., Oregon, Ohio). Complementary sources are available to the public that translate the research into practices that are easily identifiable. The National Institute on Drug Abuse (2006) *Principles of Drug Abuse*

Treatment for Criminal Justice Populations identifies 13 evidence-based practices. The Substance Abuse and Mental Health Services Administration (SAMHSA) hosts the National Registry of Evidence-based Programs and Practices (NREPP) which identifies evidence-based practices across a cadre of substance abuse and mental health prevention and treatment programs (<http://www.nrepp.samhsa.gov/index.asp>). Finally, the National Institute of Corrections has produced numerous publications on evidence-based practices (NIC, 2004; Taxman, Shepardson, & Byrne, 2004a). These resources illustrate how science and practice have emerged for federal, state, and local governments to ensure that provided services are designed to achieve desired outcomes.

To a large extent, the efforts thus far have focused on the dissemination of knowledge about policies and practices that can improve offender outcomes. The diffusion process—the mechanism to by which new or existing practices are communicated through certain channels within a social system and/or organization over time—has received less attention in the corrections field. Models of diffusion have been built primarily within the substance abuse field that echo the work of Everett Rogers (1983) to prepare for the innovation, implement, measure progress, and sustain the efforts. Different methods have been proposed with varying emphasis, including process improvements (see NIATx, 2007; McCarty et al., 2007); organizational models of change (see ATTC, 2004; Klein & Sorra, 1996); staff levels of technology transfer (see Simpson, 2002; Markus, 1983); and other organizational strategies such as fidelity and adherence models. These models were built for a discipline—primarily substance abuse—where the goals are clear, and tend to be unified, such as improved health and well-being of the client. The translation of these types of models to the corrections field, with its conflicting and contradictory goals of public safety and health as well as a more negative approach to service delivery, has been difficult to achieve. This White Paper is devoted to the diffusion of evidence-based

substance abuse treatment within the corrections environment by presenting a model that responds to the characteristics and needs of the corrections system. We propose a Community Corrections Technology Transfer Model as a conceptual framework for fostering organizational change in corrections settings.

Community Corrections is a Unique Setting for Substance Abuse Treatment Interventions

The Community Corrections Technology Transfer Model evolved from our review of the corrections and substance abuse fields to learn about organizational change processes. Four major steps were taken: (1) a review of dissemination, diffusion, and organizational change research across disciplines, (2) a review of survey findings on corrections practices (see Taxman, Young, et al., 2007; Friedmann, Taxman, & Henderson, 2007; Henderson, Taxman, & Young, 2008), (3) interviews with key informants in the field, and (4) a review of the lessons learned from the National Institute of Corrections Evidence-Based Practices project (Clawson, 2008). The research indicated that the model must address these four unique facets of corrections agencies that are not as pertinent in other disciplines.

1. The conflicting mission and goals associated with evidence-based treatment practices and traditional goals of sentencing (e.g., punishment, incapacitation, deterrence, and rehabilitation) must be addressed to achieve mission clarity and organizational support for the evidence-based practices.
2. New evidence-based practices need to be aligned into existing processes or procedures, which will require either adaptations of the evidence-based practices or modifications in existing processes (i.e., the quality improvement model; see Ford et al., 2007). Often the introduction of evidence-based practices will require an assessment of existing processes with an eye toward modifications, reductions in duplication, or clarity of importance assigned

to these processes. This process is needed to overcome organizational barriers to innovation and changes in work practices.

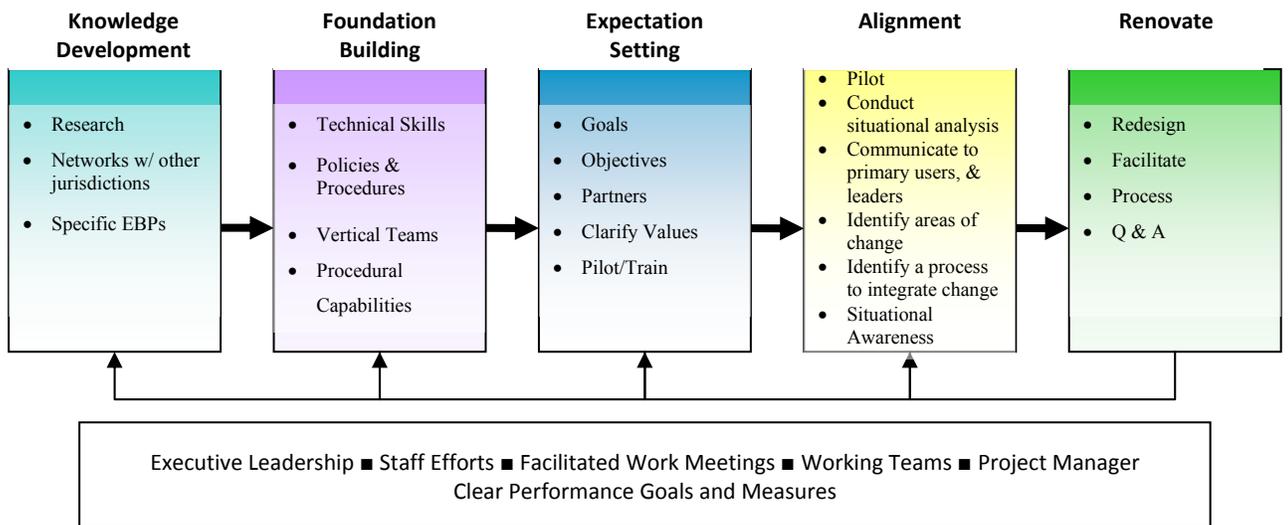
3. Staff working in corrections agencies (e.g., managers, supervisors, and line staff) requires both the development of knowledge and the skills to use these practices. More attention needs to be given to organizational strategy to engage the organization as a whole in the change process. Work requirements in corrections settings generally mean that staff does not have the basic competencies in interviewing and interaction skills that are present in other disciplines (e.g., substance abuse, mental health, etc.), and that are needed to support rehabilitation efforts and offender change. The need exists to give more attention the development of basic and advanced skills in evidence-based practice areas.
4. Improvements in feedback loops are critical to “incentivize” the system, and to provide the organization and stakeholders with information about the advances made and to provide the momentum to change. Feedback loops can include management information systems, benchmarks, performance monitoring, testimonials, or public media messages to address the social networks associated with diffusion, and to ensure that the feedback builds momentum. Within the corrections setting, attention needs to be given to internal (e.g., staff, supervisors, other agencies) and external (e.g., judges, prosecutors, legislators, public health officials, etc.) stakeholders that are interested in refined outcomes.

Community Corrections Technology Transfer Model

Our Community Corrections Technology Transfer Model (CCTTM) evolved from the existing literature and the unique features of corrections agencies. It provides a framework for managing the change process through five steps: 1) knowledge development; 2) foundation building; 3) expectation setting; 4) alignment; and 5) renovation. Although the model is presented in a linear fashion, it is recognized that it is not necessary linear and that organizations

may have different “starting places” for different content areas. For example, an organization that contracts with a well-established substance abuse treatment provider delivering evidence-based interventions (e.g., cognitive behavioral therapy, family-focused interventions) to provide dedicated treatment slots for parolees, or one that has been using a second generation risk tool (e.g., Wisconsin Risk and Need), may need less knowledge development in moving toward expanded use of evidence-based interventions. And, this model underscores processes of change that involve active leadership, staff involvement in change processes, facilitated meetings and workshops to develop strategic and implementation plans, project management that is clearly defined with authority and timeframes, working teams at multiple levels, cross-systems organizational collaborations, and clear performance goals and measures.

Conceptual Model for Community Corrections Technology Transfer



Unlike other technology transfer models, our “preparation” phase is separated into two components that include knowledge building and foundation setting. Knowledge building is designed to familiarize the organization with the evidence-based practice(s), including the nature of the scientific studies, the type of intervention, the measures used, and the key components of

the practices. In this phase, the knowledge development is shared with others to integrate stakeholders (other justice agencies or other health agencies) into the change process.

The next phase is the development of the skills of the individual and the organization to implement or support the evidence-based practice. In some cases, the community corrections agencies will implement the innovation, in other cases, they will support a treatment agency to do so. That is, at an individual level, managers, supervisors, or staff may need to learn new skills such as motivational interviewing, use of geographical information systems, or other technologies. Similarly, the organization will need to review its work processes and procedures and refine them to integrate the evidence-based practice. The integration can be bilateral—an adaption of the evidence-based practice (while adhering to the core components) and an adaptation of the work processes to align or fit in the new innovation.

The third phase is expectation setting. Each new practice or innovation is coupled with rationale and logic about the improvements that will occur. Expectation setting is designed to allow internal and external agencies to establish desired goals associated with the change. This method therefore addresses the problem of unrealistic expectations (e.g., reductions in recidivism by 50 percent) and to align support for the modest, small steps that need to be taken to build the implementation for the practice.

Alignment serves to use the pilot to align the agency's processes and procedures to accommodate the change, and the impact of the changes on the offenders. The pilot, or phase one introduction, allows for all parties to work toward a common goal, and to address the barriers to full implementation of the evidence-based practices. The alignment phase serves to ensure that the process allows stakeholders, both internal and external, to appreciate how the new evidence-based practice requires modifications that cut across agencies and units, and that demand a renewed focus on desirable, and achievable, outcomes.

Renovate is the final stage to refine the change innovation to fit within the procedures of the agencies and to link this one change to other evidence-based practices. This model recognizes that community corrections agencies must receive support from external agencies to implement evidence-based practices and treatments and to develop internal capacity for the change. Sustaining the innovation over time requires ongoing adherence to the overall strategy, willingness to continue devoting resources and development to the evidence-based practice, and data to provide feedback on the progress obtained. Sustainability is achieved when the practice becomes routine, and is incorporated into the daily work.

Conclusion & Moving Forward

This White Paper was motivated by a desire to provide the corrections field with a model to facilitate and encourage adoption, implementation, and sustaining the use of evidence-based practices to improve outcomes for substance-involved offenders. It recognizes that the addiction treatment field and corrections agencies are different, and that there is a need for different implementation dynamics that must be addressed to facilitate change. These dynamics include:

- The complexity underscoring the corrections field must be addressed in the change model
- The mission and goals that encompass EBP must be clarified to demonstrate cohesion with public safety and public health, and to demonstrate how offender change (abstinence from drug use as a result of successful treatment) improves public safety
- As a whole, basic skills that involve the dynamics of human services (e.g. assessment, communication/interviewing, engagement, treatment placement, and so on) are needed within corrections environments, and it cannot be assumed that these are currently available
- Performance measures provide wholesale support to the organization regarding the change model by ensuring that managers and staff link the change to the goals of the organization and continue the momentum associated with the change

- Community corrections agencies and treatment providers must be cross-trained and co-trained in order to more closely align their goals and expectations for offender management and progress, and to enable more informed choices about treatment placement and responses to offender progress in treatment

The value of this approach will be determined when community corrections agencies begin to systematically test the model as part of their strategies to implement evidence-based practices for substance abuse treatment.

Key Terms

Innovation: A new idea, program, or concept or a refined idea, program or concept

Evidence-Based Practices (EBP): Research or consensus based ideas, programs, or processes that are related to improved outcomes

Dissemination: The process of sharing information about EBP to organizations

Diffusion: The process of using communication strategies—management, social networks, and meetings—to share information

Adoption: The decision to try an innovation (or EBP)

Implementation: The series of phased steps to put the innovation in place into the workplace

Sustainability: The ability of organizations to maintain implementation of an innovation over a long period of time and across changes in the environment; the EBP becomes part of the organization's standard practice

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CHAPTER I

INTRODUCTION

By
Steven Belenko, Faye S. Taxman, and Harry K. Wexler

The connection between illegal drug abuse and crime has been well documented (Collins, 1982; Gandossy et al., 1980; Seddon, 2000; Taxman, Perdoni, & Harrison, 2007; White & Gorman, 2000), and nearly two-thirds of the annual \$168 billion social costs of illegal drug use are tied to drug-related crime (Belenko et al., 2005). In most jurisdictions a majority of arrestees test positive for an illegal drug (NIJ, 2004); 83% of state and 72% of jail inmates have used illegal drugs, and 69% of state prison inmates reported regular lifetime illicit drug use (Belenko & Peugh, 2005; Taxman, Perdoni, & Harrison, 2007). Half of state inmates were under the influence of drugs or alcohol while committing their crime (Mumola, 1999). Within 3 years, 95% of released state inmates with drug use histories return to drug use (Martin et al., 1999), 67% of drug offenders released from state prison are rearrested, 47% convicted, and 25% are sentenced to prison for a new crime (Langan & Levin, 2002). Finally, 37% of state prison commitments were due to violations of parole or other conditional release (Bureau of Justice Statistics, 2000), mainly related to substance use and abuse. Offenders under community supervision also have high rates of illegal drug use. About one quarter of the 4 million adults on probation were convicted of drug offenses (Glaze, 2003). More than two-thirds of the 2.5 million adults sentenced to probation or released to parole each year have a history of illegal drug use (Mumola, 1998).

In response, a number of treatment interventions have been implemented over the past decade in the criminal justice system (CJS) that have achieved reductions in recidivism; these include drug courts, treatment diversion, prison and jail treatment, and post-incarceration

aftercare (Belenko, 2000; Friedmann, Taxman, & Henderson, 2007; Knight, Simpson, & Hiller, 1999; Prendergast et al., 2004; Taxman, 1998; Taxman, Perdoni & Harrison, 2007; Wexler et al., 1999a; Wexler et al., 1999b). However, such treatment has been able to serve relatively few offenders with drug problems (Taxman, Perdoni, & Harrison, 2007). Only 24% of state and 8% of jail inmates reported receiving any treatment; including non-clinical interventions such as self-help groups or drug education (Belenko & Peugh, 2005). Among probationers, only 25% with histories of drug use receive treatment while on probation (Mumola, 1998). The percentage of parolees receiving clinically-based substance abuse treatment is unknown, but is likely to be low relative to need, given the low percentages of released inmates who engage in aftercare treatment following release from prison (Knight et al., 1999; Prendergast et al., 2004; Wexler et al., 1999a). Despite the large number of drug courts (Huddleston et al., 2005), most are small and have been estimated to serve less than 5% of the eligible population (Belenko, 2002; Taxman, Belenko, Young, Perdoni, & Hiller, 2008).

Given these high rates of substance abuse treatment needs but low rates of treatment access, it is likely that providing expanded access to evidenced-based interventions could contribute to public safety and to the reduction of the growing substance-involved population in the criminal justice system. As Joan Petersilia (1999) has emphasized, achieving meaningful recidivism reduction is difficult without providing effective treatment and rehabilitation services. This is especially true in community corrections settings, where caseloads are high, substance-abuse related violations are common (Taxman, Perdoni, & Harrison, 2007), and research on the integration of treatment and community supervision has been lacking (Taxman & Thanner, 2004b; Taxman, 1998; Taxman & Bouffard, 2000).

There has been growing interest in introducing evidence-based practice (EBP) to the treatment field. Professional organizations and federal agencies have been actively promoting

the identification and implementation of EBP in mental health, education, and substance abuse (NIH, 2004). This interest has spurred the creation of several initiatives to synthesize scientific knowledge, conduct literature reviews, disseminate scientific findings to the field, or train practitioners in evidence-based interventions. Examples include SAMHSA's National Registry of Effective Programs and Practices (NREPP; <http://www.nrepp.samhsa.gov/index.asp>), the National GAINS Center, the Cochrane Reviews, and the Campbell Collaboration (www.cochranecampbellcollaboration.org). These efforts have focused primarily on reviewing literature, establishing criteria for evidence-based treatments, identifying and rating interventions, and producing summary papers that systemically review research findings.

The National Institute of Corrections (NIC) has been active in translating the research literature for the corrections field and promoting EBP for community supervision (NIC, 2004). NIC has developed a strategic approach to advance practice and learn about these implementation issues through a community corrections initiative that focuses on the sustainability of planned change and resource investment at the policy, procedural, and operational levels in several jurisdictions (NIC, 2004). The NIC model focuses on programs, organizational development, and collaborations with other organizations, and is summarized in Chapter III.

Despite this recent emphasis on defining EBP, implementing and sustaining these interventions and practices in real-world settings has been fraught with difficulty. Most of the emphasis has been on the formative stages of defining EBPs with the publication of systematic reviews or meta-analyses, listing evidence-based programs or "best practices," providing manuals, or providing one-time training or time-limited technical assistance. These efforts largely ignore the difficulties and limited effectiveness of simple dissemination of policies and practices, the feasibility of implementing the key features of the EBP, sustainability

(compromised by staff turnover, budget constraints, and staff skill levels), alignment with current policies and practices, and associated policy change in real-world settings (Rogers, 1995; Fixsen, et al., 2005; Taxman, Shepardson, & Byrne, 2004a). The National Institutes of Health has recently highlighted the importance of moving clinical findings to the field and transferring research to practice by emphasizing translational research in its Roadmap for Medical Research (NIH, 2006).

EBP utilization requires paying significant attention to the challenges of innovation diffusion (Patton, 1987; Panzano & Roth, 2006) that range from developing organizational and staff capacity, disseminating EBP, translating evidence into operational components, retraining staff in key skills needed to conduct the intervention, enhancing organizational leadership at all levels to sustain change, monitoring fidelity and performance, and establishing new business practices that comport with the translation of research. As stated by Rogers in his seminal work on diffusion (Rogers, 1983, 1995), a key element for implementing new practices is ensuring that the innovation fits within existing business processes. There is a need to synthesize the scientific knowledge in the context of practice and policy to ensure that it is sustained in real-world settings. Researchers, practitioners, and policy makers must be cognizant of the importance of sustainability, ongoing intervention fidelity (i.e. “ecological validity”), and adaptability to different settings and populations.

Consistent with the mission of public safety and accountability, community corrections agencies must balance the priorities of supervision with expanding referrals to evidence-based (EB) substance abuse treatment. However, identifying EB substance abuse treatment is not typically a community corrections priority, given that this is generally viewed as a public health issue. Thus, alignment of goals and missions between community corrections and public health systems has progressed very slowly, and is often done haphazardly rather than deliberately.

Community corrections administrators may also believe that the selection of treatment programs should be the decision of treatment agencies. In summary, the challenges of identifying EB treatment programs, assuring appropriate matches between the offenders' substance abuse and criminogenic needs (i.e. target behaviors such as substance abuse, criminal peers, antisocial values, etc.) and the particular treatment programs, building organizational capacity to implement and sustain EBP, and disseminating and sustaining EBP in substance abuse treatment for offenders under community supervision have not been adequately addressed.

As EBP has become more accepted in many health care fields, the need to encourage active dialogue among researchers, policy makers, practitioners and clients has increased greatly. The pressing need for expanding treatment access to offenders has raised the stakes for understanding the barriers and facilitators to technology transfer (TT) of EB treatment. New approaches are needed to identify and develop systematic, theoretically grounded approaches that can be disseminated, replicated and sustained. To date, the articulation of EBP has been primarily a "top down" process, one aimed at meeting scientific concerns rather than clinical applications, and which has paid scant attention to organizational and other barriers to implementation and sustainability (Brown & Flynn, 2002; Roman & Johnson, 2002; Simpson, 2002). Careful exploration is needed of the TT process for EB treatment of offenders under community supervision, and the identification of potential new approaches to increasing TT. Prior efforts to identify and disseminate EBP in criminal justice drug treatment (such as NIDA's *Principles of Drug Abuse Treatment for Criminal Justice Populations* - NIDA, [2006]) have generally lacked a balanced perspective that integrates the criminal justice practitioners' perspectives with the views of researchers, practitioners, policy makers, and clients.

Issues in Technology Transfer (TT) of evidence-based substance abuse treatment for community corrections agencies are the focus of this white paper. Chapter II presents an

overview of TT models and a review of the major frameworks for describing and understanding TT, organizational change and innovation, and the organizational, staff, and offender factors that can impede or facilitate TT. Next, we summarize the current state of community corrections in terms of addressing and improving the dissemination and implementation of EB substance abuse treatment. In Chapter IV we provide an overview of the nuances of corrections environments that warrant a different TT model than used in public health. We then present in Chapter V a new conceptual model for TT for community corrections, building on research and practice in other settings as well as the experience from NIC and other initiatives. Finally, in Chapter VI we discuss the next steps needed in theory, research, training, organizational and staff training and development and policy to ensure that the community corrections field is poised to move forward to expand and sustain access to effective substance abuse treatment for offenders.

CHAPTER II

TECHNOLOGY TRANSFER PROCESS AND MODELS

By

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Technology transfer (TT) is a complex, multi-level process (Brown & Flynn, 2002; Fixsen et al., 2005). Successful TT requires an understanding of the facilitators and barriers to adopting new practices and procedures, and tools for overcoming barriers and implementing or enhancing facilitators, at multiple levels: client, treatment program and community corrections agency staff, organizational, system (public health and criminal justice), funders, and regulatory bodies. In community corrections settings, a complex, multi-agency system characterized by the intersection of the criminal justice and public health (treatment) systems, the organizational issues become quite complex (Friedmann, Taxman, & Henderson, 2007; Grella et al., 2007; Young, Dembo, & Henderson, 2007; Henderson, Taxman, & Young, 2008; Oser et al., 2006).

Existing TT models have largely focused on efforts to inform the organization of the new innovation, but have not given sufficient emphasis on the steps needed to implement the innovation or modify practice. As outlined in the following sections, a necessary condition is that agencies must initially recognize the need to ensure that offenders with supervision orders of substance abuse treatment meet the conditions of the sanction, that the treatment is suitable to address the problem behavior (Belenko, 2006; Belenko & Peugh, 2005; Taxman & Messina, 2000), and that the treatment leads to improved outcomes.

Community corrections agencies, and their funders and oversight agencies, have been well aware of the need to improve substance abuse treatment outcomes for offenders, to monitor performance in treatment, and to improve the implementation and sustainability of EB programs. Despite this recognition, and a number of efforts to identify and disseminate EBP on a national scale, there has not yet been widespread implementation of evidence-based substance abuse

treatment in community corrections settings (Friedmann, Taxman, & Henderson, 2007; Knudsen Ducharme, & Roman, 2007; Rhine, Mowhorr, & Parks, 2006). In part, this mirrors similar problems in the treatment field in general (Institute of Medicine, 1992; McLellan, 2003; Roman & Johnson, 2002). In addition, competing priorities relating to security, risk management, and public safety for community corrections agencies tend to reduce the level of attention paid to substance abuse treatment needs and services (Henderson & Taxman, 2008). In this section, we present perspectives from the literature on organizational change, program implementation, and diffusion of new innovations. This literature suggests that community corrections agencies still face many obstacles to successfully and broadly implementing effective treatment interventions. The review of this literature also informs the conceptual model for TT that we develop and discuss in Chapter V. All agencies involved in the delivery of evidence based treatment to offenders in the community must achieve organizational readiness and embrace organizational change in adopting new technologies, and incorporate these models into their implementation and program development strategies.

