Center on Evidence-based Interventions
for Crime and Addiction

IMPLEMENTING EVIDENCE-BASED DRUG TREATMENT IN CRIMINAL JUSTICE SETTINGS:

FINAL CONFERENCE REPORT

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Center on Evidence-based Interventions for Crime and Addiction (CEICA)

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With support from the
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CONFERENCE OVERVIEW

This report will summarize the activities and results from a by-invitation conference held in Philadelphia, PA on December 6-7, 2006. The purpose of the conference was to address current issues in identifying, implementing, disseminating, and sustaining evidence-based drug treatment practice in the criminal justice system (CJS). The conference was convened under the direction of the Center on Evidence-based Interventions for Crime and Addiction (CEICA), which is housed at the Treatment Research Institute. The conference brought together a selected and diverse group of approximately 70 researchers, practitioners, policy makers, and people in recovery. The overall goal was to identify and inform the unique challenges for expanding access to effective evidence-based treatment for drug-involved offenders who are under criminal justice supervision. The conference format included targeted discussions, workshops, plenary sessions, consensus building, and action plan development. The conference was scheduled to coincide with the end of CEICA's first full year of operations; thus the conference content and themes were guided by CEICA's experience in developing evidence-based projects in collaboration with national practitioner organizations and government partners.

One unique aspect of the CEICA conference was the active engagement of CJ treatment stakeholders in discussion with researchers and policy makers. This interaction helped practitioners and researchers alike better understand the challenges of defining, implementing, and sustaining EBP. Researchers were able to appreciate

the barriers to initiating changes in practice. Conversely, the opportunity for structured and cohesive researcher-practitioner-policy maker dialogue also helped to generate new research ideas to address gaps in CJ treatment EBP and the implementation and sustainability of EBP. In addition to CEICA's experiences, the conference also benefited from the knowledge brought by some of our supporters, collaborators and conferees, including invitees from the University of Pennsylvania Department of Criminology (which staffs the Campbell Collaboration Crime and Justice Coordinating Group); the National Implementation Research Network (NIRN) at the University of South Florida; National TASC, American Probation and Parole Association (APPA), the National Association of Counties, and the National Conference of State Legislators.

CONFERENCE BACKGROUND AND RATIONALE

The connections between illegal drug abuse and crime have been well documented (Bradford et al., 1992; De la Rosa et al., 1990; Lipton & Wexler, 1988; Tonry & Wilson, 1990). Nearly 2/3 of the annual $168 billion social costs of illegal drug use are related 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). Half of state inmates and 61% of jail inmates were under the influence of drugs or alcohol while committing their crime. Within 3 years, 95% of released state inmates with drug use histories return to drug use (Martin et al., 1999), 68% are rearrested, 47% convicted, and 25% are sentenced to

prison for a new crime (Langan & Levin, 2002). Finally, 37% of state prison commitments were for 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 CJS, including drug courts, treatment diversion, prison and jail treatment, and post-incarceration aftercare (Knight et al., 1999; Prendergast et al., 2004; Wexler, 1996; Wexler et al., 1999a; Wexler et al., 1999b). However, such treatment has been able to serve relatively few offenders with drug problems. 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). Despite their popularity, drug courts have been estimated to only serve less than 10% of the eligible population (Belenko, 2002). Accordingly, it is likely that more effectively addressing drug problems by providing expanded access to evidenced-based interventions could contribute to public safety and to the reduction of the growing substance-involved population in the CJS.

The growing importance of EBP

There has been growing interest in introducing 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), the National GAINS Center, the Cochrane Reviews, the Campbell Collaboration, and NIRN. These efforts have focused primarily on reviewing literature, establishing criteria for evidence-based treatments and identifying and rating programs. In contrast, CEICA focuses on feasibility, sustainability, dissemination and policy, in addition to identifying effective criminal justice interventions. These concerns guided our planning and design for the conference.

The unique challenges of implementing/disseminating EBP in the CJS.

Within criminal justice, where the emphasis is heavily weighted toward "control" and public safety, there is a general consensus that effective treatment requires collaboration between clinicians and clients to achieve maximum program participation and adherence (Peters and Wexler, 2005). However, criminal justice environments that focus primarily on "control" are likely to accept and deliver "controlled treatment protocols" but less likely to adequately engage clients in the treatment process. Therefore, we believe that there is a pressing need to better balance scientific evidence with real-world clinical experience as EBP is applied in clinical (especially criminal justice) settings; this was one important focus of the conference.

Scientific timeliness and utility of the meeting

As EBP has become more accepted in many health care fields, the need to encourage active dialogue between researchers, policy makers, practitioners and clients has increased in importance. EBPs are essential to the field and have brought a needed heightening of attention to the importance of evidence and the development of systematic, theoretically grounded approaches that can be disseminated and replicated. The ideas behind the CEICA conference were formulated at CEICA from the perspective of drug treatment in the criminal justice system. An important principle in designing our conference was our concern that much of the articulation of EBP has been primarily a "top down" process, more aimed at meeting scientific concerns than clinical application, which has paid scant attention to organizational and other barriers to implementation and sustainability (Roman & Johnson, 2002; Simpson, 2002). There are a number of important issues that we felt needed to be explored through more balanced and focused conversations among researchers, clinicians, policy makers and clients to clarify what is EBP and to enhance their development and dissemination. The conference was thus designed to maximize these interactions and foster working relationships that were balanced and action-oriented; we also plan to work toward sustaining these conversations and interactions through post-conference follow-up activities and the ongoing work of CEICA. In contrast to the CEICA conference, prior conferences presenting information on criminal justice drug treatment have generally lacked a balanced perspective that places equal emphasis on research and practice, did not focus on implementation and sustainability, did not focus exclusively on EBP in

CJ treatment, and were not sufficiently balanced in representing the views of researchers, practitioners, policy makers, and clients.

CENTER ON EVIDENCE-BASED INTERVENTIONS FOR CRIME AND ADDICTION (CEICA)

CEICA (co-directed by Steven Belenko, Ph.D., senior scientist at TRI, and Harry K. Wexler, Ph.D., senior principal investigator at NDRI) is dedicated to using the best scientific and clinical evidence to improve treatment outcomes for substance abusing offenders. Given the clear connections between illegal drug abuse and crime and the enormous societal costs of drug-related crime, there is mounting interest in mobilizing the research community to help practitioners translate, apply and sustain effective strategies in their routine practice. Professional organizations and federal agencies have been actively promoting identification and implementation of EBP in mental health, education and substance abuse. As noted above, existing efforts tend to focus on reviewing literature, establishing criteria for evidence-based treatments and identifying and rating programs. In contrast, CEICA's goals are to place equal emphasis on research and practice, explicitly focus on implementation and sustainability of EBP in criminal justice treatment, and be sufficiently balanced in representing the views of researchers, practitioners, policy makers, and clients. A primary goal is to foster meaningful interdisciplinary conversations that advance dissemination and utilization of EBP.

With start-up funding from the Robert Wood Johnson Foundation, Drs. Belenko and Wexler co-founded CEICA in the summer of 2005. Year one of the Center, a

planning and organizing year, was devoted to developing a template and protocol for conducting CEICA systematic reviews of scientific evidence, establishing linkages with national practitioner organizations and federal partners, and initial development of training and dissemination strategies for the most relevant interventions. Identifying knowledge gaps in the treatment of substance-abusing offenders, and encouraging increased research funding to address these gaps, are important long-term goals of the Center.

Organization and Leadership

CEICA includes a small core group of external senior advisors and multiple research organizations. Current members of the Advisory Board include Dr. Roger Peters, Dr. Gerald Melnick, Dr. Faye Taxman, Dr. John Norcross, Laurie Robinson and Mr. Terry Wilkins. TRI advisors include Chief Executive Officer A. Thomas McLellan, Ph.D. and Director of the Center for Performance-based Policy, Mady Chalk. CEICA's professional organization partners during the planning phase are the Treatment Accountability for Safer Communities (TASC), and the American Probation and Parole Association (APPA). Associated federal agencies have included the National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, Center for Substance Abuse Treatment, and the Office of Justice Programs at the U.S. Department of Justice, all involved in funding treatment research and dissemination of EBP. At the State level, CEICA plans to involve such organizations as the National Association of State Alcohol and Drug Abuse Directors, the State Correctional Administrators' Association, and the National Center for State Courts.

CONFERENCE STRUCTURE AND FORMAT

This conference was a working meeting with ambitious goals, aimed at framing critical issues in substance abuse treatment for criminal justice populations, with a focus on the challenges of identifying, implementing, and sustaining evidence-based practice. With the participation of practitioners, researchers and policy makers in approximately equal numbers, along with recovering persons, the conditions were set for rich discussion that included different perspectives. One primary goal was to reach consensus on what is needed to advance the field and foster implementation and sustainability of substance abuse interventions that improve outcomes for offenders. The multiple federal agencies support and participation in the conference[1] provided a rare opportunity to impact the field and funding agendas for substance abuse treatment research and practice in criminal justice settings. One important set of goals was for the conference invitees to form a cohesive working community, reach consensus on a number of issues, and set the stage for ongoing CEICA efforts to advance the field of evidence-based interventions for substance abusers in the criminal justice system.

In the service of our goal of supporting the formation of a "knowledge community" over the brief day and one-half conference, several steps were implemented. First, CEICA co-directors worked closely with CEICA advisors and senior TRI staff to develop the specific workshop topics, and initial preliminary sets of questions/issues for each topic. CEICA senior staff then worked with the ten three-person panels to initiate development of the workshop content. Each workshop team then further developed their presentation in a collaborative fashion, which was then summarized in the

[1] National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), Center for Substance Abuse Treatment (CSAT), and Bureau of Justice Assistance (BJA).

PowerPoint slides that were included in conference material. Participants were sent a roster of presenters and conferees along with their bios and contact information so that they could familiarize themselves with fellow participants. A conference website was set up, linked to the TRI website, to facilitate communication with the invited participants and post information related to the conference to those interested in CEICA's work. Finally, with pre-conference input from our advisors and panelists, several key EBP articles were identified and posted on the conference website to help orient the group to some of the important issues facing the field. Conferees were also invited to bring additional materials to be made available at the conference resource table.

Plenary Sessions

Three plenary sessions were held to introduce, guide and summarize the conference activities and deliberations. The conference opening plenary introduced the meeting goals and structure. The plenary sessions at the end of Day1 and after the final two workshops in Day 2 reviewed the workshop results and then focused on issues that arose during the conference, and proposed action steps. The general goal of the final plenary was to begin to move toward consensus on key EBP issues and action steps.

The welcoming/overview session was chaired by Drs. Belenko and Wexler. This session presented an overview of EBP, goals of the conference, and described the conference structure, workshop formats, and expected conference products. Time was allotted for Q&A and discussion about conference goals, structure and operations (a copy of the opening plenary PowerPoint presentation is posted on the CEICA conference website).

Drs. Belenko and Wexler facilitated “wrap up” sessions on both days that were conducted in a town meeting format, with summaries of the day’s proceedings provided by designated “reporters” from each workshop panel. Since the conference proceeded on two tracks, where participants were able to attend only half the meetings, it was especially important that all participants attended plenary sessions to establish a common knowledge base of all the workshops necessary for the consensus process.

The second day wrap up was focused on prioritizing the main issues discussed across the workshops with the hope of reaching consensus on critical issues that participants were willing to work on following the conference. Drs. Belenko and Wexler developed a PowerPoint presentation of the main issues discussed at the workshop organized by general, policy-maker, practitioner, consumer and researcher headings. Examples of action steps were also provided to help facilitate the discussion (a copy of the final plenary PowerPoint presentation is posted on the CEICA conference website). Most participants actively participated in an active free flowing discussion and the main discussion points are summarized below.

Information from Field/Policy on What we Want to Know. Participants agreed that there was a need for a “National Center for Evidence-based Practices” to address the many issues that were raised at the conference in a structured ongoing manner and it was suggested that CEICA consider explore this possibility.

There was also a need to clarify the conceptual framework of EBP given the many differing understandings of the definition of EBP and how to link interventions to specific population and drugs of abuse. The focus has to be expanded from “what works” to include the identification of “what doesn’t work.” Concern was expressed about groups that are marketing programs and approaches that have little evidence of effectiveness but strong financial backing. Overall, conferees felt that the education of

policy makers was needed to help them become “informed consumers” of EBPs and that this is a critical goal that should be high on a list of CEICA priorities. The importance of keeping recommendations simple and straightforward with a focus on basic messages was emphasized.

First Products. The group energetically recommended that CEICA focus on products that would arise directly from the conference and report out what had been discussed. The need to put these products into the “right hand” was emphasized along with the need to create an action plan. Several specific products are listed below:

- White papers to frame conference main issues
- Publish a conference description/issues paper in research/policy journals
- Letter to editor/Op Ed highlighting conference issues

Strategy for Delivering Results. General guidelines for delivering EBP information were offered. The importance of reviewing and summarizing what has been done in other fields, including EBP implementation, as guidance in the substance treatment within criminal justice areas was an overarching suggestion. Several participants suggested that CEICA develop its own model but also look at other organizations for guidance on how to proceed such as the Washington Circle Model that has ongoing EBP meetings and committees that work in specific areas. CEICA will have to clarify its basic messages (e.g., Identify EBP? Improve the Field?) while being as realistic as possible focusing on what is doable and feasible.

