Using Organizational Strategies to Improve Substance Abuse Treatment for Probationers: A Case Study in Delaware[1]

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NEARLY FIVE MILLION adults are under community supervision (i.e., probation or parole) in the United States (Maruschak & Parks, 2012). Many of them are placed under community supervision due to drug-related criminal offenses. According to the National Center on Addiction and Substance Abuse (NCASA, 2010), approximately 70 to 85 percent of all convicted offenders have violated drug laws, were intoxicated at the time of the offense, committed the offense to support a drug habit, or have a history of drug addiction. Drug arrests have fluctuated over the last ten to fifteen years, but have remained fairly stable in overall arrest counts. In 2014, of all possession drug arrests (representing 83% of drug arrest totals), marijuana remains the most significant problem (40%); but, heroin, cocaine, and their derivatives are second (17%) and climbing since 2009, while synthetic or manufactured drugs fall behind (5%), and all other drugs are collapsed together (21%) (FBI Uniform Crime Reports 2015). Opioid dependence is gaining momentum as a particular problem for criminal justice systems, as it includes both illegal drugs (e.g., heroin) and prescription painkillers (e.g., oxycodone, hydrocodone, morphine) that are being used for non-medical purposes.

In response to demands for more cost-effective practices as well as an emerging public sentiment favoring treatment for drug offenses, many recent state-level reforms are aimed at enhancing community-based treatment alternatives for drug offenders (Rengifo & Stemen, 2013). Community correctional officers are usually in a position to influence a substance-dependent offender's engagement in addiction treatment (Marlow, 2003; Young, 2002). Since the 1970s, research has shown that drug abuse treatment helps many drug-abusing offenders change their attitudes, beliefs, and behaviors toward drug use, avoid relapse, and successfully remove themselves from a life of substance abuse and crime (NIDA, 2012).

In combination with behavioral modification techniques, the use of specific medications (e.g., methadone, buprenorphine, and extended-release naltrexone) is recommended as one of the 13 principles of effective substance abuse treatment for criminal offenders (NIDA, 2012). Medication-assisted treatment refers to the use of pharmacotherapy along with traditional substance abuse counseling to attenuate withdrawal symptoms, reduce cravings, and/or eliminate the reinforcing euphoria resulting from alcohol or drug use (Friedmann et al., 2012). Despite the benefits of these medications for drug-dependent individuals, medication-assisted treatment is still underutilized in the treatment of alcohol- or opioid-dependent criminal justice populations (Oser et al., 2009; Nunn et al., 2009). An important contributor to the underutilization of this type of treatment for offenders being supervised in the community is the lack of support among criminal justice organizations. Overall, community correctional officers have unfavorable views of offenders using medications as part of their treatment plan, even though there is considerable evidence that they are effective in treating opioid dependence (Amato et al., 2005; Ling & Wesson, 2003; Marsch, 1998).

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Opioid Addiction and Delaware's Criminal Justice Population

Like other states, Delaware must manage a criminal justice system plagued by problems related to the offender population's dependence on alcohol and opioids. According to the Delaware Department of Corrections, 80 percent of the offender population is affected by issues related to substance use. State officials estimate that recidivism rates for substance-dependent offenders could exceed 70 percent in the absence of purposeful intervention and treatment (State of Delaware, no date). A surge in the illicit use of prescription drugs in the state has expanded the population that potentially becomes involved with the criminal justice system.

Many of these lower-risk, non-violent drug offenders who are supervised in the community by the Bureau of Community Corrections may benefit from treatment-based services. As part of their probation, many offenders with a history of alcohol or opioid use regularly meet with their assigned probation officer and complete a risk and needs assessment (State of Delaware, no date). Offenders who report substance abuse during the assessment are often referred to the Treatment Access Center (TASC). In Delaware, TASC is the primary liaison between the Division of Substance Abuse and Mental Health and the criminal justice system. TASC is responsible for assessing, referring to treatment, and providing case management services to offenders as they move through both the criminal justice and treatment systems. When TASC determines that treatment is needed, individuals are referred to local community treatment providers, some of which provide medication-assisted treatment.

The community corrections treatment model for offenders with substance abuse problems is envisioned as a collaborative effort among probation, TASC, and community treatment agencies all working together with the goal of rehabilitating the offender and protecting the community. In reality, however, agencies often have disparate philosophies and competing organizational priorities that complicate an inter-organizational treatment strategy. For example, the probation agency relies on court-mandated sentencing guidelines and directives in making decisions, and has as their main priority protecting the public from further infractions by the offender. From a treatment perspective, recovery is understood to be a long, complex process involving occasional setbacks for the recovering addict. Developing a therapeutic alliance between the treatment provider and the offender—a key element for an effective treatment plan—requires trust and confidentiality.