Organizational Change and Diffusion: Overview

When implementing new technology, it is important to assess each agency's readiness to change. If even one department or unit within an agency is not ready, implementation is likely to be compromised. It is also very important for programs to truly understand the value and of implementing a new innovation or practice, rather than perceiving it as a threat. There may also be organizational or staff resistance to being held accountable for new procedures. Ensuring readiness to change can be accomplished through a process that includes new technology exposure (demonstrations, etc.), technology adoption, more careful staff selection, implementation, and routine use (Klein & Sorra, 1996; Lehman, Greener, & Simpson, 2002; Rogers, 1995).

Despite more than two decades of research on how organizations change to enable them to successfully adopt and implement new innovations (e.g., Klein & Sorra, 1996; Rogers, 1983, 1995; Rothman, 1980), relatively little is known about how public-sector programs such as treatment and other health service delivery interventions use new innovations and technologies. What is apparent, however, is that innovations are very slow to be incorporated into the daily practice of such programs, even after extensive training (Baer, Ball, & Campbell, 2007; Bero et al., 1998; Roman & Johnson, 2002; Simpson, 2002; Sholomskas, Syracuse-Siewert, & Rounsaville, 2005). Although community corrections agencies have been referring offenders to treatment for many years, many service-oriented agencies still struggle to adapt and fully implement new evidence-based treatments. Moreover, treatment remains a relatively low priority for community corrections agencies (Miller, Koons-White, & Ventura, 2004).

Research on the diffusion of medications treatment, which has a relatively strong evidence base with a long history of randomized clinical trials, indicates that such practice has been slow to be adopted in the substance abuse treatment field (Institute of Medicine, 1992; 2002; 2006). Knudsen et al. (2007) found that such organizational factors as structure, availability of treatment, accreditation status, staffing and funding type, and workforce professionalism affected the adoption of medications treatment. Adoption rates were highest for hospital-based centers with detoxification and inpatient treatment, having a physician on staff, use of other medications, private clinics, and accredited or larger clinics. Unfortunately, these settings are not typically used by community corrections agencies for treatment referrals (Latessa, Cullen, & Gendreau, 2002). A recent national survey of criminal justice treatment found that fewer than 10 percent of offenders on any given day are in treatment programs, and that the majority of treatment is psycho-social educational programs (Taxman, Perdoni, & Harrison, 2007). Research as indicated that psycho-social educational programs are not

effective, but cognitive behavioral therapy, contingency management, and family-focused therapies are (NIDA, 1999; NIDA, 2006).

Another common factor is lack of resources available to support treatment services, such as insufficient case management staff, high caseloads, and inadequate training and referral materials (Eliason, 2003). There is some evidence that involvement of a researcher improves the fidelity of the innovation and outcomes (Lipsey & Landenberger, 2006). Yet, other studies have found that involvement in research trials did not predict adoption of EB treatment after controlling for other factors (Ducharme, Knudsen, Roman, & Johnson, 2007). But this may only be the case during the early stages of diffusion, because these investigators defined adoption as any use of the innovation. Thus, it may be that different models are needed to understand adoption depending on whether the innovation is in the earlier versus later stages of diffusion.¹ The importance of fostering researcher-practitioner collaborations has also been noted (Eliason, 2003), especially because staff may have negative attitudes toward or lack of knowledge about research, as well as substance abuse treatment, and the collaboration helps establish a partnership between the agency and the staff.

Although these TT barriers have not been extensively studied in community corrections, lessons from research and theory on the diffusion of new technology and other innovations into other types of organizations are informative. These studies suggest important organizational and staff factors that facilitate the successful adoption and implementation of new technologies, including building foundations for organizational readiness and change, alignment and fidelity considerations, developing performance monitoring systems and measures, and “renovating” the systems to be able to support sustained implementation of EBP. In the following sections we

¹ Early stage adoption occurs at a time when the innovation was a new idea, whereas later stage adoption occurs after the EBP has been used by others.

summarize some of the main conceptual frameworks that have been developed to understand the TT process and how it can be improved. These frameworks are summarized in Table 1.

Organizational Factors

Klein and Sorra (1996) consider the implementation of an innovation to be a function of (1) the strength of the organizational climate for implementation or the factors that help facilitate the organization being able to integrate into daily operations, and (2) the fit of the innovation to the values of targeted users. In their view, adoption of an innovation, and consistent use, will be facilitated by a combination of a strong climate for implementation and a good fit between the innovation and the existing organizational and staff values. The idea that the intervention needs to conform to organizational and staff values and norms has been a fundamental tenet of innovation diffusion theory (Rogers, 1995). If the innovation does not fit values of an organization's members, they will not be committed to the changes needed (Klein & Sorra, 1996). The importance of the alignment of values and norms has been cited by researchers in the diffusion of EB substance abuse treatment as well (Eliaison, 2003; Henderson, Taxman, & Young, 2008; Knudsen, Ducharme, & Roman, 2006; Schoenwald & Hoagwood, 2001; Taxman & Bouffard, 2000). Success in implementing an innovation may in part depend on how program staff and administration perceive the differences between usual program or clinical practice and the new intervention (Schoenwald & Hoagwood, 2001).

Given that many community corrections agencies place relatively little emphasis on substance abuse treatment, a first step in developing organizational readiness (i.e., knowledge development, foundation building) may be to outline the importance of SA treatment to public safety, the clinical benefits to offenders, and economic benefits for the CJS and society as a whole (e.g., Belenko et al., 2005). Without detracting from the core supervision and public safety goals of community corrections agencies, discussions about how corrections staff can

benefit from effective SA treatment can provide a relative advantage over the *status quo*, making offenders easier to manage and providing access to additional community supports and more effective referrals. Exposure to an innovation is a necessary initial condition for innovation adoption (Backer, 1993; Simpson, 2002) but this exposure stage has not been studied sufficiently to understand the types of exposure that are more likely to lead to adoption. Because corrections agency staff need to develop a “comfort level” with SA treatment, the challenge is how to best develop this comfort level. Research in institutional environments suggests that involvement with substance abuse treatment programs can reduce staff turnover and improve working conditions and job satisfaction for corrections officers (Burdon, Farabee, Prendergast, Messina, & Cartier, 2002; Farabee, et al., 1999).

Piloting is a common practice in corrections agencies. Although Rogers (1995) raises the concept of “trialability” as important to diffusion, the nature of the pilot or trial is not well-described. As such, there are varying approaches to the pilot process. Some agencies decide to pilot only a small portion of a new initiative, while others set a specific length of time to pilot. If a new innovation can be tested first, it reduces uncertainty in the organization and can demonstrate feasibility and lead to initial implementation (see also Fixsen et al., 2005). But the nature of the test and the intervention components need to be addressed to determine how it impacts adoption or sustainability.

There has been limited research on the influence of interorganizational relationships on the adoption of treatment in community settings, especially for offenders (Taxman & Bouffard, 2000; Fletcher, et al., 2008). Organizational factors found to be important in treatment innovation include philosophical orientation that supports innovation, organizational resources, counselor credentials, and client characteristics (Ducharme et al., 2007). One important domain may be an organization’s “absorptive capacity,” or ability to identify and incorporate new

information (Knudsen & Roman, 2004). Research on SA treatment programs indicates that outcomes are improved when effective interorganizational working relationships exist (D'Aunno, 2006). Such interorganizational relationships become crucial in community corrections settings because most agencies contract for such services rather than provide them directly (Taxman & Bouffard, 2000). The need for more interorganizational research is important to understand how treatment and justice agencies work best together to improve client outcomes (Fletcher et al., 2008). The emphasis on seamless system, policies and procedures, and operations stems from the concepts of “boundaryless systems of care” where the client is unsure which system is providing care (Taxman & Bouffard, 2000).

In the following sections, we describe some of the existing TT models, which are these are summarized in Table 1.

Organizational-Level Models of Technology Transfer

A number of scholars have proposed a systematic process for implementing and sustaining effective interventions. Lessons from organizational and implementation studies encompassing a number of health, mental health, and social interventions teach us that identifying programs and practices that drive positive changes in client outcomes are only the first stage in improving the delivery of treatment services. Despite the designation of a number of interventions and practices as “evidence-based,” such interventions are slow to be disseminated to the field (Kilbourne et al., 2007), are often poorly implemented (Bourgon & Armstrong, 2005), or difficult to sustain (Brown & Flynn, 2002; Miller et al., 2006). Successful TT must recognize the importance of improving program implementation to help drive the criminal justice treatment services toward more sustainable interventions that improve offender outcomes.

TT will be most successful if it leads to the implementation of interventions that are *fully implemented*, and *sustainable* (Fixsen et al., 2005; Schoenwald & Hoagwood, 2001), under ongoing organizational and systems collaborations. In the model proposed by Dean Fixsen and colleagues at the National Implementation Research Network (NIRN), this is best achieved by following systematic and scientifically-based principles of program implementation and positive organizational and systems change (Fixsen et al., 2005). Of key importance is the *effective* implementation of *effective* programs, encompassing both an evidence-based program or practice, and an implementation plan and process. Implementation components and outcomes exist independently of the quality of the program or practice being implemented. Ineffective programs can be implemented well, and effective programs can be implemented poorly (Fixsen et al., 2005). *Desirable outcomes are achieved only when effective programs are implemented well.*

The work of Fixsen et al. (2005) suggests three overall themes derived from implementation research: (1) guidelines, policies, and/or educational information alone, or practitioner training alone are not effective, (2) longer-term multilevel implementation strategies are more effective, and (3) not enough is currently known about the functional components of implementation factors (Fixsen et al., 2005).

To guide future implementation strategies and research, Fixsen et al. (2005) identified core implementation components found to yield successful implementation and sustainability. The implementation components are the activities that need to be in place to achieve successful and sustainable implementation. The seven components are: (1) *Staff Selection* (workforce skills and availability); (2) *Preservice and Inservice Training* (to start to change staff behavior, attitudes, and perceptions); (3) *Ongoing Consultation and Coaching* (help staff learn on the job; research supports the value of ongoing coaching and behavioral skills practice); (4) *Staff*

Evaluation (performance, fidelity); (5) *Program Evaluation*; (6) *Facilitative Administrative Supports* (leadership, informed decision making), and (7) *Systems Interventions* (to ensure ongoing adequate resources and organizational support).

These components are facilitated or undermined by both External and Organizational factors. **External Influences:** Organizations exist in a shifting ecology of community, state, and federal social, economic, cultural, political, and policy environments that variously and simultaneously enable and impede implementation and program operation efforts (e.g., funding, political support, availability of skilled staff, etc.). Although explicitly adopted changes can help minimize barriers to implementation and enhance facilitators, there has been little research on these issues. **Organizational Influences:** Assuring the availability and integrity of core implementation components is the functional work of an organization. An organization decides to proceed with implementation, selects and hires/reassigns personnel, provides facilitative administrative support, works with external systems to assure adequate financing and support, and so on.

Implementation Outcomes refer to the degree to which a program, policy, or other innovation is implemented as planned. Fixsen et al. (2005) summarize three broad types of implementation outcomes: (1) changes in adult professional behavior (knowledge and skills of practitioners and other key staff members within an organization or system), (2) changes in organizational structures and cultures, both formal and informal (values, philosophies, ethics, policies, procedures, decision making), to routinely bring about and support desired changes in adult professional behavior, and (3) changes in relationships with consumers, stakeholders (location and nature of engagement, inclusion, satisfaction), and systems partners.

Implementation outcomes are related to the chronological *stage of implementation* of a specific innovation (see also Klein & Sorra, 1996; Rogers, 1995):

- **Exploration and adoption:** An agency perceives the need for change and considers different options. Service providers, planning groups, advisory boards, and technical assistance providers exchange information to identify the need for an intervention, assess the fit between a potential intervention program and community needs; assess barriers to adoption; and mobilize organizational support.

- **Installation:** Here, an agency prepares for implementation of a new intervention. This stage commonly includes acquiring funding and other resources, and developing referral mechanisms, initial staff training, and outcome expectations.

- **Initial implementation:** A new program or policy is first put into practice. This is an important and gradual process with many challenges. To reduce implementation barriers and enhance facilitators, changes in the practice environment (e.g., staff practices) and broader changes in organizational culture and capacity may be needed. A positive organizational climate is associated with adoption and extent of initial implementation.

- **Full implementation:** At this point, a new program or policy becomes fully operational and is integrated into daily practice with full staffing, full client loads, and all the realities of “doing business.” Staff reaches the criterion skill level for delivering the intervention, and management support is in place. Full implementation requires that new learning becomes integrated into practitioner, organizational, and community practices, policies, and procedures. It may take several years to reach this stage, and many programs or practices are never fully implemented.

- **Innovation:** Over time, the program or policy must adapt to changes in its environment (e.g., staffing, funding, target population, political changes). *Innovation* refers to positive changes in implementation that are explicitly intended to improve implementation practices or outcomes. However, some changes may be undesirable: these are defined as

program drift and constitute a threat to fidelity. Continued monitoring over time is needed to assess and ensure fidelity.

- **Sustainability:** The goal at this stage is long-term survival and continued effectiveness of the implementation site in the context of a changing world. As time passes, turnover in skilled practitioners and leadership is inevitable, and funding streams and program requirements change. To maintain and sustain the intervention with fidelity, adaptation is needed, but change agents must adjust without losing the functional components of the evidence-based program or losing essential financial and political support.

In practice, moving through these stages takes a number of years and intensive sustained efforts; relatively few interventions reach the Innovation and Sustainability stages. But to make meaningful impacts on reducing drug-related crime, a goal of TT should be to move evidence-based practice toward these stages.

Liddle et al. (2002; 2006) consider technology transfer to be similar to designing an intervention, and outlined an organizational process that includes: (1) *Organizational assessment* that incorporates the rules, norms, practices and policies of the organization; (2) *Staff assessment* that considers each staff member's contribution to the new technology, such as how they might respond and be induced to accept it; (3) *Preparing staff for change*, such as explaining the rationale for the innovation, the steps involved, and new skills required; (4) *Establishing priorities* by deciding which aspects of the innovation are most likely to be adopted; and (5) *Facilitating positive developmental processes*, such as monitoring staff reactions, assessing progress, and making changes to implementation strategies as needed.

TABLE 1

SUMMARY OF MAIN TECHNOLOGY TRANSFER MODELS

	Preparing for TT	Implementing the Innovation	Measuring Progress	Sustaining the Innovation	Other
Klein & Sorra (1996)	-Assess Strength of Org Climate -Align Innovation to Org & Staff Values				
Fixsen et al. (2005)	-Exploration and Adoption -Staff selection - Preservice training	- External influences - Organizational influences - Changes in organizational climate, culture, and capacity		-Adaptation necessary -Maintain financial and political support	- Importance of implementation outcomes
Liddle et al. (2002)	-Org assessment -Staff assessment	-Prepare staff for change -Establish priorities -Facilitate positive developmental processes			
Liddle et al. (2006)	-Baseline, pre-exposure	-Training Implementation under supervision		-Durability, without supervision	
Backer (1993)	-Bring innovation to attention of the organization	-Make innovation accessible	-Determine that innovation is feasible and effective	-Implement interventions to encourage staff and org change	
ATTC Change Book (2004)	1. Identify problem 2. organize team 3. identify desired outcome(s) 4. assess organization 5. assess target audience	6. identify most appropriate approach 7. design action and maintenance plans	8. implement action and maintenance plans 9. evaluate progress of change initiative	10. revise action and maintenance plans	
Schoenwald & Hoagwood (2001)	-Determine efficacy of the intervention	-Determine transportability from efficacy to “usual care” settings	-Evaluate the dissemination process	-Determine transportability into broad dissemination	-Transportability Model
Simpson (2002)	-Exposure to innovation	-Training and motivation to change -Adoption and individual and group levels -Implement with testing of feasibility and utility		-Practice, innovation incorporated into regular use	
Coiera (2003)	-Staff perceives that benefits of innovation are greater than costs		-Maximize adoption rate	-Provide staff incentives	-Cost benefit model

Liddle et al. (2006) have proposed a four-phase TT framework that is modeled after their Multidimensional Family Therapy intervention. This model has the following phases:

- Phase I: Baseline/pre-exposure (12 months)
- Phase II: Training (6 mos.)
- Phase III: Implementation, with clinical supervision (14 mos.)
- Phase IV: Durability/practice, without supervision (18 mos.)

For Simpson (2002), organizational factors are important determinants of innovation adoption. These factors include leadership attitudes, resources for staff (Bero et al., 1998; Knudsen & Roman, 2004; Backer, 1993), organizational stress, regulatory or financial pressures, management style, an organizational tolerance for change (Ash, 1997; Lehman et al., 2002), and the personal characteristics of program leaders and staff. Positive management support for change has been found to be a factor in increased use of computer databases among health care professionals (Gosling et al., 2003), and Klein, Conn, and Sorra (2001) note that such support leads to better quality implementation of an innovation. Management support is also likely to result in investments in policies and resources that promote the use of the new technology (Klein et al., 2001). The important role of organizational climate and culture in facilitating or impeding the adoption and sustainability of innovations has also been noted by Schoenwald and Hoagwood (2001) and Lehman et al. (2002).

The presence of “champions” (respected individuals who actively promote the innovation and build support and overcome staff resistance) in an organization (Howell & Higgins, 1990) has been noted by a number of researchers as an important factor in innovation diffusion (e.g., Ash, 1997; Coiera, 2003; Gosling et al., 2003). Others note, however, that organizational climate (i.e., readiness) may interact with the presence of a champion to determine whether dissemination is successful; it is also possible that a champion improves dissemination but not effectiveness, unless presence of a champion also is related to adherence to the protocol (Schoenwald & Hoagwood, 2001).

Social networks within an organization that foster communication among users of the new technology can also facilitate successful implementation (Coiera, 2003; Kaplan, 1997; Klein et al., 2001; Wejnert, 2002). In addition, innovations that are developed from a consensus process also may be more successful (Bero et al., 1998). Although it is important to have the support of senior management, innovations that are imposed from outside or above but are not relevant to the daily work routines of line staff may not be implemented successfully (Kaplan, 1997). The innovation needs to be internalized by staff as important to their daily work (Liddle et al., 2002; Simpson, 2002).

Another TT model has been developed through SAMHSA's Addiction Technology Transfer Centers, as described in the Change Book Model (McCarty et al., 2007). This 10-Step blueprint for TT includes the following steps:

1. Identify problem
2. Organize team
3. Identify desired outcome(s)
4. Assess organization
5. Assess target audience
6. Identify most appropriate approach
7. Design action and maintenance plans
8. Implement action and maintenance plans
9. Evaluate progress of change initiative
10. Revise action and maintenance plans

Although this process is logical and has face validity, it has not been tested empirically.

In one study, the Change Book model was used to train rural treatment programs to use buprenorphine treatment. Positive attitude changes toward buprenorphine were found, and most participants intended to prescribe the drug, but there were no comparison samples (McCarty et al., 2004).

Schoenwald and Hoagwood (2001) propose several key multilevel factors for moving EBP from efficacy studies to broader dissemination that include the intervention itself, practitioner and client characteristics, model of service delivery, organization, and service

system. Their “transportability” model is based on clinical treatment development models (e.g., Drake, Gorman, & Torrey, 2002) that include organizational factors and research on dissemination and sustainability.

The study of adoption behavior is highly relevant to treatment research, and helps us understand the organizational, community, and individual factors that affect adoption of an intervention. In addition, research is needed on whether the innovation changes as it is adopted, and which factors affect sustainability. It is important to distinguish diffusion and dissemination; most literature focuses on the unplanned or natural adoption of innovation rather than proactive or directed dissemination (Schoenwald & Hoagwood, 2001). Systematic, experimental research is needed on these issues to help clarify this process and identify the facilitators and barriers to dissemination.

In the initial stages of transportability (i.e., after limited efficacy trials), some treatments will not be effective when moving to real-world settings. Few community-based treatment settings can adequately implement all features of an intervention. If some parts of the intervention have to be modified, then what is the effect on the intervention? What aspects can be changed without reducing the impact of an intervention? These are important research issues that can affect implementation and sustainability. In latter stages of transportability, effectiveness studies may overlook differences in clients, programs, and service delivery financing that may occur after broader dissemination. For example, structural barriers to service access (e.g., eligibility, costs, transportation) that conflict with other supervision requirements are not always considered, but are important issues for offender populations. Accordingly, it may be useful to study transportability before dissemination occurs. In the end, interventions that are disseminated prematurely can undermine credibility and give the false impression that the intervention is not effective (Schoenwald & Hoagwood, 2001).

Backer (1993) suggests four necessary conditions for successful TT: (1) the innovation must be brought to the attention of the organization and made accessible for dissemination; (2) evidence must indicate that the innovation is feasible and effective; (3) there must be adequate resources available; and (4) interventions must be used to encourage staff and organizations to change.

Finally, economic considerations are always an important systemic factor that can affect adoption, implementation, and dissemination. Is the new intervention more cost effective than practice as usual? What are the costs associated with clinical training, certification, and fidelity monitoring? Although research on the economic impacts of SA treatment consistently demonstrate substantial cost savings and a positive benefit-cost ratio, especially for criminal justice populations (Aos, 2006; Belenko et al., 2005), high upfront implementation costs or competing budget priorities may limit dissemination even in jurisdictions where there is strong organizational support for evidence-based substance abuse treatment.

Staff-Level Models of Technology Transfer

The ability of the staff to adopt and institutionalize the new innovation can determine whether or not implementation will be successful. A key challenge to implementing new technology is overcoming staff resistance to adopting new practices by those who are socialized into, and committed to, existing practice.

Three models of resistance to innovation implementation have been proposed by Markus (1983): (1) User-centered: resistance is due to factors related to the users, such as lack of knowledge or resistance to change. The characteristics of decision-makers may determine the results. Staff is considered passive, resistant, or dysfunctional if they don't use the system as intended. (2) System-centered: the new innovation is viewed as problematic. (3) Interactional: resistance is a result of interrelationships and interactions among users, the system, and the

organizational context in which system is used.

Simpson (2002) suggests that there are four key stages relating to staff factors in a process model of organizational change: (1) Exposure, in which staff are trained adequately and are motivated to change; (2) Adoption, indicating the intention to try an innovation at the individual staff or group level; group adoption is necessary for systemic implementation; (3) Implementation, referring to a period of trial use and testing of the innovation's feasibility and utility in which there are appropriate institutional supports and climate for change; and (4) Practice, wherein the innovation has been incorporated into regular use; this may depend on staff attributes and incentives.