Marketing Plan and Analysis. Marketing was an important topic for the group and a number of excellent points emerged from the discussion. First, the “audience(s)” must be identified and messages for specific audiences need to be compartmentalized.

There was a general consensus that the conference invitees were an excellent resources network that spanned most of the criminal justice areas where substance abuse treatment is delivered and the practitioner, policy maker, researcher and consumer perspectives were adequately represented. A major initial task will be to prioritize the many and diverse goals and projects that emerged at the meeting.

The marketing analysis discussion was comprehensive and quite constructive. The three main things that guide the analysis are settling on the product(s) and understanding the supply and demand. The marketing plan needs to be tied to a dissemination strategy that that answers questions of what can be disseminated now and what needs to be developed over time, who is currently using and /or demanding the service/products and what do people want to do with the information. The notion "build it and they will come" was heartedly rejected in favor of researching the needs of the market being responsive as possible. Participants reminded us that the knowledge base is varied and we need to independently assess each criminal justice area. Project Reform that was very successful promulgating correctional drug treatment in the 1980s was offered as a good example successful EBP marketing that included federal technical assistance funding and the joining together of policy makers, researchers and practitioners.

Systems Issues. A systems approach was seen as the way to deal with the complexities of funders, criminal justice and treatment organizations and the many complex issues that must be handled for the field to advance. A number of people were concerned whether the existing systems structures could support EBP and the need to integrate systems for dealing with the multiple problems facing consumers. Again,

CEICA was advised to look deeply into the literature especially from of other fields and search for models that could be employed to speed up the process. Connecting to other EBP groups and support systems was encouraged. A pilot systems approach was recommended that focuses on improving the criminal justice/public health relationship by focusing on correctional substance abuse treatment along with re-entry and aftercare. The very strong message came across that whatever CEICA does next it must remain consumer and customer focused to be successful.

Incentives for States to Increase Utilization. Participants were quite excited about recent political developments and the introduction of new players in Washington that would be in need of EBP information and hopefully supportive to funding EBP efforts. Seeking governmental support for the utilization of EBP was a major concern to the group. It was suggested that CEICA should review existing models for guidance. There was a strong feeling that the federal government should be encouraged to offer planning grants to states and localities (similar to Project REFORM funding).

Overall, the final plenary discussion was focused primarily on issues and less on action steps. It became clear to conferees that consensus on issue and action steps was an overambitious goal for a day-and-one-half conference. Although the participants were very active in the discussion, agreement was reached that a survey would be developed based on the conference proceedings for conferees to fill out at after the meeting. This survey was designed and administered as one of CEICA's key post-conference activities, and the analysis of the post-conference Consensus Survey results is presented below.

Workshop Logistics

There were ten 75-90 minute workshops scheduled in pairs: four time slots on day one and one time slot in day two. Each workshop included a panel of three presenters with time approximately equally shared between the panel presentation and group discussion. PowerPoint presentations were followed by discussants providing additional information and alternative perspectives with the goal of including policy maker, practitioner, and researcher points of view. At least half of each session was dedicated to open discussion with the goal of airing different views. Panel members were asked to facilitate the group discussion and summarize the main workshop discussion points and any consensus that was reached concerning next steps (see Instructions to Panelists in Appendix A). One of the conference co-chairs was present in every workshop to help facilitate the process. In addition, all workshops and plenary sessions were audiotaped and TRI staff took notes. Because the conference time constraints and logistics allowed participants to attend only half the workshops, a random assignment procedure was developed to insure equal representation of researchers, policy makers, practitioners, and persons in recovery in each workshop. Although some participants would surely have preferred workshops that they were not assigned they graciously accepted the assignment procedure. Conferees received a workshop book that included a program with their personalized workshop assignments.

Consensus Process

Each panel provided overviews of key issues in their specific area and concluded with a summary of the issues and challenges to evoke group discussion and help the group consider action steps and recommendations for the field. Although the overall

goal was to reach as much consensus as possible on possible action steps, it was just as important to capturing differences of opinions to enrich understanding of the issues. The discussion of issues and consideration of consensus for action steps was extended from the workshops into the full group that met in plenary sessions at the end of both days. Because it was too much to expect consensus in such a short meeting time, a summary of the main discussion points and proposed action steps was prepared in the form of a survey that was send to participants for independent consideration and review to assess consensus.

WORKSHOP SUMMARIES

As indicated above, the conference included ten workshops. Each workshop included three panelists. In this section, we summarize the key points made in the panelists' presentation and summarize the general discussion that following. The conference websites contains the PowerPoint slide presentations that were used for each of the workshops.

Criteria for Evidence-Based Practice

Michael Prendergast, Ph.D,; University of California at Los Angeles (workshop leader)
Steven Schinke, Ph.D.; Columbia University
Judith Sachwald, Maryland Division of Parole and Probation

This workshop summarized some of the scientific and practical issues the surround the definition and designation of EBP. A basic definition of EBP for treatment in CJ settings was presented: "The use of the best available evidence from systematic research, combined with clinical experience and judgment, in making decisions about

delivering care to clients." It was suggested that the intent of EBP should be to shift decision-making as to what interventions to offer and fund to a rational, transparent, and systematic process that is based on scientific research and consensus among experts. This is in contrast to reliance on authority, intuition, rules of thumb, tradition, and anecdote.

A distinction was made among treatments that have not yet been evaluated but may be effective, those that have been evaluated but can only be designated as promising, those that have been found to be ineffective, and those that meet the criteria for evidence-based. A number of existing protocols and frameworks for designating EBP were summarized and discussed. These included:

University of Maryland Five-Level Scientific Methods Scale
NREPP
Department of Education What Works Clearinghouse
OMB Program Assessment Rating Tool
Society for Prevention Research
OJJDP Blueprints for Violence Research
Coalition for Evidence-based Policy
Washington State Institute for Public Policy
Oregon Evidence-based Practices Criteria
Campbell Collaboration

Each of these protocols and EBP cataloging efforts have different criteria for determining what is evidence-based, and different categories for designating levels of evidence. The difference characteristics of these initiatives were summarized and discussed. The challenges of summarizing evidence and determining what interventions should be identified as "evidence-based" were also raised and discussed. These challenges and issues 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.

Additional discussion centered around the difficulties of implementing randomized controlled trials (RCTs) in CJ settings, implementation problems with RCTs, and potential lack of external validity (generalizability) for RCTs. Finally, consideration was given to defining alternative levels of EBP review for situations where: (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; or (5) 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.

Panelist Schinke made the point that RCTs are the gold standard even for replication studies – now groups are about to require at least two replication studies before EBP status is earned. As a result,: 1) there are relatively few designated EBPs because it is very difficult to earn that designation; and 2) the rating process can be flawed so some programs are able to achieve EBP designation in order to get funding.

Sachwald noted that CJ practitioners operate in a very political environment, and she is not sure how well the research community understands this. State agencies develop well-intentioned five- to fifteen-year plans that never get fully implemented because politicians lose interest and funding dries up.

She also questioned how states can practically link to experts and their knowledge (getting help to distinguish between rigorous and “junk” science), and how to facilitate having researchers help states educate the politicians at the federal, state and

local levels where funding decisions are made? Another practical problem raised is engaging offenders into treatment when many have accepted their addiction as an inescapable fact of life and may be more focused on family re-unification, employment, housing, etc.? Finally, Ms. Sachwald asked whether mandated criminal justice clients should be in the same treatment setting as voluntary clients? Research is needed to distinguish the needs and addiction severity of the two groups.

Four key issues and potential action steps were discussed at the end of this workshop panel presentation:

1. Which EBP criteria should be adopted for treatment within CJ settings?

2. To what extent do evidence-based treatments (often based on studies of specific populations and settings) generalize to other populations and settings?

3. How can EBP be misused in policy and funding decisions?

4. What are the challenges of implementing EBP?

Workshop Discussion. The discussion then turned to how proven is an EBP if it fails to factor in political and provider resistance to it. The group felt that the EBP movement is a still maturing addiction field and that regulators are prematurely imposing a RCT gold standard on the field. The RCT model also interferes with "real world" self-selection in terms of entry into treatment.

The group then discussed that policy makers and science should be focusing on developing good treatment, but research designs frequently get in the way. A better approach may be to simply measure how well a program specifies: 1) what it is doing, 2) how it is doing it, and 3) demonstrate fidelity to the previous model. In other words, there should be a move away from over reliance on clinical trials and more reliance on

development of programs through fidelity monitoring, as well as performance monitoring.

Another major issue discussed was the fear in the criminal justice field about measurement, because there is an expectation of a 100% success rate. One adverse incident in a program that is made public and the support of politicians could be gone. Improvement from a 40% to a 35% recidivism rate may be significant and meaningful, but not to politicians, victims, or the public.

The final issue discussed was the challenge of getting NIDA funding. Many want to conduct RCTs on current issues. There is a need for developmental seed money for innovative new ideas that are coming from the fringes, which do not have access to research money from mainstream agencies such as NIDA.

Defining Outcomes for Offender Treatment

Mady Chalk, Ph.D.; Treatment Research Institute (workshop leader)
Nancy Wolff, Ph.D.; Rutgers University
Elizabeth Griffith, J.D.; Bureau of Justice Assistance

Dr. Chalk was unable to attend the conference due to illness; Dr. Wolff and Ms. Griffith jointly led the panel discussion. The presentation began with a discussion of the major users of outcome data: policy makers, practitioners, and researchers. Each constituency is likely to have different questions and data needs. Broad questions of concern that may be relevant for all data users include:

Did the policy or program work? For whom? Under what conditions?

Why might it not work?

What parts of the program, policy, or organizational structure contribute to success or failure?

How does the policy, organizational arrangement, or treatment process affect outcomes?

Data users need information in several key areas: One is detailed program, policy, organizational, and financing information. The second relates to the definition of offender risk and how such risk is being managed. The third area includes data on program structure, process, and outcomes. Finally, data related to the economic impact of the program (e.g. cost-benefit, cost-effectiveness) are important.

To best plan for and make use of outcome data in a meaningful way, the panelists argued for the need for a "reference case model" for the treatment program. This model would provide a detailed program description and case flow description that included:

Program philosophy including relationship with courts or other criminal justice agency
Organizational characteristics, components, and program duration
Client selection criteria, including eligible clients accepted/rejected, and data to help determine whether the sample is representative
Program termination philosophy and criteria
Staff characteristics and stability
Market area served by the program

Next, the panelists described the need to include System- and Policy-level outcomes in addition to the more standard Client-level outcomes. Examples of Policy-level outcomes include public safety measures, health outcomes (including mental and physical health), and continuing care and recovery. System-level outcomes include cross-system and cross-agency financing, and measures of collaboration and coordination.

Examples of more specific domains of data were presented for each of three levels: client, organizational, and systems. Individual domains include screening and assessment, strengths and deficits, services and treatment dosage, treatment outcomes, costs and benefits, and criminal activity. Organizational-level measures include treatment capacity, access to other services, supervision, staff training and professional development, performance rates, and program costs. System-level measures include interagency collaboration, increased capacity of partners, reduced crime, system costs, and cost offsets.

The final part of the presentation suggested key discussion points and action steps that are needed. These included (1) the demonstration and evaluation of performance-based contracting models between the justice and treatment systems that are designed to improve outcomes; (2) the identification and pilot testing of recovery support services to improve client outcomes; (3) development of performance indicators for both proximal and distal outcomes; and (4) the development of data sharing agreements among state and local treatment programs, criminal justice agencies, and mental health services agencies. Such data sharing agreements should be used to support research, management, and adaptation of clinical services that will improve outcomes.

Workshop Discussion. The presentation on "Defining Outcomes" lead to an intense discussion of several major issues including: the ability of outcomes to be shared with practitioners including: the need to educate outside agencies of the success of programs, the importance of addressing what is happening at all levels of the criminal

justice system, and the urgency of addressing the work force crisis that has been occurring in treatment programs.

In order to address sharing outcomes, one participant suggested that we need to use a multi-tiered system, whereby we begin by addressing short term outcomes that can be immediately impacted. This will allow a support base of the public and politicians to be built, so that if the initiative has negative outcomes there will be support against any potential backlash. Once this base has been established mid-range and long-term outcomes can then be addressed.

The next issue explored was successful programs are not aggressively promoted outside the immediate circle of practitioners and researchers. For example, drug courts have been proven to be very beneficial for both the criminal justice system and practitioners, yet some lawyers and policy makers are unaware of their existence and success. Researchers and practitioners need to "sell" successful programs on the basis of evidence based research. By educating policy makers about the benefit and limitations of these programs they are more likely to be funded. Furthermore, it was suggested that practitioners need more immediate feedback, especially in regards to positive outcomes. This will raise the staff and participants esteem and could possibly lead to better outcomes. Group participants expressed concern that there was a lack of data to address this. Outcome measures have different meanings for different groups, so it is challenging to try an address this concern in a way that will satisfy all potential stakeholders.