Coiera (2003) has proposed an economic framework for understanding innovation diffusion, arguing that the use of new clinical tools will be low as long as the costs of using them are perceived by staff to outweigh the benefits. Only when the benefit-cost ratio shifts will the technology be accepted and used. New technology is also not effective if it is not readily or widely adopted. In addition, clinical staff may perceive existing practice as being just as effective as the innovation; thus the way in which staff *perceive* effectiveness may be as important as an intervention's actual impact. Coiera (2003) notes that the impact of an innovation is a product of its adoption rate and its clinical impact. Thus, a less than ideal innovation may be preferred if its adoption rate is higher than for an "ideal" system. The costs and benefits of being able to access and apply new information are at least as important as the costs and benefits of the information itself. The economic perspective proposed by Coiera (2003) suggests that incentives to use the technology may be needed to increase the perceived benefits to staff (Klein et al., 2001). Even where financial rewards are not possible, use of the new technology may increase job satisfaction and provide opportunities for professional development or advancement (Ash, 1997). Ongoing incentives (e.g., contingency management

models) may help sustain the innovation once implemented (Andrzejewski, Kirby, Morral, Iguchi, 2001). New systemic efforts to provide budgetary incentives to treatment providers to achieve certain performance benchmarks is another model being tested in several jurisdictions with encouraging results (McLellan, Kemp, Brooks, & Carise, 2008).

The success of any TT effort cannot be assured without a plan for long-term implementation and maintenance that will lead to sustainability (Fixsen et al., 2005). The ability to institutionalize new EB practices into daily routine (the “durability/practice” Phase IV of the Liddle et al. [2006] technology transfer framework) is of crucial importance (Taxman & Sherman, 1998). This concept is a key aspect to our proposed TT model for community corrections (see Chapter V). As noted above, sustainability is often a barrier to the adoption of new technology, which is frequently implemented without consideration of an agency’s business practices and staff roles and responsibilities (Kaplan, 1997; Liddle et al., 2002) and is imposed on top of regular duties and tasks. To be effective, training and technical assistance should incorporate staff roles and responsibilities to enable staff to relate the technology to their particular role. Staff should be slowly engaged with the new technology beginning only with what is necessary for his/her responsibilities and exposed over time to the full intervention or practice.

Staff Training

Other challenges to implementation relate to staff training issues. These include poor or inadequate training that does not use TT principles (e.g., building in motivation, providing incentives to change practice), lack of ongoing training or booster sessions, and insufficient support at different staff levels resulting in a lack of trained opinion leaders (ATTC, 2004; Eliason, 2003).

Training and skills development are important adjuncts to TT. Although outside training is important, passive learning environments do not generally foster the adoption or use of innovations (Bero et al., 1998; Eliason, 2003). For example, the traditional workshop approach has had mixed results in improving the skills of probation officers over the long term (Taxman et al., 2004a). Trainees and new users can also be overwhelmed by too much information (Coiera, 2003). Moreover, technology innovations that are too complex, such as web-based performance monitoring systems, are also less likely to be effectively implemented (Ash, 1997). The importance of social networks and staff communication suggests that peer trainers may facilitate increased acceptance and use of an innovation (Wejnert, 2002). On the other hand, it is important that peer trainers avoid imparting information simply based on anecdotal or non-evidence-based practice, which can undermine successful implementation and protocol fidelity.

Early on in the TT process, techniques are also needed to improve the organization's capacity to learn, through interactions with other organizations and promotion of the use of external information sources (Knudsen & Roman, 2004). As an example, Griffiths and Riddington (2001) found that health care professionals who used computers at home were more likely to use computerized databases at work, and have more confidence in the system. This suggests the need for providing resources and professional development opportunities to treatment and community corrections staff that increase their knowledge and skills about treatment intervention (Knudsen, Ducharme, Roman, & Link, 2005). Taxman et al. (2004a) suggest that one-time training efforts are unlikely to increase skills and lead to successful technology implementation, and suggest that an ongoing process, using interactive technology, is needed to foster the implementation of new technologies in criminal justice settings.

Emerging evidence about the effectiveness of training on innovation adoption and diffusion suggests several important factors that can facilitate or impede changes in staff

behaviors. Common barriers to using workshop training materials include lack of time, insufficient training, lack of resources, and already using a similar approach (Bartholomew, Joe, Rowan-Szal, & Simpson, 2007).

It has been suggested that program-level planning and preparation be implemented before training, to introduce staff to the innovation and its relevance to their jobs. It is also important to maintain leadership support, have adequate resources, gauge how other staff will react, and determine the fit with the agency's philosophy of care (Bartholomew et al., 2007). As Saldana, Chapman, Henggeler, & Rowland (2007) point out, additional clinical training and experience for counselors is related to acceptance of innovations, but caseload size may be an important barrier to engaging in training and implementation of innovations.

Key elements to improve training effects include cognitive approaches (e.g., TCU's node mapping techniques; see Dansereau, Dees, Greener, & Simpson, 1995), hands-on practice, feedback, rewards for progress, being realistic about skill requirements and limitations, organizational team building, peer support, and incentives for change (e.g. Coiera, 2003).

Knudsen et al. (2005) found that several counselor characteristics were associated with perceived acceptability of buprenorphine treatment: these included training participation, internet use, 12-step orientation, education, and professionalism. They point out that in addition to diffusing knowledge about an innovation, staff attitudes must be positive toward the innovation. If the innovation is not compatible with current practice, orientation, or values, then a persuasion process is needed (through training and access to information). More research is needed on the attitudes of counselors and community corrections staff toward implementation of innovative treatment methods (Knudsen et al., 2005; Taxman & Bouffard, 2000). Counselors may lack knowledge or may not believe in the effectiveness of an innovation; a low rate of knowledge may indicate that the innovation has not diffused. Staff professionalism and education level is

likely to be related to more knowledge that in turn facilitates the acquisition of new knowledge (D'Aunno, 2006; McCarty, Fuller, & Arfken, 2007). The literature on organizational absorptive capacity suggests that knowledge can be built by accessing information from external sources, suggesting a need to increase and improve external training and technical assistance for community corrections and treatment staff. Empirical research on training strategies is needed (Fixsen et al., 2005; Schoenwald & Hoagwood, 2001).

Substance Abuse Treatment Staff

The above discussion is particularly salient in the substance abuse treatment field because it is plagued by institutional and staff uncertainties. The general lack of adequate and consistent counselor training, high staff turnover rates, low salaries, and low job satisfaction (Knudsen et al., 2006; McLellan et al., 2003; Roman & Johnson, 2002) can readily undermine dissemination efforts. At the organizational level, lack of resources (especially for training and staff development), regulatory barriers, and administrative staff turnover may limit interest or capability to change treatment curricula or intervention designs. Turnover and resource constraints may also affect the stability of community corrections agencies, but to a lesser degree. Low job satisfaction, staff resistance, cynicism, and lack of rehabilitative focus and interest among staff can be important barriers to dissemination, adherence, durability, and fidelity (Taxman & Bouffard, 2000). Knudsen et al. (2006) found that among treatment counselors “emotional exhaustion” was related to intending to leave the job and poor job performance. Counselors may be at high turnover risk because they are continually dealing with people’s problems (Knudsen et al., 2006). The role of emotional exhaustion and workplace stress are important to examine both for community corrections and treatment counselor staff. There is some evidence that emotional exhaustion is higher in organizations with a centralized decision-making structure (such as corrections agencies) rather than those with more horizontal

decision-making. Organizations in which staff perceives procedural or distributive justice may have lower levels of emotional exhaustion, and thus lower turnover and better job performance (Knudsen et al., 2006; Taxman & Gordon, in press).

These considerations suggest a need to improve *capacity building* for organizations and agencies involved in supporting and delivering substance abuse treatment to offenders in the community (Schoenwald & Hoagwood, 2001). Such efforts are an important and generally ignored step in improving TT.

Client Factors

Although organizational and staff factors are central to an understanding of innovation diffusion, the client perspective has been almost entirely overlooked. Criminal justice interventions typically originate and are necessarily more aligned with public safety concerns than client needs and preferences, unlike health interventions where client concerns are primary and guide acceptance and application of specific treatments. Offenders move through the criminal justice system into community-based services under different levels of coercion. Voluntary services (e.g., evidence-based substance abuse treatment interventions) for offenders must be able to recruit, engage and retain offenders so that interventions can be delivered over time to engaged participants. A good example is in recent prison treatment studies in California, finding that only 20% of released offenders choose to attend aftercare programs and only 50% of that group remain the required 90 days or longer needed to produce the empirically verified recidivism reductions (Wexler, Burdon & Prendergast, 2005). Increasing our understanding of the offender/client perspective related to treatment engagement will thus help clarify barriers or facilitators to innovation diffusion.

Fidelity and Program Integrity

Implementation and program fidelity go hand-in-hand. Without knowing whether an EBP has been implemented in such a manner to retain the integrity of the EB intervention, there is no guarantee that an EBP will deliver and achieve its effectiveness in a new setting or with a different population. Experienced program planners will need to know whether the new intervention was implemented, whether it was tried but poor clinical practice interfered with the implementation, whether implementation was faulty or whether the program was implemented but went adrift (Fixsen et al., 2005). All of these factors can determine whether or not the innovation was well-received in the practice setting, as well as how to modify the program to improve outcomes. However, achieving and maintaining fidelity in real-world settings can be quite difficult (Bourgon & Armstrong, 2005; Morrison, 2004). A number of organizational and staff factors can compromise fidelity, as can responses to external pressures (Rhine et al., 2006). For obvious reasons, maintaining fidelity may be more difficult in larger programs. Lack of program integrity in a large program may account for the lack of effect observed for cognitive skills training interventions implemented in larger corrections agencies (Van Voorhis, Spruance, Johnson Listwan, Ritchie, & Seabrook, 2004). Such manualized EB interventions may work better in small settings.

Manualized interventions have certain advantages in that they offer a set curriculum for the intervention, provide guidance for the counselor, and reflect a certain treatment philosophy. All of this points to more organizational cohesion and consensus about the model of recovery, and how offenders change than relying upon counselor-driven strategies that largely depend on the qualifications of the counselor. Manualized treatment allows for some degree of standardization so that the treatment offered is consistent, regardless of who is delivering the services. Acceptability is desired but the staff may be too rigid to change, and prefer existing

practices with which they are familiar and comfortable. In order to determine the efficacy of an intervention strict fidelity is required, but in determining effectiveness under real world conditions may require that a treatment be modified appropriately to client needs and environmental conditions.

After initial implementation, the program should continue ongoing monitoring that includes booster training, retraining, training of new staff, fidelity monitoring, and other technical assistance. Although it may be necessary in certain situations (Fixsen et al., 2005), fidelity drift is a real concern and must be measured and addressed regularly if the intervention is to be considered evidence-based (Rhine et al., 2006). This may be compounded by staff resistance to change (CEICA, 2006; NIC, 2005) and high counselor turnover rates (Knudsen et al., 2006).

Performance Monitoring, Benchmarking, and Quality Assurance

Performance monitoring

Given the difficulties of defining EBP and the time and cost of determining treatment effectiveness using multiple randomized clinical trials, policy makers have begun turning to alternative approaches to improve treatment delivery. Such an approach focuses more on measuring how well a program specifies: 1) what it is doing, 2) how it is doing it, and 3) whether it can demonstrate fidelity to the previous model. In other words, there is some movement away from over-reliance on clinical trials and more reliance on development of programs through fidelity monitoring and performance monitoring.

One recent initiative in this area suggests that oversight agencies can obtain improved performance from treatment providers by establishing performance contracts that specify benchmarks to be met, and deemphasize central control over the design and content of an intervention. In Delaware, the state substance abuse treatment agency instituted an experimental

performance contracting system in 2002 that tied provider funding to the ability to meet performance goals. In place of the standard cost-reimbursement models, contracts with outpatient treatment providers required them to meet specified benchmarks in order to receive full reimbursement on their contract. Failure to meet these benchmarks meant that the provider would not receive full funding, which could jeopardize their continued operational viability. Achieving the performance goals meant that the full budget amount would be reimbursed, and providers that exceeded performance goals received monetary performance “bonuses” on top of their contracted budget. Incentive payments were calculated and disbursed monthly.

An evaluation of the program found that contracted providers improved client outcomes in terms of capacity utilization, percentage of clients meeting treatment participation requirements, and program retention over a four-year period (McLellan et al., 2008). Because the State did not mandate treatment techniques or clinical approaches, this experiment suggests that treatment outcomes can be improved solely using incentivized performance contracts.

Quality Assurance Measures/Performance Measures

It is widely recognized that organizations need a process for systemic feedback in order to grow and thrive. In the NIC EBP project (described below) CJI developed a manual to guide agencies on some standard quality assurance (QA) procedures (see http://www.crjustice.org/cji/QAmanual_122705.pdf). QA should be applied throughout the implementation process; however, the tendency is to concentrate its use in some of the more difficult components, such as using an assessment instrument to identify treatment placement (responsivity components), ensuring the quality of offender interviews, and so on. The Pew Foundation, in their Criminal Justice Initiative (www.pewcenteronthestates.org), has taken a further step and recommended that community corrections agencies produce “COMPSTAT” (COMPUterized STATistics) type reports piloted in police organizations that include feedback on

progress (e.g., offenders in treatment, offenders attending appointments, etc.) (Weisburd, et al; 2003; Willis et al., 2007).

Information Sharing

Another barrier to improving interagency cooperation and technology transfer is the difficulty of collecting and sharing information on client treatment progress. Community-based treatment providers and other health services agencies lag behind in incorporating information systems into daily practice, and often lack the computer infrastructure to take advantage of existing systems (McLellan et al., 2003). Few programs have the capability to electronically share client information across agencies and still rely in at least in part on paper records. With some information captured electronically and some captured on paper, generating performance measures and communicating client progress milestones become cumbersome tasks. HIPAA limitations, other confidentiality concerns, and information-sharing boundaries for community corrections agencies also make it difficult or impossible to share client information across the CJS-public health system boundary.

Quality Improvement Models

Schaffer and Thomson (1992) suggest that rapid and tangible successes help create a context for supporting continuous quality improvement and organizational innovation. A model developed by the Network for the Improvement of Addiction Treatment (NIATx, 2007) emphasizes strategies (like involving the consumer in the change process) designed to improve access to and the quality of drug abuse treatment through practice improvement. The results-driven quality improvement approach underpinning NIATx, and emphasis on performance benchmarks agreed to across agencies, offers a useful conceptual framework for organizational research in CJ settings. In the NIATx approach, organizations must improve *processes* in order to better serve their clients (e.g., reduce waiting times and no-shows, increase admissions,

therapeutic engagement, and retention). The processes required to implement effective treatment services may include changes in clinical or administrative infrastructure and practices. Organizational changes might include attempts to increase treatment entry and retention through each stage of a continuum of care; improving adherence to defined practice standards; improving the linkage between drug treatment and corrections agencies by improving information sharing; or building an organizational infrastructure to support the sustainability of quality improvements in the delivery of treatment services to offenders. Examples include changing criteria to admit high-risk offenders to treatment, delaying facility transfers that impede program adherence, revising risk classifications that limit participation, increasing offender (and treatment staff) incentives to participate and adhere to program requirements, and re-examining sanctions.

The NIATx approach seeks to develop a Learning Collaborative Model that helps to facilitate a “culture of process improvement” (NIATx, 2007). Such a model would include action plans to overcome barriers to expansion of treatment services through improvements in staff training, changes in policies and procedures, and systems integration efforts. Under the NIATx approach, it is important to identify performance indicators to be targeted for improvement. Examples for substance abuse treatment programs include: (1) reduced waiting time from first request to first service; (2) increase client attendance and participation; (3) increased use of effective interventions (e.g., skills-based models, peer-led); (4) increased service completion. As a *learning collaborative model*, the NIATx framework suggests the importance of sharing innovative ideas among members, and including strategies such as learning sessions, trainings, interest circles, coaching, and weekly/monthly electronic newsletters.

A important goal of NIATx is to create a “community of practice” committed to process improvement and more effective services, which in turn should result in greater use of treatment

interventions, increased knowledge about treatment and acceptance of the need for treatment services, and increased use of transitional planning and referrals. For example, training parole officers to identify substance abuse risk behaviors or relapse triggers and to understand the importance of treatment services for at-risk parolees, could increase the number of treatment service referrals and facilitate successful engagement of parolees in such services. These types of activities can improve the diffusion and implementation of EBP.

CHAPTER III

CURRENT STATE OF THE FIELD

By

Faye Taxman, Steven Belenko, and Harry Wexler

In the field of community corrections, evidence-based practices (EBPs) incorporate a variety of practices and programs that are considered innovative in that they offer an advantage to existing practices, based on scientific findings. To provide a context for understanding adoption of EBP in community corrections, we reviewed the NIC community corrections initiative on EBP, analyzed data from the CJDATS National Criminal Justice Treatment Practices (NCJTP) survey (Taxman, Young et al., 2007), and conducted interviews with stakeholders in the field. The goal was to inform our discussion about TT and the needs of the field for improving the adoption of EBP in substance abuse treatment.

NIC Initiative

The National Institute of Corrections, in a cooperative agreement with the Crime and Justice Institute (CJI), began an initiative in 2002 to advance the use of evidence-based practices in community corrections agencies. The EBP initiative involved three activities: 1) to develop materials that will be helpful for defining the components of EBPs; 2) to work with two states (Maine and Illinois) on their implementation of EBPs; and 3) to work with the field of community corrections to improve understanding of EBPs.

The first set of products involved four articles describing EBPs: an integrated model overview, evidence-based practices, organizational development, and collaboration (see http://www.crjustice.org/cji/niccji_initiative.html). These materials set the foundation for working with the selected states in the CJI/NIC project. The emphasis was on organizational preparedness so that the agencies involved in the change process were making investments in

ensuring that the adoption was routinized. Similar to the work articulated by Fixsen et al. (2005), the focus was on issues of sustainability of the innovation in the practice environment. This approach differs from previous efforts to test an innovation and then determine how that innovation works in that environment.

Between the two selected states, Maine has a centralized department that is responsible for all corrections services (probation, parole and prisons) while Illinois has a state-wide prison and parole system, with probation administered by the county governments. In Illinois, the state Judiciary provides oversight but does not have direct authority over operations at the county level. This configuration is similar to the US overall, wherein 29 states have centralized systems; however, even within these centralized systems there are local governments that operate supervision agencies.

The CJI/NIC cooperative supported a three level strategy for working with these states to implement EBP. First, the cooperative provided support to state leadership and assisted them in developing management teams, organizational strategies to improve communication within the organizations, and trainings to develop the leadership teams. Second, each state undertook efforts to develop or refine their existing management information systems to generate benchmark reports that could be used by the state to better guide decision making. In both states, efforts were undertaken to bring in the state's Statistical Analysis Centers (funded by the US Department of Justice) to assist with these efforts. In each state, the existing management information systems had not been used to develop reports to the agencies on offender characteristics, progress in different initiatives, outcomes, etc. Developing these systems was seen as critical to providing the organization with other means to make decisions, and to allow other agencies to understand the needs and issues of the corrections department. Third, the projects brought efforts to improve skills of the agency in using EBPs. A series of trainings were

provided on various topics (depending on the state and the needs) in areas of motivational interviewing, use of the Level of Service-Inventory risk assessment instrument, quality assurance, and case planning.

This three-pronged strategy is still ongoing in these jurisdictions. The goal was to have the cooperative begin the process, but eventually rely on the state and/or local organizations to further improve operations. The design seeks to build the knowledge base in the organizations as well as provide tools for future decision-making and sustainability, and to develop the change strategies that focus on inclusive team processes.

EBPs in Community Corrections Agencies: Results from the National Criminal Justice Treatment Practices Survey

As part of the National Institute on Drug Abuse Criminal Justice Drug Abuse Treatment Studies (CJDATS) initiative, a survey was conducted of community corrections agencies on the use of EBPs (see Friedmann, Taxman, & Henderson, 2007; Henderson, Taxman & Young, 2008). The survey, which also included prisons and jails, was part of an effort to understand the current state of practice, but also to develop models of organizational change focused on adoption (see Taxman, Young, Wiersema, Mitchell, & Rhodes, 2007, for a description of the survey). In this section, we provide a summary of the survey findings for community corrections agencies (adults and juveniles), and analyze the factors that predict the adoption of EBPs in such agencies.

Survey respondents were drawn from a nationally representative sample of communities and prisons. The community sample was comprised of probation and parole agencies, jails, community treatment programs, and other community corrections agencies in a stratified representative sample. A two-staged stratified cluster sampling strategy (Kish, 1965) was used to identify eligible facilities. In the first stage, counties (or county equivalents) were categorized into three strata based on their general population sizes, and into eight categories based on

geographical region. In the second stage, a census of all criminal justice agencies and programs in the 72 selected counties provided a listing of 644 potential respondents. Survey instruments were sent to agency administrators and the directors of substance abuse programs. The survey polled respondents on issues such as the size of their facility, the average daily population of offenders, common practices, and their opinions on various organizational and treatment related topics. The response rate for the community sample was 71%.²

Best, Evidence-Based, or Strongly Supported Practices

Leading researchers, practitioners, and clinicians - informed by meta-analyses, systematic reviews, and consensus panel reviews - have articulated a number of effective practices for improving offender outcomes. Referred to as consensus-driven evidence-based practices, these recommendations include: treatment orientations (such as therapeutic communities, family-based treatment, and cognitive behavioral therapy) (Andrews et al., 1990; Sherman et al., 1997); using standardized substance abuse and risk assessment tools to match offenders to treatment (Andrews & Bonta, 1998; Andrews et al., 1990; Lowenkamp, Latessa, & Hoslinger, 2006; Peters & Wexler, 2005; Taxman & Marlowe, 2006; Taxman & Thanner, 2006); incorporating treatment phases with aftercare services (Taxman & Bouffard, 2000); treatment duration of 90 days or more (Simpson, Joe, & Brown, 1997; Hubbard et al., 1989); the employment of qualified staff to deliver treatment (Brannigan, Schackman, Falco, & Millman, 2004; Knudsen & Roman, 2004; Landenberger & Lipsey, 2005; NIDA, 2006; Taxman, 1998); the use of incentives and sanctions (Marlowe & Kirby, 1999; Sherman et al., 1997; Taxman, Soule, & Gelb, 1999); and the implementation of services that address co-occurring substance abuse and mental health disorders (Friedmann, Saitz, & Samet, 2003). NIDA's *Principles of Drug Abuse Treatment for*

² In this paper we discuss probation, parole, and other community-based criminal justice agencies. See Taxman, Perdoni, and Harrison (2007) for a more detailed discussion of the state of substance abuse treatment services across all adult corrections settings; see Young, Dembo, and Henderson (2007) for a discussion of juvenile findings.

Criminal Justice Populations (NIDA, 2006) underscores these concepts, and provides a framework for integrating treatment services into the criminal justice system.

Implementation of EBPs

The extent of EBP implementation in community corrections agencies as well as treatment programs is displayed in Table 2. Agency administrators reported implementing a mean of 5 of 13 key EBP components, with comprehensive treatment (85%) and systems integration (67%) most frequently in place. Practices such as treatment orientation (12%) and engagement techniques (22%) are rarely implemented.