The third area of concern was the need to address what is happening in the courts. By elevating the standing of issues dealing with patients and participants

receiving the treatment we will get better outcomes. Members of the group felt that client concerns were often ignored because the criminal justice system is driven by legal concerns. If issues dealing with clients were effectively addressed, this could lead to more desired outcomes.

The final major area of concern was the work force crisis in criminal justice treatment. Members of the group expressed concern regarding the high turnover rate, the education and training staff receive, and conflicts that can arise with worker unions. It was suggested that in order to address these concerns we need to look "back stream" to examine who the staff is, what training they have, and how improvements could be made in the selection and retention of staff.

Clinical Trials and Clinical Practice: Can Science Inform Service?

Redonna Chandler, Ph.D., National Institute on Drug Abuse (workshop leader)
John Norcross, Ph.D., ABPP; University of Scranton
Foster Cook; TASC, University of Alabama at Birmingham

After reviewing different levels of evidence rigor used to determine EBP in substance abuse treatment, Dr. Chandler summarized key current NIDA initiatives that use multi-site RTCs to identify effective interventions for criminal justice and other high-risk populations. These include the National Drug Abuse Treatment Clinical Trials Network (CTN), and the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS). It was emphasized that for scientific knowledge to be useful it must be used in actual treatment practice. In order to accomplish this several factors need to be attended to, including the organizational structure and climate, the external environment (e.g. stigma, financing), provider knowledge and behavior, and client access and

engagement. Understanding these factors can enhance empirical findings by providing context and information about mechanisms of change, helping to prepare for dissemination (including cost issues and clinical acceptability), and laying the groundwork for future research including implementation processes.

Another key point made is that policy makers can be informed by economic analyses of new interventions, including cost effectiveness and cost-benefit analyses. The remainder of the panelists' presentation summarized data collection issues and strategies that can facilitate the ability to answer questions about the ability to implement and disseminate EBP. Some of these data need to be collected up front, and some can be collected *post hoc*.

For example, some important cost data to support economic analyses must be collected from the beginning of the treatment process. Examples are payment for services, in-kind contributions, client transportation costs, and the value of wages lost due to treatment attendance. The DATCAP was suggested as a useful instrument for collecting such cost data. Other data can be collected post-treatment, including the dollar value of various client outcomes. Important client and organizational baseline data to be collected include readiness to change, organizational climate and culture, staff efficiency and attitudes, and client satisfaction with treatment. Other measures such as continuity of care, staff job satisfaction, quality of care, and staff turnover should be collected both at baseline and follow-up. Finally, organizational and management data that can be collected after treatment include treatment retention, organizational climate and culture, job performance and staff turnover, and staff/patient satisfaction.

The panel presentation ended with a set of questions for discussion, which included:

What are the limitations of clinical trials?

What are the unique challenges of implementing clinical trials in CJ settings?

What can be done to address the limitations of clinical trials?

Workshop Discussion. There were several areas of concern expressed by the group, starting with the practitioner concern that randomized trials have the potential to violate equal protection and due process rights. Methamphetamine treatment was cited as having the criminal justice system as is biggest treatment referral service. If the criminal justice system is to work with a treatment that utilizes randomized clinical trials, there is a need for a common understanding of the services being delivered, and the nature of the study, including any limitations and possible infringement on due process or equal protection issues. Further, group participants expressed concern regarding the consequences for participants of failed intervention - do these participants face harsher consequences than participants in other treatment programs?

The next area of discussion was treatment motivation. The group felt there was is a need to utilize a conceptual model that acknowledges a patient's treatment motivation. The patients, as well as the treatment, social, and organizational environment all influence the ability of an intervention to be effective.

The group then discussed work force issues such as staff training turnover rates, which are of immediate concern because if there is not a staff to implement the program correctly, there is a decreased likelihood of success for the intervention. Participants expressed concern about assigning people to control groups; this is "artificial" and not

how assignment would happen in the real world. Perhaps a balance could be reached by utilizing a more naturalistic model.

The group attempted to come to a consensus on three issues: (1) what is the value of clinical trials and how can practitioners be informed. (2) The need to expand upon and take into consideration what predicts a successful treatment effect and (3) what information is useful to the criminal justice system. The group felt that random clinical trials need to be elaborated, not abandoned. Practitioners agreed that there is a need to supplement the randomized clinical trials, not abandon them. In order to address the second concern there has to be an acknowledgement of the methodological challenges that are unique to the criminal justice system (e.g. participant involvement in aftercare); they can be removed from the treatment if they re-offend, not the typical challenge faced by RCT's in other fields. The group addressed the final area of concern by stating that randomized clinical trials need to be implemented in the correct place, if not they could force a bifurcation between policy and practitioners. A group participant expressed concern for the need for "real time" research that is conducted in such a manner that treatment that is effective is identified, and for those for whom the treatment is not effective are placed in another treatment as soon as possible.

Efficacy vs. Effectiveness

Douglas B. Marlowe, J.D., Ph.D.; Treatment Research Institute (workshop leader)
Carl Wicklund, American Probation and Parole Association
Kenneth Robertson, Center for Substance Abuse Treatment

The panel presentation began with explanatory definitions of efficacy ("can an intervention improve outcomes under optimal, controlled conditions") and effectiveness (does the intervention improve outcomes under real-world conditions"). The several practice and policy barriers to effectiveness were delineated. Practice barriers include lack of staff buy-in, reliance on top-down diffusion, large staff caseloads, increasing conditions of supervision required of offenders, inadequate staff training and resources, high staff turnover, and unmeasured variables. Policy barriers include lack of buy-in from constituencies, philosophical conflicts (e.g. bias against methadone), conflicting values, and adverseness toward risk-taking.

Traditional solutions to these barriers have been more horizontal diffusion, trying to encourage systemic buy-in, cross-disciplinary training, increased staff supervision, tool kits and manuals, and web-based training tools. Because past efforts at disseminating EBP and technology transfer have had limited success, the panel suggested placing more emphasis on evidence-based principles rather than practices. Such principles (e.g. use of behavioral and cognitive behavioral methods, targeting criminogenic risks and needs, monitoring and accountability, continuity of care) may be easier to implement than new interventions and have a substantial scientific base.

In addition, it was suggested that field-to-laboratory innovations need to be considered, rather than the traditional laboratory-to-field approach. Finally, there may be value in focusing on success-based practices by implementing performance contracting models, rewarding program innovation and then studying these innovations, and focusing more on outcomes rather than interventions.

Workshop Discussion. There was consensus reached on two main issues by the group during this session. The first was embracing EBP principles, but not programs. The group felt this was sound because many diverse programs have shared common principle; this may be the only way to get evidence based practices into rural programs, which are small and have generalist staff; and it may be a way to activate a success-based effort (e.g. Delaware's performance-based system) that does not tell programs what providers must use, but instead the principles they must follow. The group also felt cautious about emphasizing principles because they felt it would be provocative, and would go against the trend pushing EB programs and practices (e.g. the APA), so if CEICA recommends something different it would have to be accompanied by an education programs). In addition, there needs to be a discussion about the practical application of principles and what they imply about change at the provider level; a possible action step for CEICA would be providing clearer specification of what the principles are and how they can be elements of many diverse programs or practices.

The second issue was to improve communication between researchers and politicians in conjunction with practitioners. The group felt that researchers need to be interested in questions that are important to politicians. There is a need for researchers to understand the role, relationships, and responsibilities of the policy maker or politician that they are communicating with (e.g. governors vs. mayors). The group felt that it is important to communicate information in a timely fashion during the legislative/regulatory process, where it can influence the outcome. Researchers need to communicate information to politicians in a clear and concise manner, in ways that

will resonate with and be understandable to legislators. Finally, a marketing plan may be needed to disseminate important research findings.

There were three final points made by the groups: 1) Evidence based practice should not be discarded as it is still very important; 2) clients should not be ignored in communication efforts (drug courts did this quite well with politicians; 3) priorities from the field must be expressed to those funders or the most pressing research may not be funded.

Implementation and Diffusion of Evidence-Based Practice

Dean L. Fixsen, Ph.D., University of South Florida (workshop leader)
D. Dwayne Simpson, Ph.D., Texas Christian University
Gary Field, Ph.D., Arbor Counseling

This workshop presentation was in two parts. First, Dr. Fixsen discussed what is necessary to successfully implement and EBP. Evidence about the intervention's effectiveness is not sufficient to help implement the program. Several ineffective implementation methods were mentioned: simple dissemination of information, training by itself, implementation by edict, implementation based on where the funding is, and implementation without changing supporting roles and functions. EBP are effective when they are implemented with fidelity. But the challenges are in how to achieve and sustain fidelity over time across practitioners. The best training protocols combine theory and discussion, demonstration, practice and feedback, and coaching. Implementation should occur in stages: exploration, installation, initial implementation, full implementation, innovation, and sustainability.

In the second part of the workshop, Dr. Simpson presented the TCU process model for treatment and organizational change. Results from studies using the

Organizational Readiness for Change assessment instrument indicated that some programs may lack the organizational cohesion necessary to implement change. A successful implementation process requires organizational readiness to change (including resources and motivation), a stable treatment environment with positive staff climate and attributes, and a linear implementation process that incorporates training, adoption, implementation, and routine practice. It is important to engage in a strategic planning process prior to training to ensure that program staff training needs and readiness to change are addressed. In addition, the level of program functioning predicts staff response to training.

Dr. Simpson noted that we need to look at these issues from a programmatic point of view, focusing on what changes are needed and how to implement them. These issues should be addressed through a "blueprint process" in which how the treatment should look and a list of what changes need to be made are identified. Further, the notion of staging treatment out, finding where assessment and interventions would fit should be laid out in a "menu" style format. Dr. Simpson also stated that we need to look at systems and organizational readiness for change, identifying ways to fix dysfunctional programs before adding new components.

He suggested developing process models and needs assessment measures that are evidence based and reliable. Such models track patient movement from readiness, to engagement, to early recovery to retention; patient readiness for each phase is based on assessment, and such assessment is repeated and continual. There is a need for assessment measures that are evidence-based and reliable to be used to move people through the above processes. In addition, it is important to use targeted interventions –

behavioral and cognitive. Such interventions are needed for each of the process areas – readiness, engagement, early recovery, and change.

The final point raised by Simpson was that a lot of time has not been spent on the treatment environment, motivation, resources, staff attributes, and climate (e.g. as directors change, missions change, and staff become confused). There is also a lack of cohesion among program staff that can inhibit innovations.

Next, Dr. Field, who was an MHSA administrator for the Oregon DOC, raised several key issues that he has found in his experience. These included utilizing participatory planning for implementation instead of "guerilla" implementation, the importance of obtaining written agreements from the perspective of the service agency within the DOC (or lower agencies) in order to specify how clients will be identified and serviced, and having a strong centralized service branch in any CJ SA organization, if this is not done services may be dictated by local controls.

The panel then presented several key issues for audience discussion. These included selecting an EBP (being sure to match EBP capabilities with local needs), the importance of decision support data systems, assuring fidelity, and assuring that systems are aligned with the bureaucracy supporting provider organizations that support new innovations.

Workshop Discussion. The discussion then turned to what the role the federal government should have when dealing with questions of fidelity and having standard approaches. The challenge is if the federal or state governments are providing funding, and there is a lot of respect for local control, how you can generalize while preserving

flexibility? The group felt that there is a need to identify "immutable" parts of the EBP, after that everything else become flexible.

Another issue raised was the role of change. The group felt that too much change too quick would be resisted by staff. Staff resistance, risk aversion, and organizational ossification can work against EBP implementation. There may be a need for staff incentive measures such as re-insurance to stimulate innovation. In Criminal Justice, everyone is risk averse, potentially on the front page of newspapers every day.

The final major issue in the discussion was the role of academics. Many in the group felt that academics don't have enough knowledge about management. Also the way information about theories and research is communicated can be esoteric and ultimately irrelevant. here is a need for a more holistic approach between practitioners, academia, and researchers to process and disseminate information more efficiently.

Dissemination and Training

Andrew Osborne, NDRI Training Institute (workshop leader)
Todd Molfenter, Ph.D., University of Wisconsin-Madison
Richard Baron, UPENN Collaborative on Community Integration

The presentation began with a brief discussion of some of the limitations of existing training methods. One was the common reliance on one-time training versus ongoing training with follow-up. Another issue is that training should be geared toward a targeted audience rather than mixed groups. A third issue was the importance of cross-disciplinary training, and the final issue was the role of scientists in advising training curricula and methods.

Several principles that are characteristic of effective technology transfer training were raised. These were relevance, timeliness, clarity, credibility, a multifaceted approach, continuous, and bi-directional. In addition, several effective practices were described. First, assessing the organization's and staff's readiness for change is important. Second, using interpersonal strategies to engage trainees. Third, it is important to obtain organizational support for the new innovation. Finally, it was recommended that trainers take advantage of key program personnel necessary for effective dissemination and organizational change, including translators, early adopters, and champions of change.

Dissemination needs to be linked to the characteristics and experiences of the target audience. Trainers must understand audience's philosophical perspectives and belief structures, keep track of public policy shifts, be aware of program design alterations, and observe practitioner behaviors.

The role of service consumers was then discussed. Consumers are important to help define relevant outcomes, inform research, defining dissemination and utilization needs, and responding to research results. Finally, the panel raised some issues about the relationship of research to political and policy power. One point was that research rarely drives policy changes or shapes program designs in the real world. A second point was that research rarely translates directly into practice. A third suggestion was to maintain modest goals for translating research into practice.

The presentation ended with broad questions raised for audience discussion: these included future training models, barriers to implementing improved training protocols, and the identification of cutting edge issues in training and dissemination.

Workshop Discussion. The first issue discussed by the group is what factors need to be incorporated into future models. Numerous group participants expressed concern about the level of training received at all levels of formal education. There was a great deal of concern regarding the poor quality and low level of training. The general consensus was the fear that future counselors and staff will not effectively trained. Many felt that training was inapplicable, outdated, or not relevant to treatment, leaving treatment providers to provide training in house.

Another issue raised was the lack of a standardized terminology. This leads to an inconsistent operationalization of terms. A final area of concern deals with the need of human service training for lawyers. There is a marked disconnect between the legal profession and human needs. In order to address this, group participants felt that law schools need to provide training in these areas in order to establish a link between the fields.

The next area addressed was future barriers to evidence based research. This discussion began by addressing the disconnect between existing governmental agencies. Participants felt that those who graduate with criminal justice degrees and law degrees are disconnected from evidence based practices and research. In order to address this, a new business model of training needs to be adopted that will incorporate evidence based research and training in the criminal justice curriculum as well as law schools.

Next, in order to avoid barriers we need to decrease the length of time between an intervention/treatment development and its utilization. Information needs to be delivered to practitioners in a solid, clear, and concise manner so it is effectively shared.

Another method through which future barriers could be avoided is to assimilate an organizational staff member into the realm of researchers. This would allow for treatment providers to have an "in house" source for new programs and innovations.

The final area addressed by the group was action steps that address future practitioners and researchers. The first step suggested was adapting manual training and information to individual agencies. Further, it was suggested that having online summaries for practitioners and project managers may provide an additional level of support. Another suggestion involved the implementation of modern as a component of training in order to reach the "MTV Generation" of future practitioners and providers. Utilizing this technology will connect the information directly to the individual. The final action step suggested is the use of a needs assessment in order to assess the depths and limit of knowledge regarding evidence based research and assessment.

Program Fidelity and Manualized Treatment

Faye S. Taxman, Ph.D., Virginia Commonwealth University (workshop leader)
Roger Peters, Ph.D., University of South Florida
Rod Mullen, Amity Foundation

Dr. Taxman began the panel by explaining the history and importance of manualized treatment. Benefits of manualized treatment include the ability to standardize treatment sessions, as guidance for treatment programs, and improving fidelity. Several drawbacks were also noted: the manuals are not always based on research, and they may overcome staff skills that are more important.

The presentation then moved to a discussion of the appropriate practice or program model that we want the treatment providers to replicate. Different standards of

evidence levels were noted (including expert driven but not tested, consensus-based, meta-analyses or systematic reviews, and consistent evidence across populations, settings, and treatments. Key issues include both program and system factors, and the importance of program fidelity (e.g. dosage, target population, setting).

Key program components have been distinguished by researchers and need to be distinguished from other factors. These include screening vs. assessment, assessment vs. diagnosis, clinical therapies vs. services or programs, interventions vs. therapies, and treatment readiness vs. treatment. Again, it was stressed that dosage (amount, frequency, and type) are important to specify.

The main body of the presentation presented a model of factors that affect fidelity and adaptation of EBP. These factors relate to the program's organizational capabilities in the context of the external environment, interacting with the organization's mission, leadership, and culture. Specific issues and principles that facilitate EBP adaptation were divided into three categories: staffing, dosage, and management.

In terms of staffing, issues include skill sets, workload and caseload size, staff education, gender and racial composition of the staff, and level of professionalism. These factors can be addressed by skills enhancement strategies, role clarification, use of incentives to implement EBP, and a focus on performance outcomes or benchmarks.

Dosage issues raised by the panel include the pressure to minimize the number and length of sessions, demanding less of staff, employing user-friendly workbooks and videos, and the tendency to emphasize "toys" rather than case processing or quality or services. Adaptability can be improved through skills enhancement, monitoring

treatment outcomes rather than number of sessions, and providing more effective training and skills development tools.

Management issues include the importance of leadership, improving management information and performance monitoring systems, the tendency to manage contracts rather than outcomes, and the leaders' position within the organization. Suggested solutions to these problems include emphasizing performance goals, creating an environment of learning in the organization, taking small steps rather than large leaps, obtaining interagency supports, and establishing benchmarks.

In summary, Dr. Taxman presented an "Innovation Management Process Model" that incorporates a need to define key programmatic components; the importance of alignment to staff, the internal environment, and management; readjusting the intervention after implementation; analyzing performance benchmarks, adopting and realigning as needed, and routinizing the practice.

Finally, the panel raised a series of questions for discussion by the audience. These were the following:

What are the scientific principles of adaptation?

What should science use to guide the field on dosage units given that most studies do not adequately measure dosage?

What type of management efforts are likely to improve adaptation?

Will the development of a better taxonomy of programmatic components and fidelity result in better adaptation?

Workshop Discussion. The discussion of Program Fidelity and Manualized treatment begin with Dr. Peters noting a lack of enthusiasm towards implementing evidence based practices, especially manualizing because it is viewed as a limit to counselor creativity. Several challenges were mentioned by discussants including:

practitioners belief in their own intuition over scientific evidence; replacing existing practices with EBPs may be dangerous because EBPs may not be as effective as existing practices; EBP counselors face an "information overload" due to an overabundance of manuals being produced. This has caused many new EBP counselors to be unsure how to prioritize the information; many agencies lack a designated staff to implement evidence based practice, a challenge is to embed staff to serve as a designated EBP person; the lack of centralized communication to shape information on EBP on a state level, as well as the overall lack of an EBP infrastructure. In addition, EBP requires ongoing monitoring and staff supervision, and the EBP may not be a reimbursable service.

Dr. Peters also noted that states generally lack infrastructure to help programs implement EBP. Yet how you roll out EBP is critical to how it's implemented and how well it works. Moreover, there is no formal network of people to communicate about EBP issues at the state or system level, to help programs share information. So there is a need for a centralized communication agency. Providers cannot always t continue implementation after funding is gone and researchers leave, so there may need to be some ongoing incentive for programs to foster sustainability.

The other major issue is the problem of measuring program fidelity. We know that the impact of fidelity is huge for EBP. When you try to apply fidelity scales to existing practices, those with highest fidelity measures are those with best outcomes. One suggestion was to apply incentives across organizations to improve fidelity.

Discussants made several suggestions to address these challenges including embracing a new business model that will: 1) designate staff as EBP specialist at the

program level. Find people who are credible through a network analysis and provide incentives to get people to do the work. 2) Provide incentives for those asked with identifying, adapting, and helping implement EBP in agency, especially for coaching. There is a need for management to support and incentivize use of EBP. 3) Establish a network or coordinating body at the state or systems level to mobilize opinion leaders to identify EBP, see what fits the identified gaps, and communicate the results statewide. 4) Find sources of funding to support these changes.

Panelist Mullen responded to these suggestions by discussing his TC program. He stated that the development of a curriculum, in lieu of a manual, provides more advantages by guiding those who have never worked in a TC program by showing them how to do it. He gave several advantages to curriculum including increased cohesiveness among staff, consistency in the program, allowing the program to slowly develop, allowing incentives for staff because promotions may be dependent upon ability to implement the TC model, reducing staff attrition, and increased fidelity of the model.

The discussion then turned to the evidence supporting manualized approaches to improving outcomes. To date there has only been a limited amount of research. The product of a research enterprise should be a manual that has been shown efficacious. Kathleen Carroll's work is the best researched, but she is unsure that manuals are being utilized, and if so, nothing can replace training or coaching. There is much emphasis on the importance of manuals, but little research on their adaptability, or how best to maintain the integrity of an EBP. That is, what are the evidence-based principles of adaptation? What needs to be changed in the protocol to improve

outcomes? Protocols need to be more flexible to allow adaptability for local client populations and conditions.

It would be helpful if there were case studies about implementation issues that were translated for lay and political audiences. There are difficult burdens imposed on program staff to quickly implement EBPs, and case studies might be helpful to them. Researchers and people in government endorsed use of EBP but there hasn't been enough of a reality check to see if the practitioner world is ready. It was suggested that CEICA might develop some case studies or scenarios that could be used for training purposes (for supervisors as well as line staff).

The focus on technical assistance and staff training may have had two negative side effects: cottage industries have sprung up around many manualized programs, and training programs can be expensive; once a staff person has been trained and certified, they become a valuable commodity and may leave the program. Also, a lot of discussion around EBPs focused around the grant process, but it is also important to focus on systemic processes – not just what works in a grant environment but what works in an operational setting.

The final area of discussion in this session was issues with funding. There is a potentially important federal role in funding training and technical assistance on best practices/EBP but it is hard to sell that notion as an appropriate federal role. Congress wants grants to go to constituents, and programs want grants to survive. Federal appropriations for training and TA are shrinking.

Although EBPs are improving, there is no guarantee that the state will find them. Researchers need to work with practitioners to ensure that decisions about which

manualized treatments and EBPs are both politically and programmatically appealing. In order to accomplish this case studies talking about implementation issues should be utilized to present information to lay and political audiences. Case studies may help them understand the burdens imposed on program staff when trying to quickly implement EBPs. A statistically significant effect may not be programmatically or politically significant.

A final point was raised about medication-assisted therapies – these are often manualized but often not used much in CJs settings. Knowing your clients and what their needs are is critical to achieving good outcomes.

The Consumer Perspective

Marsha Weissman, Center for Community Alternatives (workshop leader)
Yvonne Smith Segars, J.D.; New Jersey Public Defender
Jonathan Porteus. Ph.D.; California State University, Sacramento

The key goals of this workshop were to discuss the ways in which EBP might help consumers of EBP in criminal justice treatment, to identify the obstacles to using EBP in CJS settings, and to discuss ways of moving the practice and research agenda forward for the benefit of consumers.

The first part of the workshop dealt with the fundamental question of defining the what is meant by "consumer." There are a number of ways in which this term could be defined. Criminal justice clients who participate in treatment programs come from different parts of the system where they have difference needs and issues: pretrial release, probation, jail, prison, and parole. CJS agencies and staff are also consumers whose perspectives are important to consider: the judiciary, prosecution, public

defenders, probation, corrections, and parole. Government stakeholders (legislators, executive branch), regulatory agencies, communities, families, service providers, policy advocates, and academics can also be considered as consumers.

The presentation then turned to identifying the benefits of EBP for consumers. First, EBP provides a common ground to engage in discussion and debate about best practices and shifts the discussion from myth to fact. Second, the use of EBP allows the discussion to be centered on concrete, measurable outcomes: recidivism, recovery from addiction (abstinence, reduced drug use), or improvements in human capital (employment, family functioning, etc.).

A number of obstacles for implementing EBP were identified. The different consumer groups have different agendas and goals. Second, their may be a disconnect between client consumers and other CJS consumers that result from culture, race, ethnic, or class differences. Clients tend to come from marginalized and stigmatized populations; they come to treatment with a number of needs and barriers to successful outcomes that may need to be considered or undermine the EBP effectiveness. These factors include poverty, limited education, high rates of mental and physical health problems, low employment experience, or co-occurring mental illness. They are stigmatized by media and politicized images that make it difficult for them to reintegrate into the community. Finally, CJ clients are often under the social control of multiple agencies and systems, which can make it difficult for them to adhere to treatment requirements.

A number of strategies were suggested as best practices for improving treatment outcomes for CJ clients. These included (1) attending to basic needs such as housing,

economic support, family issues, and employment; (2) holistic, client-centered services that incorporated health, mental health, spiritual, literacy, 12-step, and life-skills training; (3) addressing mistrust through system and community advocacy; (4) combating stigma and stereotyping; and (5) demonstrating cultural competency in terms of language, ethnicity, gender, and sexual preference.

The panel presentation ended with a set of questions to guide the audience discussion. The first question was how to make EBP more efficacious for CJS clients. Suggestions might be to focus the EBP to basic client needs, and to determine which elements of the EBP should be considered and adopted so that the intervention is more responsive to people with CJS involvement. The second related question was how to make EBP more effective, such as by removing barriers to allow more effective implementation of EBP. Finally, the panel raised the question as to whether EBP should address social pathologies and conditions that contribute to individual client treatment needs. This includes the potential role of the community-level prevention.