**TABLE 2
STATE OF EBPS IN COMMUNITY CORRECTIONS**

Evidence-Based Practice (EBP): Practices In Corrections Settings to Reduce Recidivism and Improve the Criminal Justice Systems' Ability to Effectively Manage the Offender Population	% Community Corrections Administrators Reporting Implementing EBP
Use of a standardized Substance Abuse Assessment tool (Agency adopts a standardized tool that can be used to screen offenders for substance use disorders, such as the ASI, SASSI, MAST, etc.)	44%
Use of a standardized Risk Assessment tool (Agency adopts a standardized risk tool, such as the LSI-R, WRN, etc.)	34%
Employ techniques to engage the offender in treatment, such as Motivational Interviewing, Motivational Enhancements	22%
Use of evidence-based treatment, such as Therapeutic Communities, Cognitive Behavioral Therapy	14%
Use comprehensive treatment methods that address the multiple needs of offenders	85%
Address co-occurring mental health and substance abuse disorders through integrated treatment models	21%
Involve family in the treatment process	10%
Use of treatment programs that are a minimum of 90 days	40%
Have policies and procedures that integrate with other agencies to provide services for drug-involved offenders (Systems Integration)	70%
Continuing care that provides for multiple stages of treatment including aftercare	42%
Drug testing is used frequently to monitor progress of the offender	61%
Use a Graduated Sanctions schedule that ensures predictable, escalating responses to negative offender behavior	39%
Use an incentives schedule that ensures predictable responses to positive offender behavior	53%
Mean Number of Evidence-Based Practices Implemented	5.0

SOURCE: Perdoni, Taxman, & Fletcher, 2008.

Appendix A summarizes the logistic regression model results that examined the characteristics of community corrections organizations that adopt EBP. The following factors were found to significantly increase the likelihood of adoption of EBP: 1) administrators who report goals that embrace organizational learning and change; 2) innovations that use strategies to encourage innovations tend to adopt EBPs; 3) administrators who identify a need for more training for staff; 4) administrators that identify a need for staffing needs; and 5) administrators who pursue policies that integrate services with treatment providers. Organizations with administrators who tend to express personal opinions that emphasize punishment tend to adopt fewer EBPs.

Within recent years the field has seen more movement to increase interest and knowledge about EBPs. Some of the concepts have been around for nearly 30 years (e.g., use of risk assessment tools and triaging high risk offenders to services) but have not been integrated into practice. The NCJTP survey found that there are characteristics of organizations that can enhance the adoption of EBPs including creating a learning culture, having the administrator focus on staff needs, and pursuing policies that elevate interagency efforts. In many ways, these are consistent with TT models in that it positions the organization to learn, analyze, and do (put in place), and then refine, analyze and do.

The View from the Field: Results from Key Informant Interviews

To assess the state of the community corrections field with respect to identification and implementation of evidence-based treatment practice, it is important to identify leaders in the field and solicit their perspectives and opinions, their experiences in implementing EBP, the challenges of TT, and their opinions about what is needed to expand and facilitate TT at the state and local levels.

To accomplish this goal, we engaged community corrections leaders and staff in a series of discussions about EBP. First, we held two focus groups with about 20 staff (including directors, line staff, and national leaders) at the January 2006 and July 2006 training conferences of the American Probation and Parole Association (APPA). We then conducted Key Informant interviews with 15 individuals in the spring of 2007. These persons were identified primarily through their participation as members of EBP advisory groups assembled by the Center on Evidence-based Interventions for Crime and Addiction (CEICA) as part of CEICA's collaborative work with APPA and National TASC. Additional individuals were identified through either chain referral techniques or their participation in EBP focus groups held at the January and July 2006 APPA training conferences. Each of the authors interviewed five key informants (listed in Appendix B). The Interview Guide is presented in Appendix C. Interviews were conducted by telephone and lasted approximately one hour. In this section we summarize the findings from the key informant interviews. Appendix D contains additional detailed findings not summarized below. In the following sections, we summarize our key informants' views relating to key gaps in EBP knowledge, the identification of EBP, steps required to implement EBP, challenges and changes needed for implementing and sustaining EBP, and lessons learned from previous experiences with EBP.

Key gaps in Knowledge about Evidence-based Practice

A number of gaps were cited by the key informants. Several mentioned the need for knowledge about matching specific interventions to specific subpopulations: gender-based treatment, rural populations, sex offenders, high-risk high-need offenders, different cultural groups, and offenders with mental health problems. Other gaps relate to implementation and sustainability: the implications when treatment providers "mix" populations, how to motivate the offender and build trust (supervision style, officer-offender relationship, etc.), how EBPs are

actually used in practice, how to move staff to change their attitudes to better support recovery, and how to improve development of case plans. Officers and treatment staff need more practical “tools for the toolbox.” Knowledge gaps exist both among community corrections staff as well as treatment staff.

A number of respondents suggested that staff do not understand criminogenic need factors, and that the field tends to confuse risk and needs. Also, line staff do not know how to manage and overcome resistance on the part of offenders, how to handle situations where direct services are not available, or what to do with offenders who relapse. All of these issues seem to fall in the “gaps” and therefore affect how decisions are made. These practical supervision and referral issues make it difficult to improve services and outcomes.

From an organizational development perspective, agency leaders are unsure how to address the public safety vs. “soft on offender” issue. This tension is not typically addressed by the literature, and it is unclear what practices and policies need to be in place to overcome this disconnect between goals and values in a way that will lead to the reduction in relapse and recidivism desired by both the criminal justice and treatment agencies.

Other key informants focused more on the gap between “knowing and doing” and the inconsistent sharing of EBP knowledge. Judges and attorneys lag far behind in EBP knowledge and need to be reoriented through education and training. One exception may be Oregon, which is mandating EBP and trains all other agencies and actors (judges, prosecutors, defense). The gap between the initial introduction of EBP and training, as well as inadequate follow-through by supervisors and supporting policies, was emphasized. Another gap identified was the general inattention to staff attitudes, values and beliefs such as the lingering ethos that “nothing works so why try so hard.”

Key Steps Required for Successful Implementation of EB Treatment

Three key categories were mentioned by the key informants: (1) the need for strong leadership and political will, (2) the importance of staff training, and (3) quality monitoring. Other important facilitators for implementation cited by several respondents included adequate funding and available staff time.

In terms of leadership, there is a need for administrators to understand and embrace EBP and have a long-term commitment to it, along with the resources to help with implementation. Leaders also need to make changes in policies and procedures manuals to support EBP implementation, communicate the process and changes to line staff, obtain agency consensus, and provide ongoing training and supervision. Respondents emphasized that there is a need for “top down” endorsement in order to move ahead because they need administrators and leaders that can talk to the political leaders and keep the organization focused on key issues. It is easy to get sidetracked, and the leadership must make a commitment to move in this direction. The leadership must be interested and invested in the efforts. Investments in research and planning may improve the infrastructure (including the treatment system) so that it is ready for EBP.

Other leadership issues mentioned by several respondents relate to communication between the agency and community service providers. A shared vision, ongoing meetings (especially initially at implementation), and perhaps coordinated hiring strategies may also be helpful, as is an ongoing communication loop that designates a community corrections person to focus on AOD treatment.

Training issues include joint training for treatment and community corrections agencies. Managers need to be trained or retrained, so that management and staff come to embrace EBP, assessment, case management, and a functioning MIS. Distance learning models may help provide training access for more staff.

It may help to begin with EBP education, and then implement change in incremental small steps. Leadership and staff need to understand that EBP is not something that can be “tacked on,” but needs to be accepted and understood. Some PO’s and line supervisors may feel a particularly strong need to understand the EBP and its relevance to their work. Agencies must also learn what is needed for implementation. EBP education must target three levels: knowledge of core practices, ability to problem solving, and ability to translate key findings. One important issue is that much of the EBP is not geared for corrections, and only within the last five years has training been more suited for the field.

Finally, important components of good quality monitoring and follow-up include feedback to line supervisors, performance monitoring, outcomes-based contracting, and outcome measures to assist with case planning. Client considerations include identifying target treatment groups and finding relevant protocols for that group, identifying the desired results, matching the practice with the desired results, monitoring implementation for fidelity, evaluating results, and adjusting as needed. Collaboration between all stakeholders emphasizes the flexibility to adapt EBP to real world conditions, and commitment to improved outcomes. Several respondents mentioned the need for fidelity checks, quality assurance activities and tracking of outcomes (e.g., retention, completions, and drug/crime outcomes).

Key Challenges for Implementation and Sustainability of EBP

Respondents cited a number of challenges and needs, as well as strategies, to improve the extent and effectiveness of staff training. One main challenge is finding the resources and time to support training. Funders may need to be convinced of the importance of training and that it should be a priority; supporting ongoing training, booster sessions, or retraining may be particularly difficult. But if EBP is mandated or encouraged by States or Counties, then staff of various agencies needs to be trained about EBP. Some EBPs are copyright protected and require

money for workbooks and training; certification to use the protocol may require expensive training and expenses for fidelity monitoring.

Other major challenges for the implementation of and sustaining of EBP include high caseloads, limited time, and high staff turnover. Inversely, smaller caseloads, more funding, and higher quality workforces may facilitate successful EBP implementation. Large caseloads were seen as creating a number of challenges including allowing sufficient time for training on new EBPs, and ongoing supervision for sustaining intervention quality.

The issue of where to focus training and which groups to train first was discussed by some respondents. There was general support for the idea of training managers and line supervisors first, before training line staff. This “train the trainer” approach was endorsed by most of the respondents. But there is an important role for supervisors who need to relearn their jobs - they need to be trained so they can mentor and be supportive of EBP (it was pointed out that some senior staff may try to sabotage EBP or other change efforts). Instilling change at the supervisory level is important. One drawback noted was that although management typically receives training, they also have high turnover.

There was general agreement that sustaining training gains requires booster sessions and ongoing refresher training. This may require designating or hiring a staff person to maintain and monitor EBP efforts. Booster training should be made acceptable and accessible for the POs. Motivational interviewing techniques can help staff listen and reflect, but there is also a need to focus on general interviewing and other skills. Providing opportunities for PO’s and supervisors to view other programs and services was also seen as useful. Others felt that to maintain gains, professional trainers should provide ongoing TA and training. In any event, it is important to determine which methods are most effective in training or preparing staff.

Related to this, performance monitoring was seen as an important adjunct to training in order to assess the effectiveness of training, make sure that staff performance has changed or improved as desired, and assure that staff is documenting what they are doing (e.g., supervision plans). In one jurisdiction, a feedback system generates trimester reports on EBP, such as timely risk and needs assessments, employment referrals, etc. Annual performance assessment is another strategy. Although not focused in substance abuse treatment, this is an important strategy for letting staff know that training is taken seriously. Another jurisdiction gives incentive awards that tie into training on EBPs, use of risk assessments, and EBP practices. One jurisdiction hired quality assurance supervisors to monitor results.

Several ideas for techniques and strategies to improve training were suggested. These include using outside trainers or training academies, use of adult learning techniques, and moving away from traditional classroom-style passive training. Training content must be prioritized so that agencies focus on key issues; it was also suggested that agencies take remedial steps to improve EBP. In one state, EBP is now part of standard training for new staff.

Finally, the general challenge of implementing permanent changes in staff behaviors was noted as a training challenge. Not surprisingly, younger staff were viewed as more amenable to change and more flexible. Resistance from line staff must be overcome, and training needs to be more supportive.

Organizational Changes and Conditions Needed for Implementing and Sustaining EBP

At the agency level, most respondents indicated a need for a clear mission and a shift away from the traditional public safety approach to one that emphasizes the need to change offenders' behavior (or at least allow both approaches to coexist). Because implementing EBP involves a complex set of principles and strategies to change offender behavior, the agency needs to be re-aligned, as do performance appraisals. The mission and focus of the treatment providers

may also have to be changed. At the system level, stakeholders need to be realistic about what needs to be changed, and EBP work needs to be supported by research and endorsed by credible outside experts. It must be recognized that implementing and sustaining EBP is difficult and slow and involves a sustained multi-year effort. On the other hand, agencies cannot wait for “perfection” to roll out a new initiative. Another concern is if the EBP is too complex, an organization may need to focus on prioritizing what is needed, and implementing changes in a systematic way.

There is also a more general lack of understanding of the organizational change process. Some agencies do not have the organizational skills to develop EBP, or lack organizational readiness to change. Agencies need to understand how organizational change will impact on staff for an extended period of time. Organizational change is often related to leadership issues—there is lack of development of leaders in the field and this results in a number of problems.

A second set of issues mentioned by informants involves resources. Several respondents again mentioned the need for lower caseloads; nearly all respondents felt that high caseloads affect the agency’s mission. Incorporating the risk-needs principle will enable agencies to focus resources on medium- to high-risk offenders, and steer more resources toward substance abuse treatment. Another respondent noted that treatment resources are insufficient. Behavioral health care reimbursement models may not allow for long-term or residential treatment even where it is needed. Although many offenders may need a continuum of care over time, resources and staff are lacking to accomplish this goal. It was also noted that Community Corrections agencies do not always control their caseloads or workloads, increasing the importance of system-wide approaches. Courts put unnecessary conditions on offenders (especially low-risk), which affects

the ability to implement EBP. Costs and budgets need to be allocated differently to free resources for EBP.

Another organizational change issue is the need to increase support from politicians, judiciary, and defenders (and maybe other law enforcement actors) for these changes. But prosecutors, defenders, judges and legislators have different agendas and this presents a number of difficulties for bringing them “on board” to support innovation and EBP.

Organizational change is difficult because of the issues related to tenure of the average leader in the corrections system, knowledge of the leaders, interference from the political system, and the “tug and pull” from others. Respondents also felt that often people wear so many hats that they are not focused on merely one issue.

Organizational changes in policies and procedures that support EBP are needed, which will require adequate funding, staff time and MIS support. The organization must deal with basic barriers of limited time, and the fact that many activities are done in crisis-oriented environment with the ongoing threat of high staff turnover. Increased salaries, lower case loads, and higher quality staff are essential. There may be a need to move more to proactive versus reactive orientation within an organizational culture that is forward-looking and supports change and growth. There is a need for clear understanding at all levels as to why a certain EBP is being used along with value/ethic of openness and related job evaluations. Staff can be helped to see the practical and clinical usefulness of EBP and that it can make them more effective in their job. There may be a need to give up something in order to adopt new EBPs. Several respondents discussed the supportive role of research and funded research projects that include an integrated evaluation design, close researcher-practitioner collaboration; and well-planned launch with rapid formative feedback and outcome information.

Finally, a number of respondents mentioned the importance of improvements in staff hiring practices and the importance of involving staff in EBP and organizational change decisions. More attention should be paid to improving hiring practices. Who is being hired and will they be able to adapt to EBP? Should pre-employment training be implemented? What are the expectations of job and what will they be rewarded for? Younger staff may have broader training and be more open to EBPs (and thus easier to train); young staff does not just want to follow orders and may question why changes are made, and managers should be able to explain this. Staff appreciates feedback, and it is helpful to not try to change too much at once. Managers and supervisors should walk around and talk to staff. They should not ignore the complexity of the job and the implications for line staff of changes in programs or practices. If additional requirements are added to a PO's workload, then other responsibilities could perhaps be taken away.

It is a mistake to make major organizational plans solely from the top, and strategies are needed to increase line staff and supervisor involvement in decision making. Line staff can be engaged through committees, focus groups, and regular and frequent questions and answer sessions.

Necessity of Protocol Fidelity

There was fairly clear consensus that fidelity is important and necessary but is difficult to maintain in the real world, where conditions very likely differ from those in the research studies. The field must be realistic that fidelity should be the goal and agencies need to be careful about drift, but interventions need to also be flexible. Programs may be set up for failure if they are forced to adhere to the manual and cannot, or the protocol is too rigid. Too much focus on protocol fidelity rather than client needs and outcomes and be problematic. The EBP needs to be appropriate to the target population, fits the time frame (duration of client participation), and is

supported with sufficient funding and staff quality and expertise. If the manual and the intervention are mastered, then some deviation is acceptable. For some EB interventions, the curriculum is less important than for others (such as some family-focused interventions), so fidelity to the protocol may be more necessary. However, if fidelity is not appropriately maintained then poor outcomes may be erroneously attributed to the EBP.

One respondent noted that protocols can still be effective if not entirely faithful to the “proven” model. Another felt it was important to communicate changes in application of a protocol and track the results. Another suggestion was that fidelity was more important in research projects, in contrast to actual treatment delivery efforts that need to get clients’ attention, participation and engagement. Some felt that it might be better to focus on client participation and outcomes than fidelity to the manual.

Other key informants discussed fidelity in terms of EBP in general and not SA treatment. They recognized that the keys are quality of the interaction with the offender and the issues related to risk and need assessment. The emphasis was on these actions but they are difficult to measure because the tools to do so do not exist. Respondents felt that more emphasis is needed on fidelity in supervision but that there needs to be more consensus about these protocols.

Monitoring Interventions for Fidelity

Monitoring was seen as important but not always adequately implemented. Several efforts to monitor EBP were mentioned with respect to supervision or public safety related interventions: current or planned use of the Corrections Program Assessment Inventory (Gendreau, 1996) to help monitor contracted programs, building in components of the CPAI to vendor contracts, state contract monitoring (allocating a certain percentage of contract funds to EBPs), recidivism studies, and contract monitoring through a research and evaluation division. Performance monitoring was seen as occurring more with probation staff, not as much with

contracted agencies. Some states have a quality assurance system in place and computerized assessment processes, in conjunction with a reporting tool, can help to identify risk factors and write treatment plans. Others noted that monitoring is a shortcoming in community corrections that is not being done well by supervisors – it is more of a clinical supervisor’s approach; large supervisor caseloads (e.g., 6-8 or 10-12 officers per supervisor) may prevent adequate monitoring.

It is important to provide feedback to staff on what is working and what is not. Staff can be motivated by showing improved outcomes, that the EBP produces better outcomes than current practice, and that EBP makes their jobs easier and heavy caseloads more manageable (less time in courts and doing paperwork related to violations). On the other hand, several respondents noted that outcomes are almost always lower than anticipated. There is a tendency to rely too heavily on EBP instead of focusing on building healthy, long-lasting and respectful relationships with clients.

On the other hand, it appears that monitoring of substance abuse treatment programs can be even more haphazard (except if the community corrections agency is contracting directly for slots), and is typically handled at the PO level. PO’s can decide which program to refer to and will make referrals if they are satisfied with the treatment program according to their own personal criteria. It was noted that PO’s may take on faith how well the treatment program is doing; they do not have the time to monitor. Communication between PO’s and treatment programs is often inadequate, and monitoring is reactive (i.e., only if there is a problem). Agencies should work collaboratively with treatment providers and improve relationships between PO’s and treatment staff. Implementing EBP can be a problem for providers. More forums are needed for treatment and corrections staff to meet to share issues and talk about solutions, such as through case conferences, to make sure POs are notified about problems.

More outside treatment evaluators may be needed, and community corrections agencies need to recognize funding and turnover problems in treatment programs; but adequate resources are not available to do this. In the absence of internal contract monitoring units, most community corrections agencies merely refer to existing resources where they feel they have little input into the quality of the services. Corrections agencies also may not feel comfortable engaging substance abuse treatment providers in discussions about service delivery, supervision, clinical needs, or performance monitoring.

Other respondents noted that monitoring for adherence to EBP program design was commonly done systematically in research projects, but rarely under non-research conditions. As noted above there are almost no resources for adherence monitoring activities and there is little pressure to conduct such activities, except from some state agencies that are beginning to address adherence. However, a few respondents noted that their agencies monitor EBP implementation, process and outcomes including retention, completions, how clients leave, achievement of program goals and limited drug and crime outcomes. Generally, there is less concern with protocol fidelity and more concern about outcomes. Finally, one person observed that adherence is more likely when there are manuals and when supported by specific policy and procedures related to job evaluation.

Are Outcomes Regularly Obtained and Reported to Demonstrate Effectiveness?

Although there was general agreement about the importance of outcomes monitoring, whether by the state or county, the responses to this question were mixed. Outcomes can be used for feedback and to improve performance and this will help drive use of EBP. Once you measure behavior and hold people accountable, practices change. Some felt that generally there was a big hole in the system in terms of outcome monitoring, even though criminal justice funders generally require some outcomes reporting. This may especially be true for treatment

retention and other outcomes, although in Oregon treatment program funding is contingent on providing reporting forms. Even where outcomes are monitored, it may not be done frequently enough, or focus on the most significant outcomes. Where outcomes are monitored regularly, it may not be done by the unit offices or by the PO, so individual effectiveness cannot be determined. It was recommended that outcomes monitoring be web-based and automated, and that key outcome measures, such as recidivism, should be clearly defined. Although most indicated that recidivism was the key concept, agencies had difficulty obtaining this information.

More generally, a number of key informants talked about their difficulty getting management information systems to deliver reports that can be useful. Many agencies have some form of IT system to track who receives services and client progress with administrative outcomes (e.g., drop outs and completions). But as a whole, management information systems were seen as too inflexible, and updates and improvements can take too long.

CHAPTER IV

THE NUANCES OF THE CORRECTIONS ENVIRONMENT

By

Faye S. Taxman and Steven Belenko

In health services technology transfer models (e.g., substance abuse prevention and treatment and HIV/AIDS education, prevention and treatment) the goal is to develop new innovations (e.g., program models, prevention or treatment services, etc.), demonstrate their effectiveness, and then disseminate effective practices and programs to agencies responsible for providing the services. As indicated by the discussion in Chapter III, these models have largely been developed wherein the innovation is consistent with the mission of a specific organization and where the diffusion efforts are mainly internal to the organization. The classic research to practice model promoted by the Institute of Medicine (1998) and the Institute for Healthcare Improvement (www.ihl.org; Massoud, Nielsen, Nolan, Schall, & Sevin, 2006) draw from this concept that the innovation has been shown to have relative advantage over existing practices and that these improvements are consistent with the goals, values, and aims of an organization.

Corrections environments present challenges to traditional TT models because many of these assumptions do not apply. For example, 1) innovations in prevention and treatment services are not a primary (and often not a secondary) goal of the corrections agency; 2) the corrections agency does not have primary responsibility for that service, which means that a smaller proportion of the budget (if any) is allocated to these services and that a smaller proportion of the staff have skills and knowledge in the given area; and 3) the community may not have developed consensus that the corrections agency should be venturing into service provision or that offenders should be provided with prevention and treatment services. TT

models for corrections agencies must therefore acknowledge these disconnects, and be modified to address the nuances of corrections agencies, particularly community corrections agencies.