Workshop Discussion. The discussion started with a debate of how was how can evidence based practice be more efficacious for people in the criminal justice system. To begin with, practitioners in the system ignore evidence of the effectiveness of treatment. If a treatment program wants to be effective, the needs of society (employers, religion, and housing) need to be incorporated.

The next issue raised was the disconnect between the criminal justice consumer and that person as an individual. These persons are often not part of the treatment discussion; we need to speak with prisoners on how they view re-entry, what do clients of the criminal justice system view as the strengths and weaknesses of treatment?

Criminal justice research largely ignores the opinion of the criminal justice client. Group participants expressed how we can learn from those who fail, by having an understanding of the failures allows us to understand the need for services (such as employment and housing plans).

Another issue raised was jail overcrowding and they are not conducive to providing treatment to clients. Those who have more social capital are more likely to get treatment; they are not forced into drug court or incarcerated. Evidence-based practice needs to look at the community and work with other social agencies.

An additional area of concern from the group is criminal justice system staff and employee needs. A group participant stated that we need to acknowledge the "good" aspects of criminal justice. If we do not do this, it will be difficult to garner their support for treatment endeavors. We have to recognize the need to respect practitioners, but the system also needs to look at clients as people and avoid biases against offender. A panel member suggested the adoption of mission based model that work with people to make them better, if a problem arises, it should be addressed. Overall, these programs are attempting to address social problems. Using a mission-based model might allow human services to address these problems. In addition we need to realize that the criminal justice system is not a public health agency, however, part of the objectives of the system is to protect the public from those with health issues in the criminal justice system. If we want to sell this to the public we need to do it from a public safety perspective. The public needs to be educated as to why these treatment programs are in their best interest as well. Evidence-based programs need to be marketing effectively

to the public and policy makers in such a way that they are appealing and can compete with other agencies.

Finally, we need to listen to the criminal justice consumer. The single most powerful way to treat drug issues is income redistribution; this would have the largest statistical effect of everything discussed today. We need to address the expectations of the criminal justice client (e.g. being able to pass a drug test); a problem may be that researchers are projecting their agendas on offenders as to what they need, instead of listening to the consumer. Furthermore, a danger of evidence based practice is we choose a method, and then stop evaluating it; instead we continue to use it and don't look for ways to further develop or improve the evidenced based practice.

A consensus was reached that the criminal justice client needs to be brought into the policy/research discussion. Consensus was not reached on how to do this.

Principles of Effective Treatment Protocols

A. Thomas McLellan, Ph.D.; Treatment Research Institute (workshop leader)
Joan Zweben, Ph.D., East Bay Recovery Project
Peter Luongo, Ph.D., Maryland Alcohol & Drug Abuse Administration

Dr. McLellan began the workshop panel by discussing the differences among treatment approaches, practices, and components, as a suggested framework for discussing evidence-based treatment. The term *approaches* means the philosophy or model of care, and how the treatment program and staff view the illness and the recovery process. Examples are medical vs. moral issue, acute vs. chronic condition. *Practice* refers to the procedures provided during the treatment and recovery process, such as screening, motivational efforts, detoxification, or continuing care. Finally,

Components refers to the specific elements of care that are used in the treatment practice, such as Motivational Enhancement Therapy, medications, etc.

Using the FDA perspective, Dr. McLellan then reviewed the evidence for each of the above categories. Using the FDA framework, several medications have been determined to be effective and therefore EBP. These include the opiate treatments methadone, naltrexone, and buprenorphine, several alcohol medications treatments (disulfiram, naltrexone, and accamprosate), medications for cocaine abuse (disulfiram, topiramate), and rimanoban for marijuana abuse. Evidence-based therapies include cognitive-behavioral therapy, motivational enhancement therapy, community reinforcement and family training, behavioral couples therapy, Multi-Systemic Therapy for families, 12-step facilitation, and individual drug counseling.

The National Quality Forum has provided guidelines for delivering effective program *practices*. First, appropriate medications should be discussed with and offered to adult patients. Second, stabilization, detoxification, and withdrawal management are not recommended as a stand-alone practice. Third, specific, tailored, and appropriate medical and social services should be offered to address individual patient needs. Lastly, patients with severe or recurring problems should be offered continuing monitoring and support services for at least one year.

Next, two very different approaches for delivering treatment were presented and compared: the Acute Care and the Continuing Care approaches. The Acute Care model is relatively simple: a substance-abusing patient enters treatment, receives evidence-based treatment in an accredited program, and completes the treatment as a non-substance abuser. The implications of this model for the CJS are that (1) a fixed

amount or duration of treatment will resolve the client's problem; (2) clinical and supervisory efforts should be put toward placing patients and getting them to complete treatment; and (3) effectiveness is evident from observing the patient's status following completion of treatment; poor outcomes for the patient implies treatment failure.

In contrast, the Continuing Care approach, or chronic care model, moves the patient from primary care, to specialty care, and then to primary continuing care. The implications for developing CJ-based treatment interventions are that (1) the effects of treatment do not last very long after care ends, and (2) patients who are out of treatment or clinical contact are at higher risk for relapse. Accepting this model has several implications: First, a goal should be to retain patients at an appropriate level of care and monitoring. Second, during the early phases of treatment it is important to prepare the patient to succeed in the next level of care. Third, the effectiveness of treatment and criminal justice supervision are seen during treatment, rather than after treatment.

In summary, the treatment approach used should determine the treatment practices, and the treatment components should fit the goals and practices. The evidence and the logic of a particular model should be considered when choosing treatment approaches, practices, and components. Finally, patients deserve and need a cohesive plan for care. In a patient-centered care approach, treatment options need to be exercised in an informed manner.

Workshop Discussion. The initial issue raised in the session was the question of whether the new quality of care standard for patient centered care is outcome based. The answer to this question was that the quality of care standard is more dependent on

performance than outcome. It has yet to be determined whether or not practitioners will be responsible for outcomes; also liability issues may arise in the future.

Panelist Zweben stated that as a treatment provider there is a need to worry that RFPs will ask providers to choose from a list of treatment approaches, some which may not be relevant or workable given existing resources. Zweben argued that funding sources need to educated; for example recent CSAT grant announcements call for higher expectations from programs but with no increase in funding (similar issues exist with states and counties). Next, Dr. Zweben stated that the direction of the National Registry of Effective Programs and Practices (NREPP) needs to be monitored, especially with the departure of SAMHSA director Currie. NREPP was meant to be a repository for providers to pick from, and that is fine. But if it becomes a "sacred list" driving funding, that could present a problem.

Further, there are major gaps in research with a need for effectiveness trials, especially in the area of substance abuse. Research needs to focus on "what works" and how best to maintain positive client gains.

Panelist Luongo stated that a change in the Governor's administration requires an explanation of what is going to work. Dr. Luongo noted that in his state (Maryland) funding for SA increased only a small amount (1%) over the past four years whereas treatment admissions increased by 18% and length of outpatient stays increased by 10.4%. The best providers are consistent, focusing on things that work (e.g. engagement and retention), delivering a product that the consumer wants, and providing measures of retention, engagement, and completion. The state is interest in

developing standards, but they do not want to tell providers how to achieve these standards, with benchmarks.

Workshop Discussion. The general discussion then turned towards what outcome measures would be used in the Maryland model (e.g. levels of care). Examples were standardized assessment and pre-specified length of stay. To improve retention, (study in dissemination phase) the state may provide technical resources to help providers who want to add EBP such as contingency management.

Some issues were raised around the treatment model suggested by Dr. McLellan. These included the concern that chronic care does not take into consideration human development (kids grow up; others outgrow addictions). When is an addiction problem a chronic problem? This is not always known, but a similar problem exists for chronic diseases such as hypertension or diabetes. There is also a point where the acute care model no longer works, and that is an issue in medicine more generally as well. It is not always clear whether an acute approach will fix the problem, but there is an obligation to continually monitor to check whether extended care is needed. Improved risk assessment may help identify those who can eventually self-manage versus those who will require long-term management. It also may be unrealistic to assume that it will be possible to intervene for a brief period in someone's life to cure their social problems and addictions.

This led to a discussion of what is the center of the extended care issue - is it the client in the CJS? One of the issues within criminal justice is if it can truly be client centered. Being that the criminal justice system has different goals (e.g. punishment,

control) than the medical treatment, so a medical, patient-centered model may not be applicable.

An analogy was made comparing addiction to diabetes and hypertension. Addiction is typically viewed as a brain disorder, but rather as a behavior disorder. No matter who the practitioner is, they are treating behaviors. If a client is followed over time and the focus is on recovery and behavioral change, there will be evidence of recovery. This would not be the case in diabetes, since there will be no organic changes. Systems should be guided by the fact that: 1) clients have a disorder; 2) they can recover; 3) addiction has the features of a chronic disorder. Assessment should focus on whether clients have moved towards behavioral changes in their recovery.

A chronic care model for the criminal justice system was discussed, but the challenge of implementing this would be creating opportunities for re-engagement without penalty (of incarceration). Another approach would be to think of the criminal justice system as an alternative system of care that is monolithic in nature and disenfranchising. This led the group to what may be the ultimate challenge how to integrate the medical model into the criminal justice system.

The final area of discussion was around the realities of the client-centered or patient-centered approach to treatment. Dr. McLellan pointed out that the patient centered approach will become an ethic, and will become perceived as a patient's right. This does not necessarily mean the patient will not be held responsible. Client centered approach is now the norm in many jurisdictions. Some decisions are still in the hands of policy makers, but many are not. Thus, behavioral health care needs to reorganize itself in connection with the criminal justice system to make a better fit, and to maintain

control over treatment decisions. Judges and other CJ staff should not be practicing treatment or making clinical decisions.

Failure to educate policy makers about the variety of available treatment approaches was pointed out as a big failing; some in the audience felt that the client-centered approach will not work in the CJS. Finally, it was pointed out that we may already have a patient-centered system in that offenders can make a choice between treatment and incarceration.

Integrating Criminal Justice and Public Health Perspectives

Laurie O. Robinson, J.D.; University of Pennsylvania (workshop leader)
The Honorable Peggy Hora, J.D.; California Superior Court (Ret.)
Susan Shaffer, J.D. , DC Pretrial Services Agency

The panel presentation opened with a suggestion that improving educational efforts can help public health and criminal justice practitioners improve their mutual understanding. Several components of such educational efforts were suggested. First, it is important to educate judges about different language in the two systems, and about tools for understanding and using EBP. Although a core set of judges have been educated about these issues, a broader group needs to be informed. Other criminal justice staff also could be trained on treatment issues and treatment protocols. Similarly, public health staff and officials have to understand CJS language. Second, it would be helpful to integrate social science courses or training into law school and bar association training curricula. Criminal Justice departments in universities can also expand curricula to include treatment and other public health issues. Finally, members

of Congress as well as state legislators need to be educated about treatment and EBP for criminal justice populations.

On the other hand, public health staff needs to be educated about criminal justice system needs and processes. For example, criminal justice information could be integrated into certification programs for treatment counselors, especially given that a large proportion of their caseloads are or have been under criminal justice supervision.

Improved communication is another area that needs improvement. Public health officials need to understand that public safety issues are always of primary concern. They also need to understand the adversarial courtroom system and how that might affect access to or delivery of treatment services. Depending upon the individual, the judge may play a more or less active role in treatment decisions.

Another challenge presented was building support in the CJS for public health initiatives. Political support is crucial if drug treatment programs are to overcome the "soft on crime" label. One strategy successfully used by many drug courts is to reframe the treatment issue as a public safety approach that also provides economic benefits for society and the CJS (e.g. treatment is smart punishment). A second strategy is to maintain or reactivate key allies through national organizations that have supported drug treatment efforts in the past. Such allies could include prosecutors (through the National District Attorneys Association), state legislators (NCSL), governors (NGA), the National Association of State Alcohol and Drug Abuse Directors, county officials (NACO), and chief judges (CCJ and AJA).

The panel then discussed the importance and challenges of encouraging criminal justice agencies to embrace EBP. Some agencies may not have had good experiences

in the past with EBP. This might have reflected the dominant role of lawyers in the CJS, who have a poor understanding of or skepticism about social science and research, and often do not understand EBPs. In addition, the CJS may not have a sufficient commitment to rigorous program evaluation that can support EBP. An example was that the GAO criticized the drug court field for relying on weak program evaluations in the 1990s, which in turn hurt the ability of the field to make a sufficiently strong case for more generally implementing treatment interventions for offenders.

Treatment agencies also have to be encouraged to adopt EBP for criminal justice populations. Many providers have been reluctant to involve CJ clients because of public safety fears or the additional burden that such clients may place on the program staff. Implementation issues also have to be addressed: many offenders have co-occurring mental health or physical disorders, and treatment programs may not be comfortable admitting violent or sex offenders. Special CJ populations such as juveniles and females also present challenges for providers who may lack adolescent- or gender-specific programming.

The panel presentation concluded with some potential needed action steps. First, there is a need to institutionalize a "cultural change" in the field. How can the legal establishment (such as the American Bar Association) be convinced to support changes in law school curricula and judicial training? Can similar cross-training support be gained from the mainstream treatment community? Second, how can changes be brought to scale? One suggestion was to establish joint SAMHSA/DOJ support in one or two pilot jurisdictions to conduct new training efforts and showcase the results.

Federal partnerships are important to insure a foundation of support for new integration efforts.

Finally, the panel asked how the field can ensure continued political support for integrating treatment into the CJS. One suggestion was to keep DOJ involved in a leadership role. Prosecutors also need to be engaged in the forefront. New political leaders – such as Senators McCaskill and Klobucher, and Governor Ritter – might be engaged in these efforts. Such individuals have a history of strong support for drug courts. Changing public opinion and attitudes toward treatment and punishment of drug offenders is another important initiative that can increase political support for CJ-PH partnerships.

Workshop Discussion. The discussion began with a group participant informing the group of a county-level study in Oregon of offenders who are constantly going through the CJS instead of treatment. The group member commented that there is a massive waste of resources, when these offenders should be getting treatment instead of being placed in the criminal justice system. There also needs to be an emphasis on follow up care (aftercare) in the community.

Education is another issue; physicians were trained by economists that gave them a new level of understanding. There are models employed that can provide the social science and treatment training that could be provided for those in law schools. A group member responded that education needs to train not just the "technical skills", but also the critical thinking skills in political science and sociology. This will allow an understanding of the meaning of public safety by separating it from punishment.

Panelist Robinson responded that there is law schools that are teaching this type of information. Panelist Justice Hora agreed, though it needs to be expanded.

The discussion turned to the large case loads of probation and parole and treatment agencies with large treatment caseloads. Many do not have the time or resources to be engaged in evidence based research, it is not practical in all areas. We need to address the service needs of offenders, other than drug courts. A possible problem is focusing all resources on one small offender population, leaving the remaining offender populations without the necessary resources.

The next topic was how drug courts are facilitating the changes in offender behavior through graduated sanctions. This is leading to a way that treatment is done that is theory based. We need to move the system in a science based direction to get the best outcome possible. This could deal with how officers are trained and how they deal with their caseload. Panelist Justice Hora stated that there are two curricula that do accomplish this (National Judicial College and 1 in CA). There is thinking and a dialogue going on in this direction. In addition, Panelist Robinson commented that these are real problems in the field that need to be addressed.

Dr. Belenko stated that the grass roots model can be effective. A representative from the Brooklyn District Attorney's office discussed how all the stakeholders have meetings every 3 months to address issues. Once this happened it spread to other areas (e.g. domestic violence courts). A federal official stated that she has seen a "sea change" courts used to focused on justice issues, they are now interested in the success of programs. If we do more public education about this issues dealing with crime. We are seeing interest in corrections about providing service to a greater

number of offenders. The issue should be bringing resources together to serve more people. Having evaluation data assists with this, but little money is devoted to research in this area. We need to educate the legislature about the need for more funding for research. In addition, she commented that lawyers are trained in alternative dispute resolution and clinical training, students from these programs could be utilized as resources.

CONFERENCE PARTICIPANT EVALUATIONS

A conference evaluation form was developed and distributed to all conferees at the end of the meeting. Conference participants were instructed as follows:

The following evaluation is designed to assess the degree to which the structure, procedures, and follow-up conference activities were/will be successful in advancing the primary goal of the CEICA community: identifying action steps the field can pursue to foster identification, implementation and sustainability of substance abuse interventions that improve outcomes for offenders.

All of the following questions use a five-point rating scale, with 1 representing most helpful and 5 representing least helpful in achieving the goals of the conference.

Evaluations were completed by 39 of the participants and the results for each evaluation item are provided below.

1. **Was it helpful to include a mix of conference participants from the research community, practitioners, policy makers and some consumers? (Please use the space for "Comments" to list groups or individuals who you think should have been included.)**

Very Helpful				Not Helpful
1	**2**	**3**	**4**	**5**
82.1%	**15.4%**			**2.6%**

2. **Was the choice of panels and topics helpful or not helpful in framing discussions around the most important issues facing the field of substance abuse treatment for criminal justice populations?**

Very Helpful				Not Helpful
1	2	3	4	5
33.3%	46.2%	25.9%	5.1%	

3. **Was the process of randomly assigning participants to workshops helpful or not helpful to realizing the overall conference goal?**

   Yes: 84.6%
   No: 15.4%

4. **In each panel presentation, was the consensus-building process helpful or not helpful in steering conferees toward agreed-upon action steps for the field at-large?**

Very Helpful				Not Helpful
1	2	3	4	5
7.7%	18.0%	46.2%	28.2%	

5. **Were the materials provided in advance of the conference helpful or not helpful in guiding your participation? (Please feel free in the "comments" section to indicate which materials were most or least helpful.)**

Very Helpful				Not Helpful
1	2	3	4	5
5.1%	15.4%	17.9%	12.8%	48.8%

6. **Would you be interested in participating in post-conference activities aimed at continuing discussions and developing action plans around consensus issues raised at the conference?**

   Yes: 95.6%
   No: 5.4%

7. **Please Indicate the stakeholder group which you most closely identify:**

Researcher:	**31.3%**
Policy Maker:	**20.8%**
Practitioner:	**41.7%**
Consumer:	**6.2%**

The evaluations were highly positive except for questions 4 and 5 that asked about the consensus building process and background material that was distributed in advance, respectively. Based upon responder's additional comments it appears that the relatively poor evaluation of the consensus process was related to conference time limits and the need to spend more time on the issues. The very low ratings for materials that were distributed in advance was due to the lateness of the distribution, and many respondents said either they did not receive anything prior to leaving for the meeting or they did not have time to read the articles.

The evaluation results are very affirmative to the aims of the conference. Most conferees felt that it was very helpful to include members of the research practitioner, policy maker and consumer communities; the choice of panels and topics were very helpful; and the process of randomly assigning participants to workshops was acceptable. Perhaps the most encouraging result was that over 95% of participants were interested in participating in CEICA post conference activities.

CONSENSUS FOLLOW-UP SURVEY

Development of the survey

As discussed above, an important conference goal was to develop consensus around issues facing the identification, implementation, and sustainability of EBP. The final plenary session included attempts to reach consensus on issues and action steps,

but there was limited time available to complete this process. As indicated in the responses on the conference evaluation forms, many attendees agreed that more time was needed to develop consensus. In addition, we believed that it was important, because of the many issues, approaches, and concerns raised by conferees, that we carefully determine which were the most important issues and which action steps should take priority. We wanted guidance from the group to determine post-conference follow-up activities and CEICA priorities. In order to accomplish these goals, we felt that allowing some time for the conferees and conference leaders to digest the information discussed would be valuable.

Accordingly, we developed a follow-up survey that summarized and organized the key points brought up in the workshops and plenary sessions. The survey was organized into several sections: first, we included general issues. Then, key issues for different constituencies were listed. For the items in these sections, conferees were asked whether they agreed with them or not, using a five-point Likert scale ranging from Strongly Disagree to Strongly Agree. Finally, proposed Action Steps that were discussed and suggested at the conference were listed and survey respondents asked to rank-order their priorities from one to ten, with ten indicating the highest priority.

The development of the survey proceeded as follows: First, CEICA co-directors Belenko and Wexler wrote an initial draft based on notes from the workshops and plenary sessions, as well as the content of the workshop panel PowerPoint files. Initial drafts of the survey were then sent to CEICA senior advisor Dr. McLellan as well as members of the CEICA Advisory Board. We incorporated their comments into

subsequent drafts. The instrument was modified to allow respondents to fill it out electronically and return via email.

Survey Administration

The survey was sent as an email attachment to all those who attended the conference. For those not returning completed surveys, reminder emails were sent periodically until we had obtained the maximum number of responses that we could. As a consensus survey, of course, it was important to have as complete participation in the survey as possible.

A total of 65 individuals attended the conference, including co-chairs Belenko and Wexler, and each of these individuals was initially sent a copy of the consensus survey. However, four conferees were only able to attend for a limited period of time, were unable to be present for the final plenary session, or declined to complete the survey. Of the remaining 61, we received completed surveys from 56 persons (92%). Despite several requests we did not receive completed surveys from the five remaining conferees. We were quite pleased to have obtained such an excellent level of cooperation from the conference attendees. Accordingly, we feel confident that the survey responses are representative of the CEICA conference discussion and results.

Survey Results

Appendix B presents the mean scores and percentage results for each of the survey items. In this section we summarize the key findings by survey section.

Issues of Concern. The items receiving the greatest level of endorsement were Issue 8 ("*There is a need to build a collaborative, multidisciplinary, and multi-partner infrastructure…*"; 66% agreed or strongly agreed); Issue 6 (*"There is so much*

and sometimes conflicting information available and practitioners and policymakers cannot assimilate everything…"; 63% agreed or strongly agreed); and Issue 1 (*"There is a need to encourage active dialogue among researchers, policymakers, practitioners, and consumers.."*; 63% agreed or strongly agreed). Only one Issue item was not endorsed by at least half the conferees: for Issue 4 (*"Need to respectfully challenge the exclusivity of RCTs for determining EBPS."*) only 47% agreed or strongly agreed. However, further analysis indicated a split among the conferees on this issue: although 52% of the researchers and 60% of the policy makers agreed or strongly agreed, only 27% of the practitioners did.

General issues. Among these 16 items, most were endorsed by a majority of conferees. The exceptions were two items with low rates of agreement: General Issue 4 (*"EB principles are more important than EB practices"* with only 37% agreeing or strongly agreeing) and General Issue 5 (*"EB principles are easier to implement than EB practices"* with only 42% agreeing or strongly agreeing). General Issue 8 received marginal support, with 50% agreeing or strongly agreeing (*"We need to me more modest about expectations of intervention effects"*).

Five items received strong consensus from the respondents, with at least 65% agreeing or strongly agreeing. These items were:

- *Item 9: "Resources should be provided to support EBP organizational change that supports EBP implementation"* (69% agreed or strongly agreed)
- *Item 11: "EBP implementation must recognize line staff resistance"* (67%)
- *Item 12: "EBP implementation must recognize training needs"* (67%)
- *Item 13: "EBP implementation must recognize staff development needs"* (67%)

- *Item 2: "Need to take long-term recovery perspective rather than only acute care model"* (66%)

Items 9, 12, and 13 received the lowest rate of endorsement from practitioners, while Item 2 had the lowest endorsement among policy makers.

Three other general issues received relatively strong support (ranging from 60 – 65% agreeing or strongly agreeing): Item 3 (*"Criminal justice system presents obstacles to EBP implementation that need to be recognized"*), Item 7 (*"Economic issues and analyses need to be considered when implementing EBP"*), and Item 16 (*"Need to provide more information to clients so that they can make better treatment choices"*). For all of these items, agreement was lowest among practitioners.

Policymaker Issues. There was general consensus agreement around most of these thirteen items. With only two exceptions, at least 57% of the respondents agreed or strongly agreed with the policymaker issues raised at the conference. For Items 1 through 8 at least 60% of the conferees agreed or strongly agreed, with the four highest mean endorsement scores for Items 8, 1, 5, and 6. The items not receiving strong consensus endorsement were Item 9 (*"Use economic incentives to foster implementation of EBPs"*, 47% agreeing or strongly agreeing) and Item 12 (*"Legislators want to know benefits of the program in terms of value added"*, with 51% agreeing or disagreeing).

Practitioner Issues. Among these 13 items, four did not achieve consensus agreement. Only 36% agreed or strongly agreed with Item 2 (*"Programs should be allowed to do what they consider effective as long as they agree to collect outcome information"*). A range of 46-48% agreed or strongly agreed with Item 1 (*"Need to let*

programs decide what EBP they want to implement"), Item 4 (*"Pursue gradual implementation of EBPs to minimize program and staff resistance"*), and Item 10 (*"Use incentives to get staff to adopt EBP"*).

Five practitioner items received endorsement from at least 60% of the respondents: Items 3, 6, 9, 11, and 13. Item 13 in particular (*"Organizational barriers to EBP should be addressed when implementing EBP"*), with 43% of the conferees strongly agreeing, was one of only two items on the entire survey with which more than 40% strongly agreed.

Researcher Issues. Among the 13 items in this section of the consensus survey, four did not achieve consensus agreement with agreement by fewer than 50% of the conferees. These included Item 6 (*"Randomized clinical trials orthodoxy inhibits ideas generated from practice"*), Item 7 (*"Issues of equal protection and due process make it difficult to do randomized clinical trials"*), Item 9 (*"Researchers need to provide naturalistic descriptions of organizational structures and cultures"*), and Item 10 (*"Achieving outcomes as good or better then EBP protocols are more important then fidelity"*).