Corrections agencies respond to a different drummer than most other public institutions. Their target constituency is a population who are considered “lesser” citizens due to their behaviors and interactions with the legal system (Duffee & Carlson, 1996). Some offender behaviors are also considered to be indicative of bad choices or decisions, such as substance abuse, and the public often assumes that these behaviors are morally wrong and self-inflicted. Offenders are afforded limited citizenship including diminished civil liberties and diminished civil responsibilities (e.g., limitations on voting). These factors affect the responsiveness of general society to the offender population, and the public (and private) agencies required to provide services to them. Implementation of new innovations in this environment thus creates a friction for the corrections agency(s) in that there is a need to garner support from the wider community to assume responsibility for offender change, and to be in a position to offer services that facilitate that change. The public appears to be of two minds—they want punishment as a corrections goal and they also desire corrections to “correct” behaviors (Cullen, Fisher, & Applegate, 2000), albeit with limited resources devoted to such efforts. Although public opinion polls over the last decade have indicated more support for offender change (Cullen & Gendreau, 2000), these polls have not resulted in the allocation of appropriate resources to achieve these goals. In this context, agencies require slightly different steps and considerations in the change process to ensure success and support through the various implementation stages.

Opening the Doors to Offender Change as a Goal of Corrections

The public expects that a corrections agency will serve the main goal of “public safety”. This creates a dynamic in which punishment, rehabilitation, and deterrence may be commingled, and where any or all of these goals can be accomplished under the label of “public safety.”

Public safety can be a labile concept in that its definition varies considerably depending on the setting, timing, and sociopolitical climate. In addition, the concept has different meaning for politicians, the general public, public administrators, and line probation/parole staff, senior staff, and community-based service providers. The lack of a common understanding of public safety means that it is open to wide (mis)interpretation--to some it refers to violence prevention, to others it refers to protection from heinous acts, to others it refers to dangerous behavior, and to others it means controlling any aberrant behavior. But given that most offender behavior does not fall into any of these categories, the concept of public safety forces the state to act in the spirit of *parens patriae* to ensure that the well-being of the public is considered. The focus on safety generally refers to aberrant behavior where unhealthy behaviors such as substance abuse, mental health disorders, or physical health problems may be construed as falling into this category, or at least increasing public safety risk. In the past three decades, substance abuse has increasingly been criminalized, bringing more pressure on corrections agencies to deal with substance abusers in a fashion similar to other criminal behaviors (Husak, 2003).

Deviating from their core mission by marrying public safety with other goals requires the acceptance and commitment of two types of agencies external to the corrections agency: other justice-related organizations (e.g., judiciary, prosecutors, defense attorneys, parole boards, prisons, jails, and other corrections agencies) and health-related agencies (substance abuse, mental health, private providers, etc.). Traditionally, the closed system model of corrections was convenient because it protected the corrections agencies from dealing with too many demands, and allowed the corrections system to remain out of the public eye. To move away from a punishment –dominated corrections system requires the support of both justice and health constituencies. Legislative bodies and elected officials will also have to concur that corrections agencies should be involved in activities that focus on offender change. This is a major

difference from other innovation diffusion efforts in requiring the adoption of secondary or tertiary goals as part of the mission of a corrections agency.

The Changing Legal Status of the Offender: Impact on Goals

The corrections system operations are sensitive to the legal status of the offender, including whether offenders can be mandated to services based on whether the offender has been adjudicated, and whether corrections agencies must provide health services (prisons and jails are constitutionally mandated to provide basic health care whereas community corrections agencies are not). Pretrial offenders, either in jail or released to the community, must volunteer for treatment before they are accepted into programs that divert them from prison/jail. Another factor that affects the delivery of services is the length of time that the offender is under the control of the system — sentences less than 12 months are often considered too short to make it worthwhile to connect to services, and those with long sentences, especially incarceration sentences, are considered to be unlikely candidates given their tenure in the system. The emphasis on legal status, length of sentence, and constitutional responsibilities to provide basic health services often affects how an offender population is deemed eligible for services. These operational factors are part of the organizational climate regarding determinations of whether offenders are or “good candidates” for treatment services. As part of TT efforts, the legal status and mandates impact how the offender is perceived by those “insiders” or staff in the corrections agency. These obstacles cannot be ignored in TT models since they are barriers that affect how the justice system handles offenders.

A related issue is the corrections system’s preference to be “offense-focused.” The dilemma of offense- vs. offender-focus has long affected CJS policies. Offense-focused policies base eligibility for programs and services on the severity of the legal charges. Offenders with serious legal charges or convictions are considered high stakes for the corrections system—

providing services to these offenders may backfire if an offender commits another serious crime. For the most part, sentencing guidelines, the judiciary, and parole boards are offense-driven in that their decisions are influenced by the offense and criminal history. Plea bargaining and setting of supervision conditions are examples of offense-based practices. The EBP movement embraces an offender-based system which relies upon standardized risk and needs tools to identify factors that affect involvement in criminal behavior. Moving toward an offender-driven system will make the corrections system compatible with a service provision system which is more focused on individual needs.

Moving toward an offender-based system will create challenges for the operations of corrections systems. No longer will services be provided on a voluntary basis. As noted by the recent National Survey on Criminal Justice Treatment Practices (Taxman, Perdoni, & Harrison, 2007), although many corrections agencies provide educational, substance abuse, and mental health services, few offenders actually can avail themselves of the services (Klein, Tolbert, Bugarin, Forrest-Cataldi, & Tauschek, 2004; Rossman, 2001). Even though 40% of the corrections population lacks a high school diploma, an average of 8% of the prison inmates, 3.7% of jail inmates, and 1.5% of probationers/paroles can participate in educational services on any given day (Taxman, Perdoni, & Harrison, 2007). Similar findings occur for substance abuse, mental health, and medical services (Belenko & Peugh, 2005), and corrections agencies struggle to provide core services. However, the corrections system does not have the basic tools in place to make routine decisions to place offenders in appropriate services (see Taxman, Cropsey, Young & Wexler, 2007, for a discussion of risk and substance abuse screening tools) which hampers the ability to assign offenders to the limited programming based on need. This will be a major challenge to moving toward an offender-based system in TT efforts.

Lack of Infrastructure Including Basic Knowledge and Skills

In the punishment and public safety culture of corrections agencies, there is an assumption that clinical practices and standards are inconsistent with the mission and operations of corrections agencies. This is reflected in the hiring standards and practices of the agencies and in the training provided to staff. Few staff is required to have clinical skills, and many employees (e.g., corrections officers) are only required to have a high school diploma. Training programs to help corrections/supervision staff develop “people skills” and to become proficient in the tasks of assessment, matching of needs to services, compliance management, and building trust in the justice system are rare. The “non-clinical” nature of the corrections systems, and its corresponding policies and procedures, creates a substantial gulf between practice and the concepts underscoring EBPs. This premise negatively affects the ability to implement treatment-related innovations that focus on behavioral change, since these efforts are “foreign” to the culture of the agency, the knowledge of the staff, and the skills of the staff. In many ways, this presents a tremendous challenge to corrections agencies because it requires the early steps of organizational change to develop these basic skill-sets in order to have a critical mass of staff that is comfortable with the innovations.

Training for both corrections and treatment staff therefore needs to be enhanced to incorporate several new areas. These areas include basic tools for reading and understanding research reports, cross-training in other relevant disciplines and missions, comportment with offenders/clients (Taxman, Shepardson, & Byrne, 2004a), and assessment. For corrections staff in particular, the overriding punishment and retribution frameworks for corrections management that characterize the current era of corrections philosophy suggest that a new type of leadership needs to emerge. This leadership should be willing to promote a more rehabilitative focus and

link the importance of public health interventions in improving public safety (Cullen & Gendreau, 2000).

Recognizing the unique challenges of implementing EBP treatment for offenders under community supervision.

The above discussion highlights major issues that require modification to the classic TT model to account for these differences that affect the mission and goals of organizations, support for innovation, and knowledge and skills are available in the agency. The TT literature highlights a model that is critical to overcome internal barriers to new innovations. But, given the inherent differences between health and educational agencies with corrections agencies, it is important to refine the TT model. First, it is paramount when implementing new technology to build a *foundation* for facilitating EBP implementation. This can involve assessing each agency's readiness to change; assessing staff, organizational, and system needs; and then reviewing the substance abuse assessment, treatment referral, and treatment monitoring process within the corrections agency and the public health system (Friedman, Taxman, & Henderson, 2007). This lays the foundation for developing realistic expectations about the EBP and reframing perceived threats as challenges to be overcome. Ensuring readiness to change can be accomplished through a process that includes new technology exposure (demonstrations, training, etc.) and garnering support for the adoption of the innovation within the corrections agency and its key stakeholder groups.

Another consideration is the need to institutionalize and *align* new practices into the daily staff routine (Taxman & Sherman, 1998); this is often a barrier to the adoption of new technology, where technology is too often implemented without consideration of an agency's business practices and staff roles and responsibilities (Kaplan, 1997; Liddle et al., 2002), and is instead imposed in addition to regular duties and tasks. Training and technical assistance is important and should incorporate staff roles and responsibilities to enable staff to relate the

technology to their particular role. Staff should be slowly engaged with the new technology beginning only with what is necessary for his/her responsibilities and exposed over time to the full intervention, and taught how it helps improve outcomes for offenders.

Finally, no innovation can be successfully sustained without a plan for long-term application. Not only is it important to plan for and implement innovation, but it is also important to plan for ongoing training and technical assistance, fidelity monitoring, and performance feedback (Taxman et al., 2004a). After implementation, agencies need to continue oversight that includes technical assistance, maintenance of intervention fidelity³, retraining of existing staff and new staff, and performance monitoring or benchmarking. Similarly, the agency should develop an ongoing data collection plan to document program performance. Sustaining EBP over time may require changes in daily practice, organizational and systems change, and the active involvement and support of agency leadership.

For community corrections agencies, pressure has increased in recent years to implement EBP and consensus-based best practices as a technique to improve offender outcomes. Emphasis has been placed on four areas that most affect the business practice of community corrections agencies: assessment, treatment services, department, and compliance management (sanctions/rewards) (NIC, 2004; Taxman, Shepardson, & Byrne, 2004a). Assessment, department, and compliance management are designed to improve the infrastructure of corrections agencies to support offender change. For example, the importance of using actuarial risk assessment tools has been a core component because it provides an objective means to identify risk level, manage the risk and then allocate resources accordingly (i.e., provide high risk offenders with a more controlled environment and more treatment resources than medium to lower risk offenders), and link services to the needs of the offender (Lowenkamp et al., 2006;

³ The term “fidelity,” sometimes overused and misunderstood, is used here to include maintaining protocol rigor in different clinical environments, and incorporating protocol principles in the context of real-world clinical needs and environments.

Taxman & Thanner, 2006). Another component is attention to the organizational culture or the ecological setting for the supervision services that are focused on risk management, where the emphasis is on using processes of department that allow staff to develop rapport and trust with offenders (Taxman, et al, 2004a; Taxman & Thanner, 2004). Finally the use of behavioral management tools (including both positive and negative reinforcers) may be needed to improve compliance and retention in appropriate services and offender recidivism outcomes (Gendreau, 1996). The goal of these efforts is to support the offender's involvement in treatment services, whether they are delivered by the corrections agency, through a contract or through a provider service. Involving offenders in quality evidence-based substance abuse treatment services, such as social learning models, cognitive behavioral or therapeutic communities with aftercare in the community (Gendreau, 1996; Lipsey & Landenberger, 2006; Sherman et al., 1997; Taxman et al., 2004a), is the key to improved outcomes. This model must be clear to the external stakeholder agencies, the corrections agency, and those that work within the corrections agency.

CHAPTER V

A CONCEPTUAL MODEL OF TECHNOLOGY TRANSFER OF EVIDENCE-BASED TREATMENT TO COMMUNITY CORRECTIONS

By

Faye S. Taxman and Steven Belenko

In contrast to health-related organizations, innovations or changes that encompass the evidence-based practice field affect all aspects of community corrections and the corrections environment. The four areas--assessment, treatment services, department, and compliance (incentives/sanctions)—affect the operations of the corrections agency from intake to discharge and the daily activities of line staff. TT has generally been developed to respond to single innovation changes (i.e., a new treatment such as cognitive behavioral therapy or contingency management). Yet, in corrections the emphasis is generally on process changes that encompass modifying work processes, procedures, and policies that affect basic functions of the agency. An example is the Travis County, Texas Community Impact Supervision Initiative (TCSI) which is supported by no less than eleven incubator reports to describe the process changes that will need to occur to accomplish the implementation of evidence-based supervision in this jurisdiction (http://www.co.travis.tx.us/community_supervision/TCIS_Initiative.asp). Unlike most TT efforts, the need in community corrections is to develop a process that supports the implementation of the change (similar to the steps identified in the Change Book [ATTC, 2004]) as well as address the unique needs of the corrections agency.

In this section, we outline a new TT model for community corrections agencies. Our model is based on the literature of existing TT models, but accommodates the unique features of the community corrections environment (see Chapter IV), especially related to the integration of substance abuse treatment, and takes into account the procedures to manage the change. The conceptual model has five main steps, and is displayed graphically on the following page:

1) knowledge development

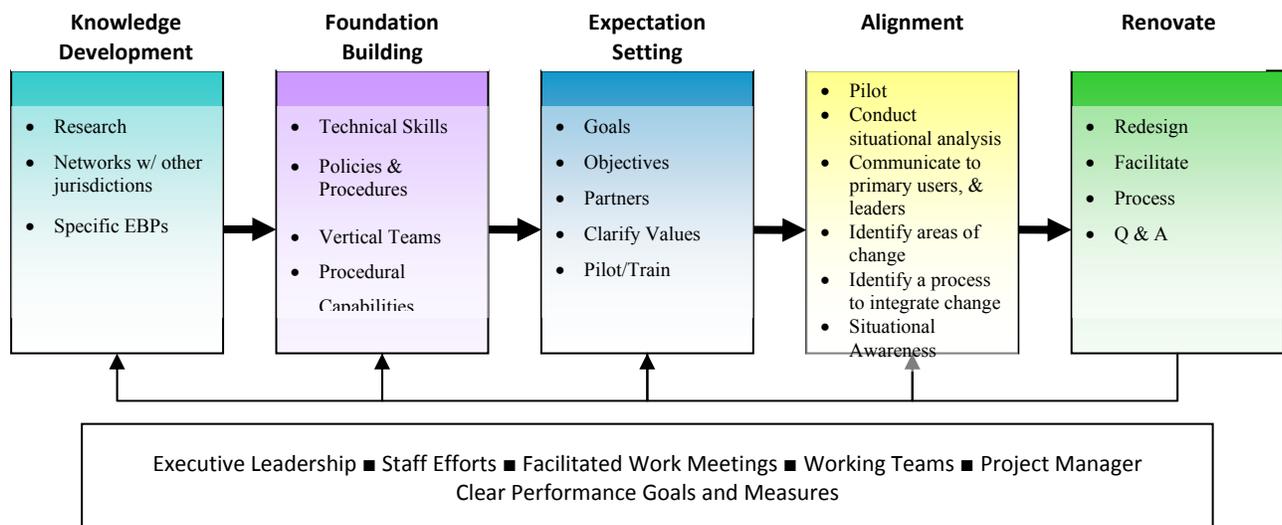
- 2) foundation building
- 3) expectation setting
- 4) alignment
- 5) renovate

In contrast to other TT models, the preparation phase is separated into two components that include *knowledge development* and *foundation building*. These are designed to integrate stakeholders (other justice agencies or other health agencies) into the change process and to develop necessary skills and knowledge in the organization. The agency needs to ensure that the supervision process includes responsibility to the treatment conditions for the offender (e.g., problem recognition, needs assessment). Key agency leaders must become educated about effective interventions, and understand the requirements for implementation and sustainability. Organizations must build or enhance their foundation and improve their capacity to implement new practices (e.g., by developing better communication skills, case planning, problem solving). Unlike other models, the qualifications and skills of corrections staff are recognized as core components. Given the nature of correctional agencies, particular attention is needed to build, enhance, and upgrade the skills of the staff to incorporate EBPs within their existing work.

Expectation setting (e.g. benchmarking, staff measures, client performance) is designed to pilot the innovation to allow internal and external agencies to establish desired goals for the change. Here the organization and individuals determine how the EB treatment and/or intervention will assist the agency. This phase is critical because it marries the innovation with the organization, and allows managers and staff to collectively form an opinion about the advantages of this new practice. **Alignment** (adherence, fidelity, feedback and review, examine organizational outcomes) serves to use the pilot to align the agency's policies, processes, and procedures to accommodate the change, and the impact of the changes on the offenders. **Renovate**

(organizational and systems change, sustainability, staff leadership and buy-in, identify staff for development) is to refine the change innovation to fit within the procedures of the agencies and to link this one change to the other changes. It is the stage where sustaining the efforts and the “design” is patterned to fit within the agency. This model recognizes that community corrections agencies must receive support from external agencies to implement evidence based practices and treatments, and to develop internal capacity for the change. At this stage, the focus is on refining the EBP to fit the agency and system needs, and maximizing positive clinical and public safety outcomes. This model deviates from the traditional EBP approach (largely based on clinical trials as the springboard of “knowledge”) by also focusing on a process where an important criterion for evidence is that desired outcomes are improved.

Figure 1
Conceptual Model for Technology Transfer



Setting the Stage for the Change Process

Before we describe our model, we discuss how community corrections organizations must prepare themselves to engage in a change process that will facilitate implementation of our model. The Change Book (ATTC, 2004) outlined the important work team processes that must occur to facilitate the change processes. As discussed in Chapter III, this ten-step model establishes that any new innovations or changes are generally modifications to existing programs or systems. Although the preference may be to allow the innovation to “percolate” into practice, TT recognizes that there is a process for change. Often, the change process is implicit, so that it is assumed that leaders of an organization have a methodology for implementing and managing the change. Here we recognize that the change process requires administrators/managers to organize specific strategies to move the organization along to acquire, integrate into existing practices, and utilize. Stated simply, the techniques to engage the organization are just as important to the success of the change, or to sustainability. It weaves the change into the fabric of the agency. Stand-alone or top-down initiatives are unlikely to be implemented or sustained. As previously discussed, a key component of the implementation process involves an organizational readiness strategy to build momentum for the innovation and then to sustain the initiative. As noted in the intermediate sanctions movement of the 1990’s, the organization at large will “fight off” anything new, increasing the importance of addressing the organization and the culture to avoid this reaction (Cochrane, 1992).

Most existing models of TT underscore that the management and staff must be involved in the process, and that work teams should include a mix of staff to ensure that the change fits within the organization. These teams become important components to the change process in that they provide a forum to discuss existing practice, review evidence-based literature, consider adaptations in the environment, and shape the implementation to fit the environment.

Empowerment is one of the key principles involved in the process—empowerment provides the framework for the organization, at its various levels and agencies, to consider how this innovation will impact operations, and the steps that must be changed to alter the process.

Traditional “top down” or “bottom up” approaches have been replaced by a hybrid that engages the whole organization in aspects of working towards sustained change. This means that the traditional methods need to be replaced by a strategy that realizes that the TT process is a series of steps that lead to a different end product.

Below we describe how a change strategy process can be implemented to support all steps of the change process. These are steps that can be taken to manage the change process. The purpose of this description is to help organizations realize that the success of the TT model largely depends on the manner in which change is pursued by the organization.

- 1) **executive leadership** to support the change process;
- 2) **staff efforts** devoted to implementing the change;
- 3) **facilitators** or staff devoted to the process;
- 4) **working teams** that are a cross-section (vertical slice) of the organization and can learn, apply, assess, and redefine;
- 5) **project management activities** that set out time-task plans, that allow the teams to monitor and measure their accomplishments, and that identify the steps in the process to keep the momentum going; and
- 6) **clear performance goals and measures** that provide objective feedback to the organization about the implementation of the innovation.

Executive Leadership

Change requires a commitment by the organization and the support of leadership to both the new innovation and the crafting of process of change. Executive leadership is needed to

achieve three goals: 1) reframe agency goals and mission to reflect the importance of the organization's commitment to change; 2) identify policies, procedures, and resources relevant to the change process; and 3) provide direction and support for the agency through the various change processes. To implement EBPs, executives must recognize the full range of change that is needed throughout various parts of the organization to support the innovation. The executives need to focus on both enhancing internal and external capabilities to increase the organization's ability to adopt EBPs. In particular, executives should focus on external stakeholders to ensure that they understand the change, understand how the stakeholder can support the change process, and outline a strategy for using the external support to augment internal changes.

Staff

Any change in practice requires mid-level supervisors and line staff to (1) understand the rationale for the change, (2) acknowledge that operations can be improved, and (3) inculcate the change into daily practice. The staff must be engaged in the change process in order to achieve these three objectives. The literature makes clear that traditional methods of "informing" the staff of the change (an example of the "top-down" approach) are much less effective than various engagement strategies where the staff is part of the process of crafting the change. The latter allows the staff to obtain ownership and investment in the change as well as tailor the change to work practices of the organization. That is, every office has a different process for handling typical events (e.g. intake, appointments, report days, sanctions), and the socio-political factors that affect work events. The staff is in the best position to craft procedures that are responsive to the EBPs, as well to understand which local practices need revision to accommodate the evidence-based practices.

Facilitators of the Change Process

Change involves a "facilitator" to manage the process and maintain the momentum. This

person is key in that they are responsible for understanding the organization's policies, procedures, and practices, and for guiding the organization to answer key questions about how to translate the EBPs into practices. The characteristics of the facilitator are very important and should include: intimate understanding of the EBP literature and studies, ability to help understand how to translate the evidence into work processes, and the skills to guide executive and staff through the steps of implementation. Careful selection should be made of the facilitators since they focus the effort on the main goals and need to have insight into the needs of the organization but while allowing others to assume ownership for the process. The facilitator can also negotiate and mediate issues that arise when differences occur between groups or factions on the implementation teams.

Implementation Teams through Cross-sectional or “Vertical Slice” Working Teams

The processing of information and utilization of knowledge is best served by work teams. The work teams should have responsibility for engaging the organization, and the degree to which they are used through the various TT stages—knowledge development through renovation—the more likely the organization is to embrace the change and therefore for the innovation to be actualized. The most effective work teams involve a cross-section (vertical slice) of the organization (More & Safford, 2004), and consist of three parts: the “old guard” that serve to protect existing practices, the staff who are excited by the new prospects, and those who are “assigned” to the project. A mix of staff and managers working together develops cohesion for the goals, furthers an understanding of the goals and purpose, and crafts the product to fit the environment.

Collaborative Agency Teams with Stakeholders

Criminal justice policy and practice are not unidimensional: most criminal justice decisions require involvement of multiple agencies in the process, and changes that occur need to

take these into account. Examples are parole decisions where the parole board determines the release decision and conditions of release, and the parole agency is responsible for monitoring the decision and linking with treatment providers to obtain the services required to fulfill the release conditions. In the CJS the collaborating agencies include law enforcement, prosecutors, defenders, service providers, educators, and community stakeholders. These agencies are often involved in many aspects, and can become critical in advancing the change process. Corrections agencies need to engage these organizations during the change process to ensure that sufficient support is provided by external agencies. For example, if a corrections agency is interested in operating a therapeutic community then the community and other agencies can provide support for the importance of this treatment program. Many strategies are available to keep the stakeholders engaged, including: 1) informing them of the change; 2) involving the agencies in the crafting of the change; 3) working on integrated policies and procedures that fulfill the change process; and 4) modifying laws, regulations, or other policy initiatives that impact the operations of the corrections agency. At a minimum, the internal work team should keep external teams informed of the progress on the change including hosting, participating in, and using existing interagency organizations on a routine basis (e.g. Criminal Justice Commission, Community Corrections Acts, etc.).