The remainder of the Researcher Issues achieved consensus agreement, with three items strongly endorsed (60% or more agreeing or strongly agreeing): Item 1 (*"Research needs to be presented in language understandable to practitioners and policy makers"* - 67% agreed or strongly agreed), Item 5 (*"Complexity of different levels (e.g., individual, agency, systems) and systems perspectives needs to be recognized"* - 60% agreed or strongly agreed), and Item 13 (*"Adapt EBPs to different offender populations"* - 64% agreed or strongly agreed).

Measurement Issues. Two of these items were not endorsed by a majority of the conferees: Item 1 (*"Accept interventions not yet tested with RCTs if performance matches or surpasses RCT-'proven' evidence-based practice"* – 40% agreeing or strongly agreeing), and Item 5 (*"Define public safety as the fundamental value; secondary goals are reduced drug use and enhanced life functioning"* – 46% agreed or strongly agreed).

For the remaining Measurement Issues there was consensus, with at least 56% of the respondents agreed or strongly agreeing.

Consumer Issues. Two of the five Consumer Issues received clear endorsement: for the general statement in Item 1 (*"Be aware of and respect consumer perspective"*) 64% agreed or strongly agreed, and for Item 2 (*"Criminal justice client needs to be an active voice in how to improve treatment"*) 62% agreed or strongly agreed. However, only 47% of the practitioners agreed or strongly agreed with Item 1, and only 27% with Item 2. Clearly, there was a disconnect between practitioners and other constituencies on the importance of involving the consumer perspective.

Action Steps. As noted above, the consensus survey listed 28 possible Action Steps discussed at the conference that might be considered to improve the identification, implementation, and sustainability of EBP. Respondents were asked to indicate the priority of each step from 1 (lowest priority level) to 10 (highest priority). The five Action Steps receiving the highest mean priority rankings were the following:

- Identify and disseminate what has already been done in EBP (8.20)
- Learn from past EBP efforts and failures (8.07)
- Improve communication among researchers, practitioners, policymakers (8.06)
- Build network and working groups to inform EBP utilization (7.98)
- Need to invest in organizational change to sustain EBP (7.86)

Five other items had lower mean scores, but had at least 40% of the respondents ranking the Action Step as a 9 or 10:

- Educate decision makers so that they can become better informed consumers (e.g., congress, state legislatures, judges), 50%
- Increase federal and state funding for EBP technical assistance, 46%
- Improve criminal justice and public health collaborations, 42%
- Conduct needs assessment of the field in terms of infrastructure gaps, 41%
- Increase federal and state funding for EBP training, 41%

NEXT STEPS

A number of next steps emerged from the conference and several actions have been taken. In the NIDA conference proposal (R13) a number of products were discussed as ways to foster conference follow-up that advances the field that are at various stages of development. An important proposal was for the formation of focused work groups to continue discussions under a relationship with CEICA and its collaborating practitioner organizations with the purpose of guiding the field. Examples of focused work groups might include: CJ focus on control versus client rehabilitation; Program Implementation; Program Sustainability; Targeted interventions (e.g. co-occurring, women, minorities). These areas are being explored in ongoing conversations and the “targeted interventions” work group is underway in conjunction with Treatment Accountability for Safer Communities (TASC).

As mentioned earlier, a major CEICA related accomplishment just prior to the conference was the construction of a CEICA conference web site, linked to the TRI website that provides comprehensive conference information. The CEICA website provides access to all conference materials that are available for download:

Conference Operations
Agenda including workshop schedule.
List of conferees with contact information.
Biographical information on conferees.

Workshop Power Point presentations:
"Conference Overview, Orientation and Logistics," by Steven Belenko, Ph.D and Harry K. Wexler, Ph.D.
"Issues in Defining & Applying Evidence-Based Practices Criteria," by Michael Prendergast, Ph.D., Steven Schinke, Ph.D., and Judith Sachwald, Ph.D.
"Defining Outcomes for Offender Treatment," by Mady Chalk, Ph.D.; A. Elizabeth Griffith, J.D.; and Nancy Wolff, Ph.D.
"Clinical Trials and Clinical Practice: Can Science Inform Service?" by Redonna K. Chandler, Ph.D.; John Norcross, Ph.D. and Foster Cook, Ph.D.
"Efficacy vs. Effectiveness," by Douglas B. Marlowe, J.D., Ph.D.; Kenneth Robertson, and Carl Wicklund.
"Implementation, Diffusion and Sustainability," by Dean Fixsen, Ph.D.; D. Dwaye Simpson, Ph.D. and Gary Field, Ph.D.
"Dissemination & Training," by Andrew Osborne, Richard Baron, and Todd Molfenter, Ph.D.
"Manualized Treatment & Program Fidelity," by Faye S. Taxman, Ph.D., Roger H. Peters, Ph.D., and Rod Mullen.
"Evidence Based Practice: Consumer Perspective on Implementation," by Marsha Weissman, Yvonne Smith Segars, J.D., and A. Jonathan Porteus, Ph.D.
"Components, Practices and Approaches in Criminal Justice Settings," by A. Thomas McLellan, Ph.D.; Joan Zweben, Ph.D. and Peter Luongo, ,Ph.D.
"Integrating Criminal Justice & Public Health Perspectives," by Laurie Robinson, Judge Peggy Hora, and Reginald Wilkinson, Ed.D.
"Conference Consensus, Final Plenary Session," by Steven Belenko, Ph.D. and Harry Wexler, Ph.D.

Recommended reading material including:
Evaluating and Using Research Evidence in Clinical Practice, by Stewart B. Leavitt, Ph.D.
Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination, published by the Society for Prevention Research.
Agency and Practitioner Rating Categories and Criteria for Evidence Based Programs, compiled by Sharon F. Mihalic, Center for the Study and Prevention of Violence, Blueprints Initiative.
Disseminating evidence based practices in substance abuse treatment: A review with suggestions, by William R. Miller, Ph.D. James L. Sorensen, Ph.D., Jeffrey A. Selzer, M.D., and Gregory S. Brigham, Ph.D.
Extending the evidence hierarchy to enhance evidence-based practice for substance use disorders, by Jalie A. Tucker, Ph.D. and David L. Roth, Ph.D.
Policy Statement on Evidence-Based Practice in Psychology: Executive Summary, issued by the American Psychological Association.

Evidence-Based Management, by Jeffrey Pfeffer, Ph.D. and Robert J. Sutton, Ph.D.

Drs. Wexler and Belenko were instrumental in the formation of the TASC Evidence based Work Group (TEBWG) and several members of that group participated in the CEICA conference. During recent planning meetings for the TASC 2007 national conference, Drs. Wexler and Belenko were asked to work with the TEBWG and head up a conference *track Evidence Based Practices-Practical Applications* for improved results that will include 4-6 sessions and workshops that will focus on targeted interventions. The CEICA co-directors have also been active with the American Parole and Probation Association (APPA) since the inception of CEICA, and several APPA members participated in the Philadelphia conference. Drs. Belenko and Wexler, along with conferees William Burrell and Judith Sachwald (key APPA members) will be presenting the results of the conference in a panel at the July 2007 APPA training conference in Philadelphia, entitled *An overview and Implementing Evidence-Based Substance Abuse Treatment for Offenders in Community Corrections Settings: Lessons from a Consensus Conference*.

A summary of the conference proceedings is provided in this final report that includes content and discussion of each workshop, plenary sessions, identification of research and practice gaps, and action plan defined in the conference wrap-up session. This final report conference summary will be posted on the TRI web site, and copies will be distributed by email to all conference participants.

Following the conference, the CEICA Co-directors reached out to the Federal Consortium Addressing the Substance Abusing Offender, and offered to present the

conference results and lessons learned at a meeting of the Consortium. The Consortium agreed and the presentation was made on April 25, 2007 in Washington DC, entitled *Implementing and Sustaining Evidence-Based Drug Treatment in Criminal Justice Settings*. The presentation and follow-up discussion focused on key issues facing the field, summarized the conference proceedings including the results of a follow-up consensus survey, and concluded with a discussion of suggestions for next steps for the field.

Based on the extensive work conducted by CEICA over the last two years, culminating in the conference, an article is being prepared that will present an overview of scientific, clinical, and policy issues in defining and implementing evidence-based drug treatment interventions in the CJS.

A related project worthy of note that is concurrent and synergistic with the CEICA conference is a project with the National Institute of Corrections, *Technology Transfer of Evidence Based Practice (EBP) in Substance Abuse Treatment in Community Corrections Settings*. Information on technology transfer issues that is relevant to community corrections agencies is scattered throughout the research literature, and is generally not translated for non-research audiences. This project is designed to fill that gap by summarizing and organizing current knowledge focusing on the identification and implementation of EBP for substance-involved offenders, and identifying key innovation diffusion issues that can assist community correctional agencies in understanding the challenges of implementing effective substance abuse treatment and related services for offenders. The project will use the EBP and innovation diffusion

literature to develop a model and research agenda for addressing the barriers to advancing practice and using EBPs in community corrections settings.

There are active ongoing discussions with the CEICA board of advisers and the senior TRI staff associated with the center concerning the future. Several of the ideas under consideration are listed below:

1. Review the major EBP developmental steps followed in medicine, mental health and substance abuse and criminal justice (decreasing progress across areas) and propose analogous steps for the combined criminal justice/substance abuse treatment field where we have CEICA
2. Focus on training and education (informed consumer goal)
    a. Policy makers at federal and state levels
    b. Funders and regulators
    c. Researchers-move focus from the RCT gold standard to appropriate methodology for specific questions
    d. Lawyer training
    e. Criminal justice education in colleges and universities
3. Informed Consumer/Translation Training Projects
    a. Briefings for Policy Makers
    b. Develop training modules
    c. Partner with ATTCs
4. Organization TA for identification, adoption and sustaining EBP
    a. Review the TCE organizational assessment and TA work to build on and take to next step

Finally, a major challenge for CEICA over the next year will be to obtain new funding to achieve the new tasks and opportunities generated from the conference. Building on the collaborations and partnerships we developed before and after the conference, we are initiating discussions with potential funders to allow the CEICA strategic planning and conference follow-up implementation process to move forward over the next year. As we work with our advisors, post-conference working groups, federal partners, and practitioner organization collaborators, we anticipate identifying

several discrete and achievable high-priority goals and projects and funding to carry these tasks through.

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Appendix A

Instructions to Panelists

First, we want to offer our hearty appreciation for your preparatory efforts that have resulted in an excellent set of PowerPoint presentations. The presentations will be placed into a uniform CEICA conference format, with the first slide identifying the panel topic and the three panelists. Second, we want to remind you of the panel procedures and consensus process. Your main presenter(s) should take between 15 and 25 minutes, and the remaining panelists have approximately 10 minutes each for elaborating some points and offering diverse points of view. As you know, we are trying to include researcher, practitioner, policy maker, and consumer viewpoints in all the workshops. At least half the allotted workshop time should be reserved for group discussion, and part of your job is to facilitate maximum group participation. Either Steve or Harry will be present to provide help as needed. Finally, you will be responsible for providing a 5-6 minute summary of your group discussion with a focus on key issues/challenges and possible action steps that emerged. You will also participate in the other workshops and plenary sessions, so there will be numerous opportunities to provide information and express your views.

Regarding the process of consensus in your workshop, we offer the following guidance:

Where there is clear consensus, the moderator should be able to sense it - get down the essence of it and move on. Where there is no consensus the moderator should try to voice the reasons for this - the specific disagreements regarding definition or a lack of comparable experience on an issue. Lack of consensus is also important

information. Although an important group goal is to reach consensus on key issues/challenges and possible next steps, the workshop panelists and audience should feel free of pressure to reach consensus or even the full meeting since we will utilize a post conference survey for that purpose.

Finally, your reporting responsibility to the full group will require boiling down quite a lot of presentation and discussion to a brief report. This report can be presented orally or in a short PowerPoint presentation if time permits. We expect a few main issues that are hopefully connected to action steps. If something “important” in mentioned that is not part of a consensus discussion, try to include it given that some of the consensus building will happen post-conference. Because the group includes policy, research, practitioner, and consumer representation, try to organize the issues/challenges/action steps by constituency.

Appendix B

Post-Conference Follow-Up Survey Results

CEICA science addiction

Center on Evidence-based Interventions for Crime and Addiction

CEICA- Post-Conference Consensus Survey
January 2007

Instructions

As we indicated at the end of the December CEICA conference, and in our previous email, we are continuing the conference follow-up with a Consensus Survey. The survey organizes and synthesizes the many ideas and suggestions that came out of the December 2006 CEICA conference.

In keeping with our discussions during the conference, the items have been grouped into eight domains (Issues of Concern, General, Policymaker, Practitioner, Researcher, Measurement, Consumer, and Action Steps). Please respond to each item in the first 7 domains by placing an 'X' in the appropriate box using the 5-point Likert scale for level of agreement. For the final domain, Action Steps, rate each for the priority level from 1 to 10, with 1 indicating lowest priority and 10 the highest priority.

To fill out this survey, (1) download this document; (2) fill in your responses directly into the Word document; (3) save the file and email it back to Steven Belenko at sbelenko@tresearch.org. Please complete the survey as soon as possible and return to us by February 15, 2007 so that we can prepare a Conference Report and Summary that will be disseminated to all CEICA conferees and our federal funders. We also plan to share the Report with a larger network of professionals interested in evidence–based practices (EBP) in criminal justice and substance abuse treatment.

Thanks again for participating in the CEICA conference and for completing the Consensus Survey. Your feedback is crucial for developing a true consensus and helping CEICA incorporate the views of all conferees.

Abbreviations Used:

EBP = evidence-based practice

EB = evidence-based

RCT= randomized clinical trial

A. Issues of Concern

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. There is a need to encourage active dialogue among researchers, policymakers, practitioners, and consumers to clarify what constitutes "evidence" and to enhance development and dissemination of EBP.	28.6%	3.6%	5.4%	14.3%	48.2%
2. "No evidence" does not necessarily mean "no effectiveness." But, we should limit use of interventions found to be ineffective.	20.0%	12.7%	7.3%	30.9%	29.1%
3. Need to consider impact, cost (see formula below) and effect size to put research recommendations into practical terms for practitioners and policy makers. OVERALL IMPACT = [Relative Positive Impact] X [Rate of Treatment Utilization]	20.0%	10.9%	10.9%	27.3%	30.9%
4. Need to respectfully challenge the exclusivity of randomized controlled trials (RCTs) for determining EBPs. Other research designs are more appropriate for some research questions.	18.2%	21.8%	12.7%	14.5%	32.7%
5. Taking into account three levels of intervention that include the individual (EBP protocols), agency/organizations (best business practices), and systems can help clarify research and policy issues within and across the different levels.	11.5%	19.2%	11.5%	30.8%	26.9%
6. There is so much and sometimes conflicting information available and practitioners and policymakers cannot assimilate everything. Researchers need to help them sift through the information (e.g. through systematic reviews, publications targeted for practitioner/policymaker audiences, user-friendly websites, decision tools and algorithms, etc.).	14.3%	16.1%	7.1%	28.6%	33.9%

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. Shift from "lab to field" focus to "field to lab." EBP has primarily been a top-down process with too little attention paid to clinical feasibility, adaptability, or relevance. So need to identify and study other aspects of the delivery system at the organizational and systems levels (e.g. organizational best practices).	20.0%	10.9%	10.9%	21.8%	36.4%
8. There is a need to build a collaborative, multidisciplinary and multi-partner infrastructure to identify, disseminate, implement, and sustain EBP in CJ treatment.	17.9%	12.5%	3.6%	25.0%	41.1%

B. General

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Need to educate policy makers to avoid "pick from list" of EBP approach.	16.4%	16.4%	12.7%	27.3%	27.3%
2. Need to take long-term recovery perspective rather than only acute care model	14.5%	16.4%	3.6%	32.7%	32.7%
3. Criminal justice system presents obstacles to EBP implementation that need to be recognized	18.2%	12.7%	9.1%	32.7%	27.3%
4. EB *principles* are more important than EB *practices*	11.1%	25.9%	25.9%	20.4%	16.7%
5. EB *principles* are easier to implement than EB *practices*.	11.5%	21.2%	25.0%	26.9%	15.4%
6. Programs need to have opportunity to adapt EBP to local conditions	14.5%	16.4%	12.7%	32.7%	23.6%
7. Economic issues and analyses need to be considered when implementing EBP.	8.9%	21.4%	5.4%	42.9%	21.4%
8. We need to be more modest about expectations of intervention impacts	14.8%	18.5%	16.7%	33.3%	16.7%
9. Resources should be provided to support EBP organizational change that support EBP implementation	9.1%	20.0%	1.8%	41.8%	27.3%

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
10. EBP implementation must recognize workforce issues	10.9%	16.4%	9.1%	34.5%	29.1%
11. EBP implementation must recognize line staff resistance	9.1%	18.2%	5.5%	47.3%	20.0%
12. EBP implementation must recognize training needs	12.7%	16.4%	3.6%	38.2%	29.1%
13. EBP impleme ntation must recognize staff development needs	11.1%	16.7%	5.6%	37.0%	29.6%
14. Need to improve client assessment so that better treatment choices can be provided	9.1%	10.9%	21.8%	40.0%	18.2%
15. There is a need to more adequately use the tools and EBP we already have.	9.3%	22.2%	11.1%	33.3%	24.1%
16. Need to provide more information to clients so they can make better treatment choices	7.4%	20.4%	11.1%	42.6%	18.5%

C. Policymaker

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Policymakers need outcome information to make the case for funding	10.9%	18.2%	9.1%	29.1%	32.7%
2. Training of lawyers, CJ professionals, and treatment staff should include knowledge about EBP for addiction treatment in criminal justice.	10.9%	16.4%	7.3%	47.3%	18.2%
3. Develop marketing messages to change simple public perceptions of offenders and build support for CJ treatment programs	10.9%	12.7%	14.5%	41.8%	20.0%
4. Help decision makers become informed consumers of EBP	14.5%	16.4%	5.5%	34.5%	29.1%
5. Increase federal funding for EBP training	14.5%	9.1%	16.4%	29.1%	30.9%
6. Increase federal funding for EBP implementation technical assistance	16.4%	10.9%	12.7%	23.6%	36.4%

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. Increase federal funding for EBP dissemination	13.2%	15.1%	11.3%	34.0%	26.4%
8. Increase federal funding for infrastructure supportive of EBP	11.1%	11.1%	14.8%	25.9%	37.0%
9. Use economic incentives to foster implementation of EBPs	7.5%	22.6%	22.6%	11.3%	35.8%
10. Develop State infrastructure to guide EBP information sharing (e.g., development of manuals)	11.1%	14.8%	14.8%	31.5%	27.8%
11. Educate policymakers about limits of research and the cost and time to do it	14.5%	12.7%	14.5%	29.1%	29.1%
12. Legislators want to know benefits of the program in terms of value added	14.8%	18.5%	14.8%	27.8%	24.1%
13. Legislators want to know benefits of the program in terms of effect on costs	11.1%	22.2%	9.3%	24.1%	33.3%

D. Practitioner

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Need to let programs decide what EBP they want to implement	7.3%	27.3%	20.0%	29.1%	16.4%
2. Programs should be allowed to do what they consider effective as long as they agree to collect outcome information	15.1%	32.1%	17.0%	28.3%	7.5%
3. Practitioners need outcome data to make a case for funding	14.5%	14.5%	10.9%	38.2%	21.8%
4. Pursue gradual implementation of EBPs to minimize program and staff resistance	7.4%	20.4%	24.1%	31.5%	16.7%
5. Program staff need to document and collect what is going on during EBP implementation	7.5%	24.5%	13.2%	39.6%	15.1%
6. Train on EBP at the delivery system (counselor) level	11.1%	18.5%	7.4%	33.3%	29.6%

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. Fund research on how to adapt manuals to local conditions	7.3%	12.7%	29.1%	38.2%	12.7%
8. Use manuals to train and maintain program integrity	3.7%	20.4%	18.5%	38.9%	18.5%
9. Develop and evaluate new non-traditional training methods	7.4%	18.5%	13.0%	31.5%	29.6%
10. Use incentives to get staff to adopt EBP	1.9%	24.5%	26.4%	24.5%	22.6%
11. Raise awareness that people can improve compared to where they were prior to addiction	5.6%	22.2%	9.3%	42.6%	20.4%
12. Support patient-centered care in criminal justice settings.	5.7%	20.8%	18.9%	32.1%	22.6%
13. Organizational barriers to EBP should be addressed when implementing EBP.	16.7%	14.8%	3.7%	22.2%	42.6%

E. Researcher

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Research needs to be presented in language understandable to practitioners and policy makers	20.0%	10.9%	1.8%	10.9%	56.4%
2. Primary focus of research must be on the questions that are relevant to practice and policy	16.1%	17.9%	7.1%	26.8%	32.1%
3. The limitations of randomized clinical trials (RCTs) need to be clarified and disseminated to policy makers and practitioners	16.1%	17.9%	14.3%	32.1%	19.6%
4. Choice of research designs need to be guided by research questions, not simply the RCT "gold standard"	14.3%	25.0%	5.4%	21.4%	33.9%
5. Complexity of different levels (e.g., individual, agency, systems) and systems perspectives needs to be recognized	12.7%	20.0%	7.3%	32.7%	27.3%
6. Randomized clinical trials orthodoxy inhibits ideas generated from practice	18.2%	20.0%	12.7%	36.4%	12.7%

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. Issues of equal protection and due process make it difficult to do randomized clinical trials	13.2%	22.6%	17.0%	34.0%	13.2%
8. Randomized clinical trials can be more useful if measures of organizational culture and climate and change are included	14.5%	7.3%	23.6%	38.2%	16.4%
9. Researchers need to provide naturalistic descriptions of organizational structures and cultures	7.4%	16.7%	27.8%	35.2%	13.0%
10. Achieving outcomes as good or better then EBP protocols are more important then fidelity.	7.3%	20.0%	34.5%	21.8%	16.4%
11. Fidelity is essential for successful EBP implementation	1.8%	23.6%	21.8%	34.5%	18.2%
12. Need to study the training process to determine what works	10.9%	21.8%	9.1%	32.7%	25.5%
13. Adapt EBPs to different offender populations	7.3%	23.6%	5.5%	29.1%	34.5%

F. Measurement

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Accept interventions not yet tested with RCTs if performance matches or surpasses RCT-“proven” evidence-based practice	7.3%	18.2%	34.5%	29.1%	10.9%
2. Develop standardized outcome measures that can inform rational decision making.	7.3%	25.5%	3.6%	43.6%	20.0%
3. Develop faster performance feedback (e.g., can’t wait 5 years for post-treatment outcomes from randomized clinical trials)	21.8%	9.1%	9.1%	25.5%	34.5%
4. Program operations need to be rigorously described so they can be replicated with fidelity	7.3%	18.2%	9.1%	36.4%	29.1%
5. Define public safety as the fundamental value; secondary goals are reduced drug use and enhanced life functioning	12.7%	18.2%	23.6%	27.3%	18.2%

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
6. Measures related to social issues (e.g., employment, housing, social adjustment) should be included in the research as outcome measures	16.4%	14.5%	5.5%	30.9%	32.7%
7. Simplify outcome measures for policy makers and practitioners	11.1%	16.7%	16.7%	31.5%	24.1%

G. Consumer

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Be aware of and respect consumer perspective	10.9%	20.0%	5.5%	36.4%	27.3%
2. Criminal justice client needs to be an active voice in how to improve treatment	10.9%	18.2%	9.1%	38.2%	23.6%
3. Criminal justice client needs to be an active voice in helping to define outcomes	7.3%	27.3%	21.8%	25.5%	18.2%
4. Stigma reduction needs to be included as an outcome	7.3%	14.5%	30.9%	30.9%	16.4%
5. Ask clients to define the research questions that are of relevance to them	5.5%	14.5%	29.1%	38.2%	12.7%
6. Invite clients to assist in developing training and dissemination strategies	7.4%	18.5%	29.6%	31.5%	13.0%

H. Action Steps

Criteria	Priority Rating (1-10)
1. Improve communication among researchers, practitioners, and policymakers	M=8.06
2. Establish common values among researchers, practitioners, and policymakers	M=6.60
3. Improve criminal justice and public health collaborations	M=7.70

Criteria	Priority Rating (1-10)
4. Need to invest in organizational change to sustain EBP	M=7.86
5. Improve knowledge about dissemination challenges and best practices	M=7.32
6. Clarify differences between evidence based protocols, principles of best clinical practice, and principles of good organizational operation	M=7.04
7. Move toward standardization and consistency of performance measures	M=6.98
8. Seek to construct a common performance measure to allow comparisons across programs	M=6.94
9. Increase focus on interim performance measures	M=7.30
10. Test performance outcome monitoring frameworks	M=6.85
11. Educate decision makers so that they can become better informed consumers (e.g., congress, state legislatures, judges)	M=7.72
12. Include EBP training in law school curricula, colleges, in-service training,	M=6.73
13. Require EBP knowledge as part of clinical staff credentialing	M=7.54
14. Implement more online EBP training resources	M=6.73
15. Conduct needs assessment of the field in terms of EBP training	M=7.02
16. Conduct needs assessment of the field in terms of infrastructure gaps	M=7.70
17. Embed trained researcher in treatment programs to facilitate implementation of EBP	M=6.38
18. Establish written agreements among agencies to support EBP implementation	M=5.98
19. Adapt EBP manuals to local needs	M=6.96
20. Increase federal and state funding for EBP training,	M=7.45
21. Increase federal and state funding for EBP technical assistance,	M=7.69
22. Increase federal and state funding for EBP dissemination,	M=7.65
23. Increase EBP cross-disciplinary training	M=7.36
24. Encourage and study new and non-traditional training methods	M=6.67
25. Reframe the punishment argument (e.g., treatment is smart punishment)	M=7.13
26. Identify and disseminate what has already been done in EBP	M=8.20
27. Learn from past EBP efforts and failures	M=8.07
28. Build network and working groups to inform EBP utilization	M=7.98