Project management activities

Within the complex activities that define the world of work, the challenges of daily activities often interfere with change processes. Change requires management of the process that includes identifying key tasks, steps to be taken to fulfill each task, and measurable performance at each step. Good project management underscores the change process by providing a task management process that allows each step to be documented, described, and assessed. The importance of a project management approach cannot be understated, given that organizational

change generally results from deliberative steps that utilize work teams to define, develop, implement, and refine efforts. Project management activities need to set time-task plans, allow the teams to monitor and measure their accomplishments, and identify the steps in the process to keep the momentum going. The facilitator is usually responsible for guiding the time-task plan.

Clear performance goals and measures provide objective feedback on progress

The importance of performance measures is that the organization can use them as a measurement tool to assess progress, to provide feedback, and to illustrate success. The performance measures provide an avenue to be able to determine the factors that affect the desired goals and objectives, and to advance implementation. One of the keys for success in most management efforts is to measure performance and to provide feedback. Major initiatives in criminal justice reform have been guided by performance measures including the COMPuter STATistics (COMPSTAT) approach in law enforcement (Weisburd, Mastrowski, McNally, Greenspan, & Willis, 2003) with recommendations for this model to guide corrections practice (Gelb, 2006; Gelb & Burrell, 2007). The NIATx and Washington Circle models have identified performance measures for treatment systems that include measures of initiation, engagement, and retention (McCarty et al., 2007; Hoffman et al., 2008; www.washingtoncircle.org). These are helpful because they provide a standardized approach to measure progress.

Similarly, in the Delaware performance contracting system for substance abuse treatment providers, performance measures focus on capacity utilization, active participation based on minimum required counseling session attendance, and program retention (defined as active participation in treatment for at least 60 days, achievement of major treatment plan goals, and a minimum of four consecutive clean weekly urine samples; McLellan et al., 2008).

**TABLE 3
EXAMPLES OF KEY PERFORMANCE MEASURES IN SUBSTANCE ABUSE
TREATMENT**

Washington Circle initiation: % of clients who have index outpatient services in the previous 60 days and received a second meeting within 14 days after the first service

Washington Circle engagement: % of clients initiating treatment who received two additional services within 30 days of initiation

Washington Circle continuity of care: % of clients with an additional 14 days of services in different levels (detoxification, residential, etc.)

NIATx Initiation (from 1st request): Time from first request for services until first treatment session

NIATX Retention = % clients receiving 4 units of services within 30 days of first treatment

Sources: Garnick et al., 2007; http://www.washingtoncircle.org/pdfs/pp_3.pdf

In the law enforcement literature, the use of performance measures along with short incremental objectives can help workgroups assess progress, refine strategies based on progress, and keep the momentum alive (Davis & Allemang, 2008). The performance measures can provide benchmarks for progress that are important in organizational change models. As demonstrated in the Delaware model, such a focus on performance benchmarks can improve treatment outcomes (McLellan et al., 2008).

The Technology Transfer Model for Community Corrections Agencies

TT for corrections agencies involves ongoing changes in organizational practices and policies and improving processes to facilitate the change. In exploring new innovation, regardless of its form or shape, the organization is examining how to integrate it into existing practices, refine processes, and facilitate implementation. Change is a process, as demonstrated by the above discussed TT models, moving from idea conception to actualization to routinization. In this section, we present a Community Corrections Technology Transfer Model

building on prior change models that are applied to the unique multi-agency system of corrections, substance abuse treatment, and criminal justice innovations. The emphasis is on sustaining change (Fixsen et al., 2005) and routinization (Patton, 1987), and moves past the standard quest to acquire new knowledge and try it, past the “readiness emphasis” toward utilization. A focus on utilization is one on building capacity and processes within the system for the new idea/concept to thrive, evolve, and transform. A focus on utilization is therefore one that recognizes that skill enhancement must be addressed. An additional key component is the reformation of policy, procedures, and practices that are congruent with planned change and that aligns staff skills to actualize and sustain the change.

Our focus on sustainability and utilization, instead of mere adoption, emphasizes that it is more than attitudes of individuals and/or organizations that can impact implementation. Although attitudes may interfere with readiness for change they are often reflective of ambivalence or insecurity about one’s capabilities coupled with cynicism about the organization’s commitment to change. As noted above in Chapter IV, it is important to recognize that the EBP movement requires corrections agencies to merge a service delivery process, including matching offender to appropriate services, into their corrections process. Our focus on skills as a foundation for sustainable innovation reflects the need to emphasize organizational and staff capabilities; in contrast, traditional models have focused more on attitudes and perceptions such as views about crime, offenders, and rehabilitation. An emphasis on skills essentially invests in the organization in a manner that can build capacity. For staff, this focus is a visible, reassuring, and deliberate statement that the TT is about utilization. It restates the importance of the mission and goals. In the following section we describe our TT model for substance abuse treatment in community corrections. The model incorporates following stages:



At each step of the process there are actions that emphasize the efforts of the staff and management, and that require the organization to refine policies, procedures, and practices that define each step, and the capacity of the organization to meet these efforts. We now describe the components and requirements for each stage of our model.

Knowledge Development

The Issues

Corrections is a discipline devoted to the humane treatment of individuals to achieve specific goals, depending upon the legal status of the individual and the laws and regulations in a given state/jurisdiction. Supervision and service requirements may differ at each stage in the process—pretrial/preadjudication, jail, prison, probation, parole—and for different types of offenders (e.g., juvenile, adult, young offender, sex offender, drug offender). Often, the requirements are a product of court cases, new laws or regulations, and new policies and/or procedures. The practice of corrections integrates knowledge across multiple disciplines (e.g., medicine, psychology, sociology, criminology, social work) and contexts (e.g., policy, business processes, organizational research). Knowledge about human behavior is rapidly expanding in scientific areas such as behavioral therapy and the effects of geographic influences; advances in neuroscience are increasingly yielding more attention to whether criminal behavior is a voluntary choice or whether there are neurological influences that may affect choices (e.g. substance abuse, mental illness; see Jones & Goldsmith, 2005; Volkow, 2001).

The purpose of the knowledge development phase is to become acquainted and aware of developments in various domains that are relevant to corrections practice. The field of

corrections requires an adequate understanding of human behavior to achieve any of the desired goals (i.e., punishment, rehabilitation, deterrence). Given that each domain has a research and practice literature, part of the challenge for corrections agencies is to keep abreast with literature spanning many different disciplines. The second demand is to assess the usefulness and quality of the literature and determine which aspects are relevant to their operations. Finally, corrections is affected by “issues *du jour*” where “hot topics” and external political pressures can affect the direction of the agency. Agencies must respond to these typically negative topics (i.e. a murderer, a sex offender near a school, etc.) that usually require immediate attention.

The complex world of corrections requires the recognition that knowledge development is an ongoing process wherein new information must be identified, distilled, and evolved in the organization. The research base for most of this information is found in scientific journals, now more easily obtainable through the internet and listservs. Traditional corrections training academies have not taken on the responsibility of transmitting research findings; instead they are responsible for the delivery of pre-service and in-service training which is generally focused on the requirements and of the job.

Very little emphasis is placed on acquiring scientific knowledge and then applying it to corrections operations. Although most corrections personnel can recite “what they are supposed to do”, the question about “why and to what benefit” often goes unanswered. Yet, the development of knowledge in the latter category greatly facilitates the change process, and must be included in a TT model since it prepares the individual and the organizational to appreciate the need, value, and benefits of changing business practice. A knowledge development phase serves to move away from attitudes and opinions (and personal philosophies) as underpinnings of change to an appreciation for the scientific value associated with the new goals. For example, in substance abuse treatment, contingency management protocols that reward positive behavior

have repeatedly been found to be effective for improving treatment engagement and retention. Yet, many counselors are unwilling to use the technology since they do not agree with the premise of “rewarding behaviors that the addict should be doing anyway.” In a knowledge building phase, the emphasis is on the science of contingency management and how the process improves engagement and treatment outcomes. Little attention would be given to assisting staff to address their personal values about incentives and how rewards can shape their own behavior.

Knowledge Building Tasks

The knowledge building tasks should address two major topics: 1) specific literature about effective practices that affect offender processing issues in the justice system; and, 2) agency policies and procedures. The first area is critically important since it defines the literature base and the scientific knowledge. A review of the literature, the findings from studies, and the types of offenders studied can

Areas for Knowledge Development

- Screening Tools and Goals
- Objectives
- Technical Skills
- Policies & Research
- Networks w/ other jurisdictions
- Specific EBPs
- Management of the Tools

assist in answering basic questions about the relevance of the literature and the findings. To appreciate this literature, some working knowledge in research design and methods is needed to ensure that there is an ability to differentiate between qualities of the studies, and studies that focus on efficacy vs. effectiveness⁴. This includes an understanding of the distinction between efficacy and effectiveness studies. Knowledge can be placed in terms of a continuum that ranges from evidence-based to new ideas. The findings from meta-analyses or systemic reviews are also important in terms of assessing the state of knowledge.

A focus on utilization emphasizes that the change affects existing practices, and that the agency goals, policies and procedures need to accommodate this change in practice. Although

⁴ Although not discussed here, it is probably worthwhile for corrections agencies to have staff that is knowledgeable in basic research design such as randomization and quasi-experimental designs, and basic statistics.

agency policy is generally covered in pre-service training and through periodic memoranda or briefings, the knowledge development phase can focus on reviewing this practice. This is part of the process of assisting employees to appreciate current practice in the context of the scientific findings, and to assess the relative advantage that the new EBP offers. It also informs how to best to integrate knowledge into practice. Practice is generally affected by the regulations that govern the agency overall, and government structure. Many employees are unaware of the process of crafting policy, legislation, and procedure, and they have expectations about how policy develops. Knowledge building can ensure that employees learn about policy-making processes which can affect their perceptions of fairness and equity of the process.

Tools to Advance Knowledge Development

The standard tools to develop knowledge about EBPs are speakers, seminars, and training workshops. As discussed earlier, studies on these seminars have basically found that single site trainings do not result in utilization of the practice (Goldstein, 1993; Joyce & Showers, 2002). The sessions serve to increase awareness about the science and research findings, but usually do not assist staff in learning to consider how to apply the information in their work processes (Joyce & Showers, 2002). Given that much of the scientific knowledge is judged on a calculus of “utility” and relative advantage to the agency, the goal is to encourage staff to translate this into how it affects the flow of offenders through the system. Knowledge development cannot occur in one session. Applying the cognitive development literature to this field, training should be facilitated within the context of a learning organization. In a learning organization, sessions should be devoted to map the concept and then outline how the policies, practices, and procedures in daily work are affected by this information. These sessions tend to be independent of other strategic planning efforts and can be used to begin the process of dealing with readiness to change, including the barriers (e.g., people, processes or things) and the strengths of the

organization. Finally, researchers must bear responsibility for translating their findings into more digestible lay language, producing shorter policy versions of academic journal articles and reports, and presenting findings at practitioner trainings and conferences. Given the pressures of improving practice faced by many corrections agencies, researchers must also become more comfortable in recommending adoption and testing of new interventions even where the evidence base may not yet be complete.

Foundation Building (Capabilities at the Individual and Organizational Level)

Information is the first step. But, as discussed in Chapter III, adopting EBPs can require skill sets that may not be available. Recognizing that the agency is not likely to have the skills to use the evidence-based technology, the organization should make a major investment to provide the needed skills. The foundation building activities require attention to improving capabilities in three areas: 1) technical; 2) procedural; and, 3) resources.

Technical

Because corrections involve a job that is multidimensional, requiring staff and managers to multi-task, it is possible that improvements will be needed in certain areas. By examining the current NIC principles for EBPs and the skills that are needed to work with an offender, we can focus our attention to the skills needed to ensure success in the application of the EBPs. These skills vary from assessment of initial risk and needs, to assessment of performance based on risk and need factors, to clinical engagement (throughout the process), to matching offender risk and needs with programmatic features. In the perfect world, one person would have the technical skills and abilities to handle all of these decisions. However, given that many of these skills are not necessarily required as part of the main qualifications for most line positions, more effort is needed to enhance these skills among key employees.

In any situation involving change, the agency should assess the existing capacity of the organization and the staff, especially in areas that advance adoption and implementation. From an organizational perspective, this process can be positive since it serves to assure staff that the change will be coupled with time to acquire and develop the new skills. This involves more than adjusting workload (see below), it focuses on ensuring that the staff has the basic skills to conduct the required change. This point cannot be understated, because many of the new EBPs require staff involvement in processes and procedures for which they may not have formal skills or knowledge. Often this lack of experience or confidence in their own skills is manifested in barriers (such as staff resistance) that can be overcome by providing staff with the training to allow them to be more proficient in their work with offenders. For example, many corrections agencies were interested in using motivational interviewing to increase rapport with supervised offenders. NIC commissioned a paper on this topic that also included a videotape and workbook, designed to enhance the skills of the staff in this particular area. Based on the knowledge of EBPs for substance abuse treatment in corrections agencies, organizations should consider the degree to which they and their contractors have sufficient skills and knowledge to provide the treatment services, as shown in Table 4.

TABLE 4**SKILLS NEEDED TO IMPLEMENT NIC'S PRINCIPLES**

NIC Principle	Skills Needed
Assess Offender Risk and Needs	<ul style="list-style-type: none"> • Proficient use of assessment instrument(s) • Proficiency in offender needs such as substance abuse, criminal peers, criminal thinking, anti-social behavior, etc. • Diagnostic skills to screen for behavior • Clinical skills to assess underlying issues
Enhance Offender Motivation	<ul style="list-style-type: none"> • Motivational engagement skills • Interviewing skills • Skills to use incentives such as communication and delivery of incentives
Target interventions	<ul style="list-style-type: none"> • Diagnostic skills • Case planning • Assess intervention strengths and weaknesses • Problem solving to adjust interventions based on staff skills
Address Cognitive-Behavioral Functioning	<ul style="list-style-type: none"> • Motivational enhancements • Clinical skills in cognitive functioning • Clinical skills in behavioral management
Provide Positive Reinforcement	<ul style="list-style-type: none"> • Motivational enhancement • Structured responses
Provide Ongoing Support	<ul style="list-style-type: none"> • Case monitoring • Service coordination and integration • Active client interaction skill
Measure Outcomes	<ul style="list-style-type: none"> • Performance-based management • Use of graphs to identify processes

Procedural Capabilities

Part of the implementation process requires an assessment of how the EBP will impact the current system. First, a procedural assessment should be conducted that examines the current infrastructure, possible barriers or resistance, protective factors, and other contextual factors that will be impacted by the innovation. Analysis of the organization's prior experience with similar programs/services can provide a series of "lessons learned" or factors that influenced the experience with the programs/services. The situational analysis will lead to a discussion of areas

where possible changes are needed, including inter- and intra-agency change in the criminal justice environment. That is, some of the capabilities derive from internal resources, while others draw upon the external stakeholders and their contributions to the organization. This can become an important part of strengthening the internal capability of the organization, and integrating other services, procedures, or stakeholders that will contribute to the innovation.

Second, the assessment needs to examine the current work environment, workload, and priorities associated with each function. Workload-related issues usually complicate the implementation of EBPs. These are essentially organizational issues that need attention to ensure that the new/modified idea or concept has a place at the table, and that it is feasible.

The skill enhancement component for procedural capabilities requires consideration of the following: 1) how managers oversee the process; 2) the existing policies and procedures that affect or are affected by the new knowledge; and 3) the modifications needed to implement the innovation. Each of these three elements provides support for the administration, and by going through a capability-building component, the organization is seeding the foundation for the innovation to become part of existing practice, and strengthening the organization's attachment to the innovation.

During this phase the implementation efforts serve to strengthen the management of the organization. It serves to demonstrate that the innovation is compatible with the mission, values, and goals of the organization; and, that the existing practice can be enriched by this process. The use of vertical teams (described above) serves to identify the procedures and operations that are affected by the innovation and to recommend changes including the elimination of existing procedures that are not adding value. In a recent initiation of EBP in New Jersey's Parole Office, the vertical team not only examined how to integrate risk and need assessment into practice, but also identified and recommended other changes in practices that will "free up" staff.

The committee found redundant forms, duplicate procedures, and disconnects that created difficult work processes. The recommendations to improve the procedures served to clarify the line supervisor's responsibility, define quality assurance procedures, and prioritize responsibilities. The review therefore led to organizational changes that could influence the work processes.

Table 5 displays a sample of procedural issues that need to be addressed for the NIC principles. Again, the manner in which the capabilities are assessed and provided serve to communicate to the staff the value and importance of the innovation, and how it fits within the organization.

Resource Capabilities

Often, organizations have “eyes bigger than their stomachs” (or their work place). An important part of the foundation building is to ensure that there are sufficient resources in appropriate places to adopt the innovation. The resources include: physical space, training and staff development, enhancements to existing technology (e.g., automation systems, assessment instruments, intervention contracts, etc.), staffing, and contractual funds for treatment or other services. Although most new innovations can have an exhaustible list of needs, the review of the resource capabilities should focus on building upon the existing structure. It is anticipated that new resources might be needed to make an investment in the organization and staff. Often in these reinvention processes, a review of resource distribution provides a solid framework for assessing the parts of the processes that need more attention and those that need less. For example, in many efforts the focus has been on reinvestment. This has been accomplished through the transfer of resources from one allotment to the next such as from prisons to community corrections, from an equal distribution of staff to a distribution of staff based on risk levels of the offender pool, from one part of the organization to the next, and so on. The

foundation building process allows for a review of how the resources of the organization are distributed, and an assessment of the adequacy of this distribution.

TABLE 5

PROCEDURAL CAPABILITIES NEEDED TO IMPLEMENT NIC’S PRINCIPLES

NIC Principle	Procedural Capability
Assess Offender Risk and Needs	<ul style="list-style-type: none"> • Select standardized instrument(s) to assess risk and/or needs • Validate the tool on the offender population • Norm the findings to identify areas that need attention and those that do not • Identify procedures to ensure that offenders with various risk and/or need levels are given the appropriate services • Identify staff requirements in this area
Enhance Offender Motivation	<ul style="list-style-type: none"> • Identify policies and regulations (especially for rapport building) • Select techniques to use for motivation • Review procedures
Target interventions	<ul style="list-style-type: none"> • Identify services available within the organization or in the community • Develop standard contract for procuring services • Establish criteria to measure the program/service Develop procedures for dealing with offender lack of progress in a given program
Address Cognitive-Behavioral Functioning	<ul style="list-style-type: none"> • Review procedures for decision making • Use the Cognitive Behavioral Model to review procedures
Provide Positive Reinforcement	<ul style="list-style-type: none"> • Identify staff rewards • Identify organizational rewards
Provide Ongoing Support	<ul style="list-style-type: none"> • Use Management Information System to improve outcomes • Use MIS to provide outcomes
Measure Outcomes	<ul style="list-style-type: none"> • Identify goals and objectives; test new ones

Expectation Setting: The Use of Benchmarks for Performance

The “finish line” can be rather obscure in the adoption of new innovations, and this can create organizational inertia. Without set goals for performance, and a means to assess the degree of accomplishment, is it difficult for the momentum to continue. The adoption of new technologies can be perceived as a never-ending process, creating the cynical view that improvements are not useful since they are merely burdensome, or that the “process is the punishment.” To avoid these emotional drains on the organization, benchmarks are a common and useful tool that provide a finish line, and when reached, a sense of accomplishment.

Benchmarks are set milestones that mark progress towards goals, are measurable, and provide feedback to the organization. Benchmarks have several purposes: 1) they allow the teams to identify the process of change and the indicators of progress towards that process; 2) they provide objective measures of the progress, and in doing so allow the team to mutually assess their goals; and 3) they develop the organization’s commitment to measuring progress at all levels. The benchmarking process, for work groups, provides a clarification of what the expectations will be and how the organization will become aware of the accomplishments. As shown below, benchmarking is another part of the process that allows the group to mutually assess the data and progress. By involving others in the definition, analysis, and interpretation process, this strengthens the organization to assess the progress made.

The benchmarking process can facilitate a review of information sources with the agency, the validity of the data, and the difficulty or ease of capturing the data. The assessment of the data collection process contributes to a shared understanding of how the organization functions, and helps to determine processes that need clarification. Similarly, the team works together to analyze and interpret the data, an important step because it allows the team to develop a

consensus on the experience, including findings that are inequitable and those that are interpretable. By “interpretable” we mean that there is some progress but the innovation raised new issues that may have affected the overall findings. Discussions of these situations are important because they lead to a more thorough assessment of the organization, and can contribute to making adjustments to align to the organization (see below).

The benchmarking process, which sets expectations, should be considered a mechanism to galvanize the organization around expectations for the agency and processes to develop solutions to work flow issues. Stated simply, a benchmark can be used to have the organization respond to identify areas that can be improved. Table 6 outlines the steps involved in the benchmarking process which engages the organization in considering the effectiveness of its actions. In *Utilization Focused Evaluation*, Michael Patton (1997) frequently discusses how the processes of defining, analyzing, and refining can be used by the organization to enhance outcomes, an important concept for our model.

TABLE 6

STEPS IN BENCHMARKING FROM DEVELOPMENT TO ALIGNMENT PROCESS

Steps	Questions to Ask
Identify Benchmarks	<ul style="list-style-type: none"> • For each goal, identify the desired steps to achieve that goal • Identify the measures of progress, and how this progress will be determined. • Specify the timeframe to expect the findings • Achieve consensus on the measures to improve outcomes
Identify and Collect Data	<ul style="list-style-type: none"> • Keep primary users informed of the data to be collected and the progress made • Involve primary users in data collection, management of the process • Assist primary users to understand how data collection can advance their efforts • Use data to expand knowledge about change
Conduct Mutual Analysis of the Data Using the Work Team and Outside Stakeholders	<ul style="list-style-type: none"> • Outline analysis for the primary users and their interests • Facilitate data interpretation by the primary users to increase understanding of findings, ownership to findings, and commitment to results • Involve users in interpreting findings and generating recommendations • Involve a broad spectrum of users and stakeholders in the process to examine the findings • Help users distinguish among findings, interpretations, judgments and recommendations • Inform primary users of important “findings” and/or decisions • Focus on analysis of various data sources to encourage an open discussion, and to guide knowledge utilization. Help users distinguish among varying degrees of certainty in the findings, being open and explicit about the limitations, weaknesses, strengths

Table 7 is an example of sample benchmarks that could be used by community corrections agencies as they begin to consider adopting EBPs or refining current work to be consistent with EBPs.

TABLE 7**SAMPLE BENCHMARKS TO MEASURE IMPLEMENTATION OF NIC PRINCIPLES**

NIC Principle	Sample Expectations and Benchmarks
Assess Offender Risk and Needs	<ul style="list-style-type: none"> • % staff trained to use the tools • % of new intakes where tool was used • % of new intakes identified with various needs/risk level
Enhance Offender Motivation	<ul style="list-style-type: none"> • % of staff using motivational tools • % of offenders that attend services within 30 days of referral/intake
Target interventions	<ul style="list-style-type: none"> • % of services that match offender needs (can be done by need category) • % of service providers that embrace evidence-base treatments
Address Cognitive-Behavioral Functioning	<ul style="list-style-type: none"> • % service sessions that are CBT • % corrections sessions that are CBT
Provide Positive Reinforcement	<ul style="list-style-type: none"> • % offenders in compliance • % interactions that use incentives
Provide Ongoing Support	<ul style="list-style-type: none"> • % offenders with non-criminal peers in the community • % offenders that use NA/AA
Measure Outcomes	<ul style="list-style-type: none"> • % reports used to target new activities

Alignment after Period of Early Adoption (Trialability)

The preceding steps are taken to prepare the organization for a period of trial and error, or a set time frame to begin the implementation process. Although there may be a desire to move ahead with innovations at full scale, it is advisable to begin the process in smaller “bites” to allow for testing the foundation and identifying the organizational resiliency. This test is designed to determine: 1) strengths; 2) assessing how the organization responds to the innovation; and 3) identifying unanticipated barriers or issues, at the policy, procedural or skill level, that will need further attention. The goal of the trial period is to assess how the design for the innovation needs to be aligned to the needs of the organization.

The alignment process should also use the vertical teams to conduct a *situation analysis* of the effort to determine the saliency of concept, design, and innovation. A situation analysis

provides the ability to examine the trial through the lenses of the various participants, and to identify areas where the foundation building needs to be developed further. The steps, as identified below, reconcile the early adoption and implementation phases as part of the sustainability and include: 1) pilot, 2) conduct a situational analysis; 3) communicate to primary users and leaders in the organization; 4) identify areas of change; and 5) identify processes to integrate change. These steps help the organization to move toward aligning the early results with desired outcomes, as shown in Table 8.

Renovation, Utilization, & Sustainability

The above simulation of the change serves to facilitate two decisions: 1) at what scale should the innovation be implemented; and 2) what changes should occur to ensure optimal performance at that scale. That is, the question of sustainability is one that is designed to give the policy makers and staff the determination as to whether a specific EBP can become part of the organization's regular business practice. The process of going to scale uses the trial period as the galvanizing force to marshal the organization's energies. Renovation, as the name implies, refers to an effort to pay more attention to building upon the foundation, and using the team members and/or staff involved in the trial to function as internal "champions" for the innovation. That is, the former steps serve to proliferate the champions through the organization, especially line staff who are often shoulder more of the demands.

TABLE 8

STEPS AND TECHNIQUES OF ALIGNMENT

Steps	Techniques
Simulate Use through a Trial	<ul style="list-style-type: none"> • Guide primary users through a trial period, and use that trial to generate discussion about refinements (or disregard if it does not work) • Determine whether design changes are needed • Have team/primary users make explicit decisions on how to proceed
Conduct Situational Analysis	<ul style="list-style-type: none"> • Examine agency’s infrastructure of processes (e.g., intake, programs, etc.) • Examine this experience in light of similar programs/services • Examine possible barriers or resistance to use • Examine facilitators and areas of support • Identify upcoming decisions, deadlines (e.g., funding decisions, etc.) or timelines • Evaluate the stakeholders’ interests and contributions, and ensure that they are involved in many aspects of the alignment process
Communicate to Primary Users	<ul style="list-style-type: none"> • Consider how the innovation will contribute to the main mission of the agency • Discuss how the trial innovation can contribute to staff knowledge and job development/enlargement • Consider how the innovation contributes to major decisions being made in the organization • Consider how the innovation affects the existing workload (and look for ways to reduce unnecessary paperwork or activities) • Use the process to generate lessons learned at all levels to contribute to an open environment and risk-taking
Identify areas and methods of Change in CJ Environment	<ul style="list-style-type: none"> • Select processes that are believable, credible, and valid to the users, and identify the steps to ensure that they are believable, credible, and valid • Assure that each step is documented to allow for review, lessons learned, and results that are visible to others • Involve primary intended users and stakeholders in processes to enhance use
Identify Processes to Integrate the Change (if renovation is to occur)	<ul style="list-style-type: none"> • Guide the pilot through internal champions to advance implementation • Identify the processes where changes in processes occur • Guide the development of processes where internal staff are experts at the implementation model

In the renovation phase, similar processes are used to adapt existing EBPs into a larger system. Knowledge development is an ongoing process that exposes members of the organization to new information; both empirical studies and clinical practice that can be useful in the change process. It is important to determine how best to allow the staff to become conversant in the skills needed to implement the innovation. But a larger issue, raised earlier, is that the focus on EBPs requires attention to some of the basic skills. In the long term, organizations may desire to alter their job qualifications to address these deficits. To adjust, current staff will require additional efforts to reshape their skills to be able to use the EBP. As noted above, this is a worthy process because it strengthens the organization and serves to enrich the employees. Moreover, the benchmarking process can serve to refocus the organization on key goals and objectives, the validity of the measures, and the importance of achieving these benchmarks. This process also serves to achieve consensus among the various parties in the organization to understand the mission, values, and goals of the organization. Consensus has been found to be an important variable in the change process (Melnick, Wexler, & Cleland, 2008).

Going to scale implies that the innovation design has been set and is constant. However, as noted in other fields, adaptations often are required to address issues of location, population served, and organizational climate issues (e.g., nature of the stakeholders, political influence, etc.). The alignment process is then considered relevant to whether the reframed design is consistent with the EBP. This is a question that needs to be consistently addressed since decisions are frequently made that may affect adherence to the EBP concept. For example, a jurisdiction implemented a cognitive behavioral therapy using paraprofessionals and a manual. However, the paraprofessionals did not understand the importance of using the manual and deviated in their discussion to be more instructive (i.e. didactic) and experiential. Although the

ingredients were in place, the benchmarks demonstrated large drop-out rates in the first 30 days. A review of the process revealed these flaws and the organization engaged in a process of quality assurance to reinforce to the paraprofessionals the importance of using the manual. Efforts were also undertaken to provide the staff with processing skills to improve their use of the manual. Other similar examples are available, such as modifying cut-offs for risk assignments based on intuition instead of offender behavior or using screening tools without a more thorough assessment of problem severity to assign offenders to treatment programs. Both are examples of adaptation altering the integrity of the EBP, which in turn diluted the impact of the EBP on the organization.

Renovation allows for the opportunity to use quality assurance tools to refine the process. As stated earlier, these quality assurance tools are more appropriate for implementation with corrections agencies since they will focus on two major challenges: 1) ensure that the operation proceeds; and 2) ensure that the process continues to deliver positive outcomes. The latter is needed because it is possible that routinization can result in passivity, such that ongoing quality assurance can ensure that the organization remains committed to the desired outcomes. Quality assurance techniques are important for sustainability and utilization efforts because they provide feedback to the organization on the how well the change has achieved its goals and objectives (Howe & Joplin, 2005). Similar to benchmarks, these quality assurance measures can be used to assess the degree to which the innovation is being implemented as intended and with the appropriate dosage and units to achieve the desired outcome. The quality assurance techniques are important in the renovation process to guard against dilution, and to ensure that the design meets the expectations of EBPs.

CHAPTER VI

DISCUSSION AND RECOMMENDED NEXT STEPS

By

Steven Belenko, Faye S. Taxman, and Harry K. Wexler

A number of TT models have been developed in the field of public health, including substance abuse treatment and prevention, and HIV/AIDS. The criminal justice field has not widely developed or adapted these models, except through some *ad hoc* efforts by technical assistance providers. However, there is an important difference between technical assistance and TT models: the latter emphasizes a greater focus on a process for planned change that will be embraced by the organization. Technical assistance is usually problem driven, intermittent and relatively brief, and is generally designed to fit within a TT framework. The field of corrections is complex, and this affects all aspects of the organization from the mission, goals, major processes, and the interrelationship of offender flow across organizations. Models of TT need to be adapted for monolithic organizations where the change must permeate the organization and its staff.

The National Institute of Corrections, in the forefront of corrections advancements, has increasingly emphasized the TT approach. As the major organization to disseminate research findings to corrections agencies, NIC has sponsored seminars at the state and local level to provide training. NIC has also sponsored management review and strategic planning sessions. All of these were part of the early phases of the TT model, which we refer to as *foundation building*. Within the more long-term NIC EBP project, NIC has ventured into more of a TT model, although the stages have evolved based on the needs of the particular organizations. Throughout this process, the need to address the interagency efforts has resulted in the development of white papers for the field to illustrate how EBP is suitable for pretrial agencies

(Van Nostrand, 2007), the judiciary (Warren, 2007), and prisons (Clawson, Bogue, & Joplin, 2005).

The TT model highlighted in this White Paper brings together the organizational change and innovation diffusion literature, experiences of states and local government agencies that have pursued the change journey, and findings from research on planned change in the complex world of corrections. TT in this environment varies considerably from the specific challenges of addiction treatment due to the steps needed to adapt the corrections environment to integrate public health and human services. Our TT model provides for a more systemic approach that draws upon principles of quality assurance, where the emphasis is on an integrated model of management of the organization that is data and performance driven, and where organizational change responds to this effort. Like quality assurance, the goal of the TT model is to be systematic but allow for staged implementation in a manner in which performance monitoring, in conjunction with regular program adjustments and outcomes monitoring, drive consideration of the continued validity of the innovation. Our TT model is designed to adapt to these constructs.

Change in the Complex Community Corrections Environment: From the Eyes of the Beholders

In developing this model, we undertook four major activities to understand the field of community corrections from a TT perspective. These activities were: 1) focus groups with stakeholders; 2) interviews with stakeholder groups; 3) a review of data from the National Criminal Justice Treatment Practices Survey (see Taxman, Young et al., 2007) and models to examine implementation of EBPs; and 4) a review of the TT and organizational change literature. In combination, these activities led us to certain conclusions about the implementation of evidence based substance abuse treatment in corrections settings, and a model tailored to the corrections field.

The corrections field differs vastly from the addiction treatment field and suggests different implementation dynamics that must be addressed to facilitate change

- The complexity underscoring the corrections field must be addressed in the change model
- The mission and goals that encompass EBP must be clarified to demonstrate cohesion with public safety, and offender change related to public safety
- As a whole, basic skills that involve the dynamics of human services (e.g., assessment, communication/interviewing, engagement, treatment placement, and so on) are needed within corrections environments, but it cannot be assumed that these are currently available
- Performance measures provide important support to the organization by ensuring that managers and staff link the change to the goals of the organization and continue the momentum associated with the change
- Community corrections agencies and treatment providers must be cross-trained and co-trained in order to more closely align their goals and expectations for offenders management and progress, and to enable more informed choices about treatment placement and responses to offender progress in treatment

From our focus groups and interviews, it is apparent that key leaders in the field of community corrections understand and value the emphasis on EBPs. EBPs bring enhanced professionalism to the corrections and provide managers with tools to measure the performance of the agency. As public managers, those involved in our study felt that recidivism reduction remained a critical goal of community corrections and required the agency to begin to deal with mechanisms to reduce “failures” by incorporating services and programs that are suitable. The use of risk and needs tools, compliance management strategies, and engagement techniques are wholly compatible with the field of corrections; they are viewed as part of the tool kit to improve the efficiency of the organization and to be good consumers of public resources.

The stakeholder interviews revealed that these public servants had in their own way used or created opportunities to build the foundations of their organizations. All had used some form of training or annual conferences to bring “news from researchers” to the forefront, and to help the field begin to absorb the implications to their own setting. In one state, the administrator hosts an annual conference that includes outside speakers and then has teams from his agency

brainstorm how to implement these research ideas into practice. This type of learning experience is designed to reinforce the connection between knowledge building, expectations and renovation that we presented in our model. In another state, they have invested heavily in an instrument for risk and need assessment while simultaneously retooling their pre-service and in-service training to reinforce the EBP concepts. These examples illustrate how organizations have moved ahead with advancing these concepts in the field.

For both community corrections and treatment agencies that do not have an in-house research capability, formal partnerships or linkages with researchers or research institutions can be valuable. Corrections administrators and senior clinical staff need to be able to identify and access evidence-based practice protocols and apply them to local settings. In addition, our TT model requires that agencies have the capability to monitor and assess implementation of EBPs and related outcomes. Because it is unusual to have the resources to fund researcher positions within local community corrections agencies, collaboration with a local university or research group can be very useful. The more reciprocity between the groups the greater likelihood of multiple and longer term joint projects that lead to program improvement.

Corrections agencies may also need assistance in linking to appropriate experts on evidence-based substance abuse treatment and their knowledge (getting help to distinguish between rigorous and “junk” science). In addition, there is a need to facilitate having researchers help agencies educate the government leaders and policy makers at the federal, state and local levels where funding decisions are made.

The interviews also revealed that the organizations are struggling with probably the most difficult part of the recommended TT model—performance measures. Some systems can produce outcome measures such as arrest and technical violations while on supervision. Few have the capacity to examine treatment access, participation, or completion. In many systems

the risk and needs tools are not automated so the information is not available for the organization to monitor use of the tools, or link the findings from the assessment to the supervision plans. The need to build this infrastructure is well-recognized by the field, but is something that few agencies have accomplished. Most public managers recognize the importance of performance measures, and how these measures can be used in the system.

Experience in Delaware has demonstrated that providing organizational economic incentives for program retention and service delivery can dramatically reduce treatment dropout rates (McLellan et al., 2008). Focusing on key outcomes of critical interest to corrections and treatment agencies (e.g., recidivism reduction, reduced drug use and increased employment) provides “buy-in.” If appropriately incentivized, the system may move relatively rapidly to effective strategies/interventions and gain the flexibility and openness needed to utilize all available resources. Incentives can be implemented at the organizational level (McLellan et al., 2008) or the staff level (Coeira, 2003). Evidence-based protocol outcomes can be used as standards (e.g., percentage recidivism reduction) against which other interventions can be compared. We believe that this approach will strongly contribute to the development of “high-performing” and flexible organizations.

Organizations and businesses that operate reasonably effectively require information on their operations, products, customers, and results. Although most agencies have basic IT capability, expanding and maintaining IT systems that can collect and provide reports on performance measures and intervention delivery are ongoing challenges for community corrections agencies, and we certainly do not minimize those challenges. Part of the knowledge development and foundation building phases of our model needs to include examination of IT needs to support performance monitoring and evaluation, and training for staff to recognize the

importance of collecting and accurately inputting such data. Such systems can serve the needs for routine offender monitoring as well as delivery of treatment services.

Staff-related issues can be one of the thorniest problems for organizations. All managers realize that dedicated and knowledgeable staff is essential for successful TT, but training academies and other opportunities are generally limited in their offerings, and most state and/or local run organizations must rely upon these resources. As previously discussed, corrections training academies are generally devoted to the job-related duties; they often do not assume responsibility for integrating research findings into the core curriculum. Nor do they focus on substance abuse treatment, a major limitation to the field given the high percentage of offenders with substance abuse problems. The workforce development piece has been one that many organizations are struggling with as more employees are of retirement age, and newer employees tend to not be prepared in human service backgrounds (i.e., few college criminal justice curricula require courses in psychology, health, or social work).

Achieving successful TT of EBP could also include identifying (and perhaps rewarding) staff who demonstrate better than average results with their caseloads (analogous to master teachers). Indicators for these results could be fewer offender rule infractions, lower violation and rearrest rates, and higher treatment retention and employment. Their behaviors, department, and procedures could be codified and such staff could participate in trainings. On the other hand, staff turnover, burnout, and negative work attitudes (both in corrections and treatment agencies) work against successful TT and EBP implementation and must be monitored and corrected. As our key informants noted, changes in hiring practices can be introduced to bring in more flexible and informed staff.

A Scientific or a Management Based Model of Change?

TT is about taking the findings from science and applying them in real-world settings.

The development and utilization of knowledge is a tricky process with a number of components. TT helps process the science and turn it into reality, while seeking to maintain the integrity of the original product. But the factors that surround in the process (e.g., socio-political environments, leadership, staffing, severity of the problem of crime and disorder, interagency efforts) should be studied to fully understand how they affect the outcomes. A new field of study, implementation science, is geared towards this effort for providing a scientific process to understand what works in implementation (Fixsen et al., 2005).

That said, it is important to realize that the scientific process already has mechanisms to develop knowledge about interventions and practices. *Efficacy* refers to evidence that a treatment has beneficial effects when delivered under carefully controlled conditions designed for experimentation; in efficacy studies, the researcher exerts considerable control over sample selection, delivery of the intervention, and the settings in which the intervention takes place. *Effectiveness* refers to evidence that a treatment has beneficial effects when delivered to heterogeneous samples of clinically referred individuals treated in diverse clinical settings by clinicians rather than researchers. Efficacy trials usually involve randomized clinical trials while effectiveness studies may also include traditional evaluations. The question about whether an effective intervention is *transportable* (Schoenwald & Hoagwood, 2001), meaning it can move from formal effectiveness trials into more general use (diffusion and dissemination), is discussed in more detail in Chapter II above.

A cautionary note is important here regarding the research process. Corrections agencies are bombarded with information about programs and practices that purport to be “research-based.” But research is about increasing degrees of scientific rigor and involving a systematic process for developing knowledge, starting with observation and qualitative research through randomized clinical trials with appropriate statistical analyses. The basic approach that underlies

all levels of inquiry is systematic observation, and what hierarchically differentiates them is the degree that threats to validity are controlled. Moving up the scientific scale, process and implementation evaluation allows measurement of how an intervention is operating and its effects upon participants as well as fidelity of implementation. Finally, rigorous designs that include well-designed control groups range from single site experimental and quasi-experimental studies to the “gold standard” of multisite randomized clinical trials.

This scientific process is different from consensus approaches. These consensus approaches involve activities such as focus groups, panels of experts and key informant surveys that access the richness of clinical experience but do not allow rigorous hypothesis testing. Consensus approaches are important to fine-tune the field and identify potential new interventions and practices, but are insufficient for testing whether the idea or concept has merit. One of the dilemmas is the research process itself. In defining EBP, the higher one moves on the scale of scientific rigor, the more time consuming and expensive the research, the more costly the implementation (training costs, fidelity monitoring, etc.), and the more narrowly defined the target population (which can limit external validity). In addition, rigorous protocols often leave little room for clinical adaptation by practitioners or adjustments to changing conditions in the real world. Less rigorous criteria for determining an evidence base are often used when there are political or operational pressures to implement new programs quickly. However, such interventions may lack internal validity, sustainability, and effectiveness once implemented in multiple settings. Implementation of an ineffective substance abuse treatment carries with it serious implications for cost, public safety, and increasing negative attitudes toward treatment by corrections personnel.

Thus, a challenge for the community corrections field (and perhaps the CJS in general) is to achieve a balance between the need for rigorous scientific evidence and fidelity to the

intervention with the need to incorporate real-world clinical experience and modify an intervention once it is implemented into real-world criminal justice settings. In addition, unlike carefully controlled research settings, treatment participants under community corrections supervision may self-select or be mandated into treatment that may or may not be appropriate for their type or severity of drug abuse problem.

The challenges of summarizing evidence and determining what interventions should be identified as “evidence-based” include: (1) quality of research design; (2) internal and external validity; (3) publication bias; (4) generalizability from research in controlled settings to implementation in community settings; (5) differences between statistical significance and clinical significance; and (6) economic issues. An important consideration is that it can be difficult to implement randomized controlled trials (RCTs) in CJ settings; such designs also have a potential lack of external validity (generalizability) because the conditions must be so carefully controlled. Because of these challenges, there are relatively few treatments that have been designated EBPs based on multiple RCTs. National review efforts such as the Campbell Collaboration and NREPP have helped by providing a process for conducting such efforts, including a systemic review process.

But the knowledge development process is different than the knowledge utilization process. It is in the utilization process that TT becomes very important, and where researchers and practitioners can merge their efforts. The components of EBP have been defined and will continue to be defined based on research. But the translation of these “laboratory-based” EBPs into action involves consideration of a different scientific process (implementation science) that is also laden with rigor and methodological steps (Fixsen et al., 2005). These processes must be more dynamic in that: (1) there is a need to make decisions quickly; (2) public safety concerns exist; (3) decisions about jail or prison overcrowding must be made; (4) agencies must respond

to court orders to provide treatment; (5) treatment resources are limited, especially for intensive or long-term treatment; or (6) civil rights or due process concerns exist. Under these conditions, it may be possible to develop less rigorous review criteria and procedures, provided that these procedures are transparent, systematic, and objective. Of course, it is important to guard against the dangers of implementing “quick fixes” that circumvent a systematic TT process; the latter is much more likely to lead to more effective and sustainable changes in organizational and staff culture, attitudes, and performance.

Accordingly, a key challenge becomes the need to maintain scientific rigor while recognizing the reality of needing to implement programs and practices, sometimes with relatively little lead time. To do this successfully will require that the foundation building and knowledge development processes we described earlier are in place, and that agencies are positioned and their staff trained to conduct evidence-based assessment, performance monitoring, regular program adjustments and outcomes monitoring, and collection of appropriate outcome information. Researchers, for their part, have to learn to focus on what is important for practitioners and policy makers.

As discussed earlier, there is a need to encourage professionalism that is respectful of research and data. Corrections training academies should include research training (part of improving organizational readiness to change) and training on substance abuse and treatment. Organizational leaders and staff need to accept the idea of program evaluation as a key part of improving outcomes. Improvements are also needed in dissemination and uptake of research findings. A challenge is to overcome skepticism among practitioners and policymakers about research. In part this skepticism reflects that researchers don't always provide information that is useful and digestible, and because research keeps evolving and is couched in equivocal terms.

This places an onus on researchers to prepare user-friendly documents that summarize research findings in more “user-friendly” ways.

The TT Model for Corrections: Integration of Science into Practice

The five step model that we have outlined addresses the climate and culture of corrections agencies. Embedded in this model is a process that calls upon the corrections agencies to be responsible to both external and internal stakeholders. The external stakeholders are well known to corrections agencies that are used to working with judges, parole boards, legislators, and others to seek support for their activities. And, as a result of work over the last 15 years, particularly on seamless models of care (e.g. Community Corrections Acts that established county-level boards, continuity of care, Reentry Council, Mental Health and Corrections Consensus Panels), the need for open systems has become more apparent to the field of corrections. The benefits are clear in that the community is assuming more responsibility for offenders and becoming involved in the delivery of service. The challenge is for staff of the corrections agency to support the change efforts, and to have a refined role that completes the offender’s involvement in services (Taxman, Perdoni, & Harrison, 2007).

To reiterate, our TT model incorporates five stages:

- **Knowledge Development.** To develop basic knowledge and understanding of the research-based findings and to translate them into practice.
- **Foundation Building.** To develop the skills in pertinent areas for staff and managers to partner with services agencies in the delivery of services for offenders
- **Expectation Setting.** To establish performance measures for each changed practice, and design the changed practice to achieve these performance measures.
- **Alignment.** To create a learning environment where the results from a pilot or trying the innovation can be used to improve practice.
- **Renovate.** To refine the process and/or innovation in accordance with a review of the performance measures, consideration of the progress of implementation, and new information from the research field.

The process we have proposed can be integrated within a framework of quality assurance and performance measures that engages the whole organization and is not confined to one unit. Preferably, it would involve many of the internal and external stakeholders who can participate in the process to assist in developing, implementing, and refining practice. Using the results from randomized studies, this process augments the internal organizational learning and provides a mechanism to continue the learning as an organization improves its own performance. The model sets up an incremental, but deliberative process to focus on improved operations and programs.

A central challenge of TT is to apply the elements of an effective intervention to the real word setting of community corrections. This model emphasizes the concept of *fidelity* or being faithful to a standard. This is an application of scientific methods in practice settings. Strict adherence to fidelity standards when conducting clinical trials research is a basic requirement because the researcher must control experimental conditions to minimize threats to validity, so that the results of a treatment intervention can be confidently ascribed to the tested protocol. When protocols are moved into practice, the field can exercise similar control over the implementation by devoting goals and resources to making sure that the standards are clear. Closely monitoring the impact of an intervention on clients takes us back to our basic purpose of getting results (what works orientation). However, care must be taken to include allowances for some clinical flexibility, especially where target populations or local conditions may differ from those under which the EBP was developed and evaluated (Bell, Newcomer, Bachrach, & Borawksi, 2007; Carroll et al., 2007)

By having performance measures, clear expectations, and clear guidance from the research literature, the field can establish standards by which to monitor their own progress. Although the effectiveness of an intervention in the community does require reasonable efforts to

be faithful to the manual (i.e., fidelity), offender improvement (e.g., reduced recidivism and drug use) is the stronger concern, and outcomes should be used to modify the intervention and to continuously improve the intervention in specific settings and populations.

Challenges to Implementation of this TT Model

With all of the concerns about the incompatibility of the EBPs in corrections environments, great strides have been made to advance the practice. These strides have been taken by executives and administrators who recognize that the control-only models of community corrections are unlikely to result in significant changes in offender behavior and have contributed to high revocation rates. That being said, it is recognized that corrections organizations are likely to confront many challenges in moving ahead with the model described in this paper.

For agencies that do not have an in-house research capability, existing formal linkages with researchers or research institutions, or experience in delivering joint programs, our model may be a challenge. Performance measures may be difficult to develop and integrate into practice, and may require improvements in IT capability and information sharing that are difficult to achieve. Incorporating incentives is also a good practice, if it can be done. The Delaware treatment performance contracting system has shown that providing incentives for program retention dramatically reduces dropout rates (McLellan et al., 2008). Similarly, in the expectation setting stage, the corrections agency can identify the basic outcomes that all interested parties agree upon, such as recidivism reduction, reduced drug use, and increased employment. If the outcomes accepted as primary outcomes are incentivized, the system will move rapidly to effective strategies/interventions and will gain flexibility and openness needed to utilize all available resources. Incentives should be considered for staff and clients (Coeira, 2003).

Although researchers search for the gold standard of experimental designs, our key informant interviews demonstrated that these individuals seek out researchers to assist them in interpreting research. They themselves do not necessarily rely solely on the “gold standard.” In shifting toward a TT perspective, these experts indicated that they focus on science-based factors and then try to put them into place through a process of measuring and observing the change (much like the NIATx process discussed earlier). Because the primary focus in criminal justice is behavior and attitudinal change, the use of cognitive and skill-building concepts are relevant. Goals that include both mastery and helping others think for themselves (in a socially acceptable manner) are part of assisting offenders to make progress toward following rules and developing drug free self-sufficient lifestyles. A corollary is to identify staff demonstrating better than average results with their caseloads who can serve as models, coaches or teachers in their organization. This contributes to a learning culture and assists with the internal skill building that is needed. This approach further moves the community corrections field from an efficacy-oriented (e.g., randomized designs) concern for protocol fidelity toward performance evaluation that can drive rapid organizational change.

Conclusion

Research-practitioner partnerships are bilateral in that each party can contribute to the goals of improving outcomes and protecting public safety. The science-driven model of identifying EBPs is laudable in corrections and substance abuse treatment, and frankly, needed, to create policies and practices that are based on more than personal philosophy about offenders and punishment. Policy that is driven solely by opinions, personal experience, or anecdotes, or is crisis-driven, is policy that makes it difficult for organizations to grow and thrive (and does not generally improve outcomes). Evidence-based policies assist organizations in identifying the core practices that need to be in place to achieve the desired goals. It provides for a more

empirical-rational model of management where “evidence” guides action. And, it removes the partisan approach to policy making.

Technology transfer is an art that includes science, management, leadership, and collaboration across disciplines and agencies. The model we propose seeks to help the corrections field recognize that there are additional steps needed due to the uniqueness of the corrections environment. It is not at all our intent to suggest that science is not useful (as scientists, we would never take this stance); instead it is designed to suggest that a partnership of scientists and practitioners can create *effective and useful* knowledge. But a process is also needed to create appropriate and effective utilization. The focus on utilization brings together many different practices and principles that can be of value to the field. Our contribution here is to recognize that the existing TT models, and the focus on technical assistance as a stand-alone process, are insufficient for the corrections field. Our key informants intuitively knew this and have implemented processes that would allow for growth and improvement in their organizations. The foundation setting and expectation setting components provide corrections with new paths to consider how best to turn research into practice. Learning from the experiences of organizations that use this approach (e.g., through EBP conferences or learning collaboratives) will further the model to better understand the utilization process. The desire is to ensure that all community corrections agencies work towards implementing and sustaining EBPs, and this model has hopefully given them a process to achieve this crucial goal.

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APPENDIX A

FACTORS ASSOCIATED WITH USE OF EBPs IN COMMUNITY CORRECTIONS

Variables	Beta	P
Average Daily Population	-.022	.783
Administrator's Perspective on Punishment	-.177	.042
Administrator's Perspective on Rehabilitation	.063	.52
Organizational Learning	-.369	.40
Future Goals	.439	.019
Training	-.15	.366
Innovation	.399	.039
Risk-taking	-.081	.63
Cohesion	-.003	.98
Hierarchy	-.061	.599
Performance Achievement	.051	.638
Innovation	-.022	.857
Needs Assessment for Training	.243	.025
Funding for new programs	.064	.496
Resources	-.033	.702
Staffing Needs	-.212	.032
Community Support	.043	.659
Integrated with SA Programs	.233	.006
Perceived Importance of SA Treatment	-.063	.454
Internal Support	.077	.471
Human Service Background of Administrations	-.067	.406

APPENDIX B

PARTICIPANTS IN KEY INFORMANT INTERVIEWS

Barbara Broderick, AZ

William Burrell, NJ

Mark Carey, Consultant

Foster Cooke, AL

Julia Hoffman, CO

Justin Jones, OK

Robert Macarrone, NY

Pam Rodriguez, Ill

Judith Sachwald, MD

Scott Sylak, OH

Kathleen Treb, OR

John Tuttle, PA

Raymond Wahl, UT juvenile

Carl Wicklund, KY, APPA

Dale Willetts, NC

APPENDIX C

KEY INFORMANT EVIDENCE-BASED PRACTICES ASSESSMENT INTERVIEW:

INTERVIEW GUIDE

1. What is the level of priority for community corrections agencies to implement and sustain more effective SA treatment practices?
2. Does your agency/organization currently use any evidence-based practices?
3. How would you describe the current level of knowledge in your organization about EBP from the managers? From line staff?
4. In the absence of multiple randomized clinical trials of an intervention's effectiveness, what are the standards of evidence that are acceptable to you to determine that an intervention is evidence-based?
5. What are the key gaps in knowledge about evidence-based practice for offenders in your agency and the field?
6. What steps are taken to identify an evidence-based practice – how are you informed about what is an evidence-based practice?
7. In your view, what are the key steps required for successful implementation of EBP in CJ treatment?
8. What are the key challenges/needs for training staff to implement evidence-based practices for offenders?
9. What are the key challenges/needs for training staff to sustain evidence-based practices for offenders?
10. What organizational changes are needed for the implementation of EBP?
11. What organizational conditions are needed for sustaining EBP?
12. Do you think it is necessary to be completely faithful to the protocol requirements?
13. How are Criminal Justice treatment programs and/or interventions currently being monitored for adherence to the program design?
14. Are state or federal regulators now requiring or requesting EBP?
If yes, what do regulators consider acceptable evidence based practices?
15. Are outcomes regularly obtained and reported to demonstrate effectiveness?
If yes, how is this done?
16. Lessons Learned
Have you encountered "mistakes" and problems when implementing EBP?
Do you have any recommendations for others based upon the problems you encountered?
Can you recommend techniques to engage staff?

APPENDIX D

ADDITIONAL FINDINGS FROM KEY INFORMANT INTERVIEWS

How Evidence-based Practices are Identified

There were several types of strategies mentioned. Several respondents read research articles and reports (larger community corrections agencies that have a research department are at an advantage), bulletins, and trade journals. Others rely on NIC publications that are fairly widely distributed. Conferences are another source of information commonly cited, although perhaps may not have sufficient focus on SA treatment and targeting of agency managers. Technical assistance was also popular (from NIC or others), including bringing in trainers or outside speakers, going on site visits to look at other programs, and communication with other stakeholders in their organizational or practice network. One site hired a half-time consultant to advise them on assessment, case management strategies, and identification of EBPs. Ongoing identification may also include monitoring and quality assurance efforts. A connection with “trusted” researchers and publications was also cited. Other key informants mentioned the value of information from NIDA and CSAT websites as main sources of EBP information.

However, knowledge needs to be disseminated down to the line supervisors and line staff. On a practical basis, POs and chief POs may not have internet access, making it difficult for them to access information. Also, it is important to translate the information for treatment programs. One agency specifies EB principles in their RFPs that must be included in applications.

Current Use of Evidence-based Practice

The general consensus was that EBP was a high priority for community corrections agencies in terms of offender supervision, but somewhat less so for substance abuse treatment.

Substance abuse single state agencies are highly concerned with EBP utilization, while criminal justice agencies are primarily interested in public safety issues.

Several reasons were given for this disconnect. First, concerns were raised that substance abuse is just one issue faced by offenders, and the agencies need to work on broader corrections practices that affect the delivery of services, such as classification and treatment assignment practices, monitoring, compliance, and risk reduction. SA treatment may be important but might not address many of the other needs of offenders. In other words, a focus on the corrections delivery system, including incorporation of the risk principle framework and the “NIC principles” may facilitate more effective implementation of EB SA treatment.

Second, although there may be statewide structural support from the SA/MH agencies, such support may break down at the local (i.e. implementation) level where staff may understand EBP but not use it. There is local variation. Third, the support for and understanding of EBP by line staff is important to make it work. The “nothing works” mentality may still exist with supervisors and administrative staff. Agencies and officers don’t understand SA treatment, which is necessary to work effectively together; a collaborative model is needed (not just a referral). On the other hand, treatment agencies also have to support and understand EBP for offender supervision, while maintaining responsibility for the effective delivery of treatment in their own agencies.

Finally, the pressures caused by large caseloads were mentioned as a determining factor for EBP priority along with political pressure and regulatory requirements.

In terms of current use of EBP, the responses were mixed. Several agencies use manualized cognitive behavioral therapy, validated risk assessments, contingency management, and family-based and strength-based interventions. Use of Motivational Interviewing was commonly mentioned as an EBP utilized by community corrections agencies. However, it was

one respondent's view that nationally a relatively small percentage (about 10%) is doing "quality" or systematic EBP.

Most agencies use MI as a technique to facilitate the relationship with the offender. Some states include MI practice in their training for new officers, and also provide some in-service training. Other states are less systematic in terms of MI training, although any recognize that MI can be used to improve support for treatment; it is unclear how treatment can be offered within the community corrections system if there is little trust between offender and officer.

Compliance management appears to emphasize sanctions, with little use of incentives. It can be difficult to get staff to move away from sanctions-focused monitoring that is strongly supported by the prevailing organizational culture. Although most community corrections agencies report having "structured" graduated responses, there is little to document this.

Evidence-based assessment tools and treatments that are utilized by TASC agencies include Motivational Interviewing, Cognitive Behavioral interventions, anger management, Living in Balance (adult), the GAIN assessment tool, CSAT approved EBP for adolescents, Charting a New Course, Methadone, Thinking for a Change, Trauma Reduction Empowerment Model, Survival Skills, Strengthening Families, Parent Project and Expect Respect, and strengths-based case management.

Incorporation of the 8 NIC principles was mentioned by a number of respondents, although these principles naturally focus on community corrections services generally rather than SA treatment. It may be that agencies that are organized and manage their staff around the 8 NIC principles are more likely to use EBP more generally; they may be more organizationally ready. Overall, the NIC 8-point model was a common reference point. For example, in terms of assessment and case planning, most if not all states have adopted a risk and need tool and feel that it is useful, but does not meet all supervision and referral needs. Agencies are concerned

that the tool (all use the LSI-R except NY which uses the COMPAS) has limitations that affect the use in the field. In particular, NY worked with the developers of COMPAS to modify the tool and suggest that a shorter tool is better for the field as it takes less time and requires the officer to focus on the information instead of just using the tool. With the LSI-R, the general feeling is that the tool is very limited and they do not receive sufficient assistance from MHS. Many respondents felt that case planning is the lynchpin but it is the hardest area to do anything about, and staff feel resistant to do case planning. Staff seems more focused on just using the conditions assigned by the court/parole board, instead of tailoring the case plan to the offender. The biggest issue is that there are not services to address some of the criminogenic factors. TASC agency respondents did not mention the 8 point NIC principles indicating that the TASC programs see themselves primarily as treatment agencies and service providers rather than criminal justice agencies.

Substance abuse treatment is under emphasized in the NIC model. It is one component of many but more attention could be focused on the quality of treatment in a variety of settings. OK has developed a quality assurance model for treatment providers, and uses the leverage of the contract to monitor the use of EBPs. Similar approaches are used or are under development in OR and AZ. PA focuses on quality issues of treatment for parole, but not probation. NY has not dealt with this issue at the state level but they have initiated discussions with Alcohol and Drug Administration. MD has not dealt with this issue mainly because they do not fund treatment and therefore do not feel they have much of a role in monitoring treatment quality. Nationally, there may be a sense that community corrections agencies are not comfortable “telling” SA treatment providers how to deliver their services, although there is a feeling among community corrections leaders that treatment providers would not be open to discussions about treatment quality issues. This places corrections agencies in a bind.

However, attention to EBP may not always translate into successful implementation or practice, and many community corrections departments leave the EBP to the treatment providers, although contract and compliance monitoring may be used, as suggested above. But treatment providers may not always be held to implementing EBP. Resource limitations may also limit the number of slots available in EB programs, and such programs may be much less available in rural areas. It is important to be aware of the service limitations in rural areas, where there may be only one program that must be used whether or not it is evidence-based. The resource concern was expressed by several respondents, but this may be a “knee-jerk” response. In one state, for example, the POs said they did not have time to do additional tasks, but a workload analysis by the state indicated that they did in fact have time.

Current Level of Staff Knowledge about EBP

The consensus was that knowledge among agency managers was better, although the depth of knowledge may be superficial. Staff may know the basics. Respondents agreed that knowledge among line staff ranged from limited to moderate, and was relatively superficial. They may be familiar with the NIC principles but not much beyond that, and certainly lack knowledge about evidence-based SA treatment. In one jurisdiction MI training has helped improve understanding of EBP. Respondents felt that staff needs to be more directly involved with researchers to gain a better appreciation for the issues and need more one-on-one training to improve their EBP understanding and knowledge. OK has adopted a policy of having management involved at least once a year at meetings to “learn and apply,” and MD uses the forum of organizational learning by circulating materials and encouraging discussions.

One problem may be the collision between missions: the public safety/law enforcement vs. social worker conflict.

It appeared that there is basic “knowledge” about core principles but that it is difficult to translate this knowledge into practice. For example, the issue of high risk is confusing to the field. What does this mean when you can have someone who is dependent but they are not high risk — the agency is not sure what to do with these offenders. As another example, community corrections staff may be skeptical about the value of CBT because the providers are not doing actual therapy, and there is additional concern that although many treatment providers indicate they are doing CBT they are not actually implementing the practice with fidelity.

Some differences were reported related to type of programming with greater EBP knowledge among clinicians who deliver adolescent programming as opposed to community corrections.

Acceptable Standards of Evidence

Under certain conditions, respondents were comfortable with broader, less rigorous standards than the traditional multiple RCT model. These circumstances include a manualized curriculum, fidelity to the protocol, some research evidence (with well-controlled comparison groups), use of validated assessments, practices recommended by respected authorities, and evidence of positive outcomes. Specific to SA treatment, respondents look for a manual and fidelity to the protocol, and a “name brand” such as the Matrix Model. Comfort level is increased if an intervention includes a process evaluation that can explain the outcomes, and if there are multiple outcomes that demonstrate improvement. Also, if a meta-analysis has been conducted and shows a significant effect, that would be convincing even if there the studies included few RCTs. Respondents recognized the difficulty of implementing RCTs in criminal justice settings, that there will never be enough RCTs to support all interventions, and that there is a need to expand services now and start somewhere even in the absence of multiple RCTs. If

the risk/needs/responsivity framework and the 8 NIC principles are used, that may also be sufficient evidence to move forward with an intervention or practice.

Another issue is that some respondents did not fully understand the difference between RCT and quasi-experimental studies, and they consider any research “valid”. A number of respondents felt that one study, a researcher they trusted, or a trend in the field is sufficient to be considered worthy to pursue. A few were aware of the Campbell Collaboration. These results indicate the importance of expanding and improving training for practitioners about research methods and designs, and research standards for evidence.

For TASC staff, the importance of local performance indicators and measurable outcomes were considered more important than RCT evidence. Desirable performance measures included decreased waiting lists and greater retention, and important outcome measures were standard recidivism and substance abuse reduction with improved social behavior. One administrator noted that RCT results were not especially impressive unless there was a “big” comparative effect and another commented that if a service is shown to improve staff/client relationships it would be considered an EBP.

Are State and Federal Regulators Requiring EBP?

Several examples were given of states that are requiring EBP: these include Arizona (by statute and also specified for county-funded programs), Oregon for substance abuse treatment programs seeking block grants, and Colorado, where use of CBT in offender treatment is required. The Pennsylvania Board of Probation and Parole was also noted as having made tentative inroads into EBP (e.g., training state parole staff on the LSI-R). In Utah there are more generic requirements in terms of EBP without specifying the programs (except for drug courts). Illinois has begun performance contracting and encourages the use of EBP and at the minimum

providers must make a case that their services are evidence based. The state offers TA and makes site visits.

Many states have some requirements and provide lists of EBP that agencies must use or provide evidence for what they are doing. At the federal level, several TASC agencies noted that they needed to choose from a list of approved interventions when pursuing funding from CSAT. Finally, several states are requiring evidence based assessment procedures. Other than those specific examples, it was felt that states focus more on risk reduction, or requiring outcome measures that center on recidivism, contacts, etc. Even where states are mandating EBP, there is the challenge of how to introduce EBP at the local level.

Some respondents stressed that EBP must have an obvious value to staff, and make the job easier, more effective, and more meaningful. Other major concerns were the need for adequate supervision focused on specific EBP, follow-up with line staff, supportive policy and procedures changes, and ongoing staff feedback on what's working. Finally, several responders mentioned the need for fidelity checks, quality assurance activities and tracking of outcomes (e.g., retention, completions and drug/crime outcomes).

APPENDIX E

GLOSSARY OF KEY TERMS

Absorptive capacity: The process by which new innovations can be absorbed into existing practices and policies based on the current distribution of resources.

Adoption: The decision to try a new innovation or modify an existing practice.

Alignment: The process by which a new practice, policy, or operations are intertwined into the existing organization.

“Champions:” Respected individuals who use their role to actively promote a new or refined practice to build support.

Cohesion: Cohesion is shared responsibility and direction on a given topic.

COMPSTAT: CompStat—or COMPSTAT—(short for COMPuter STATistics or COMParative STATistics) is the name given by the New York City Police Department for their management initiative to provide police administrators with timely information on crime events that are geographically located, and use that information to monitor progress.

Consensus: Consensus is a general agreement about that a given idea, evidence-based practice, or technique; whether it is useful or not.

Diffusion: The **widespread adoption of an innovation into multiple organizations.**

Dissemination: The process by which information or practices spread or are disbursed within a field.

Effectiveness: Evidence that a treatment or practice can contribute to achieved outcomes. Usually the studies are not as rigorous as experimental designs.

Efficacy: Evidence that comes from experimental designs which test that a given practice or treatment achieves greater desired outcomes than the alternatives.

Evidence: Evidence in the scientific information on a given topic.

Evidence based Practice (EBP): Practices or techniques that are derived from scientific research and/or consensus panels about certain practices/techniques that will improve desired outcomes.

Evidence based program: A treatment or corrections program that has sufficient scientific evidence of certain methodological rigor that demonstrates consistent findings.

Expectation building: New or refined practices are introduced into an organization with certain desired outcomes. These create expectancies about the desired outcomes.

Exposure: The process by which new or refined ideas or new research evidence are presented to the organization. Exposure provides the means by which managers, staff, and stakeholders become aware of new information that is relevant.

Fidelity: The degree to which the delivery of a treatment intervention adheres to the manual or protocol.

Generalization: The degree to which the findings from a study or a series of studies can be applied to the field at large.

Implementation: The process by which an organization pilots and phases in a new or refined idea.

Innovation: A new or refined idea or practice that refocuses the organization on a new practice or process.

Manualized interventions: A standard practice that outlines what should occur in a treatment program.

Organizational Climate: The operating climate of an organization that determines the values, norms, and orientation of the agency.

Protocol: A document that describes the objective(s), design, methodology, statistical considerations, and organization of a clinical trial.

Randomized Clinical Trials/Experimental Design: A scientific experiment where subjects or units are randomly assigned to a condition or another condition (control).

Renovation (*organizational and systems change, sustainability, staff leadership and buy-in, identify staff for development*) is the stage where the results from the trial are aligned to the organization.

Researcher-practitioner collaborations: Partnerships between researchers and practitioners that are geared to advance the state of practice.

Sustainability: The process by which organizations expand implementation of an innovation across an organization to standardize the practice for use.

Technology Transfer: The process of transferring scientific findings into practice in an organization.

Threats to Validity: Research is conducted to answer questions about whether the innovation is sound (internal) and whether the innovation is likely to work in other places (external).

Transportability: The extent to which local external and organizational conditions are appropriate to what is needed to successfully implement an innovation. An innovation is ready to be adopted into the target organizations.

Trialability: The trial and error period (e.g. pilot) where an innovation is tested for its applicability.