Thus, the Criminal Justice Drug Abuse Treatment Studies' (CJDATS) Medication Assisted Treatment in Community Corrections Environments (MATICCE) funded by the National Institute on Drug Abuse (Ducharme et al., 2013) targeted improving inter-organizational relationships and attitudes toward MAT through an inter-organizational linkage intervention. Although criminal justice research has helped to determine the effectiveness of programs and interventions targeting substance abuse treatment for offenders, the purpose of this research was to use practical tools that would bridge the gap between research and practice and unite evidence-based practice and implementation science.

Overview of CJDATS and MATICCE—Methods and Procedures

CJDATS is a national cooperative research program aimed at improving public health and public safety outcomes for offenders with substance use disorders who are preparing to re-enter the community from either prison or jail. For the MATICCE sub-study, Delaware was among nine research centers that tested the implementation of a linkage intervention as a strategy for improving drug abuse treatment coordination with supervision activities by community corrections (see Friedman et al., 2013).

The main objective of the Organizational Linkage Intervention (hereafter, intervention) was to promote and strengthen inter-organizational linkages and partnerships between community corrections settings (e.g., probation and parole) and community-based treatment settings where addiction pharmacotherapy is available. The intervention was specifically designed to educate criminal justice staff about the effectiveness of medication-assisted treatment (MAT) for individuals with opioid and/or alcohol dependence. Improvement in the linkages to evidence-based substance abuse treatment (through closer partnerships between community corrections and community-based treatment agencies) is likely to result in significant gains to public health and public safety, as well as quality of care to the clients themselves.

The intervention centered on structured communication between community corrections and community-based treatment agencies through a "pharmacological exchange council" (hereafter, Council). The Council consisted of staff from community corrections and community-based treatment agencies, in addition to representatives from other agencies linked to treatment involving medication-assisted treatment. The co-chairs of the Council included one unit supervisor from the community corrections agency and one program manager from the community-based treatment agency with decision-making authority. The Delaware Council also included criminal justice line staff and clinical staff from a local treatment center (one nurse and one counselor). The Council was administratively supported by a Connections Coordinator, who helped set the agenda and facilitate discussion. This Council proceeded through a strategic planning process in order to meet target objectives. To understand fully the issues surrounding greater use of medication-assisted treatment within community corrections, the group process of the PEC enabled the concerns of all agencies involved to be vetted in an action-oriented open dialogue.[2]

The Organizational Linkage Intervention Process

The intervention involved a 4-phase process: 1) an assessment phase, 2) a strategic planning phase, 3) an implementation phase, and 4) a follow-up phase. Progression through the 4-phased OLI lasted approximately 12 months and required approval from a senior executive in both community corrections and community-based treatment agencies prior to moving forward between stages. The Center for Drug and Health Studies at the University of Delaware was a research partner to the study and collaborated to design the structure, goals, and activities of the intervention. All research centers involved in the MATICCE study continued to communicate with each other through weekly calls during the course of the intervention to discuss any problems or questions that emerged and to try to ensure standardization of the process across sites.

The purpose of the first phase of the intervention, the assessment phase, was to inventory the existing policies and procedures at both the community corrections

[2] In some sites, this may have included TASC or some other agency responsible for AOD assessments. It was anticipated that the Connections Coordinator would be selected from the community corrections agency, but in Delaware this person was a representative from the research center with relationships with both community corrections and treatment staff.

and community-based treatment agencies regarding the assessment process, referral to treatment, and MAT for adults in community corrections. Based on these findings, the Council then determined how policies and procedures currently influence or constrain and facilitate the referral and assessment of individuals who might be eligible for medication-assisted treatment, for the purpose of identifying existing logistical, financial, and other barriers.

During the second phase of the intervention, the strategic planning phase, the Council was charged with constructing a detailed organizational linkage strategic plan from the gaps and barriers identified during the assessment phase. Some of the objectives identified in the planning phase in Delaware and across other MATICCE study sites included reassigning staff, hiring additional staff, developing new procedures, and preparing documents that articulate how cross-agency collaboration and conveyance will occur.

The major task during the intervention Implementation phase was for members of the Council and their respective agencies to implement the tasks and actions specified in the planning phase. This phase lasted approximately six months and was considered complete. The intervention was also considered completed if the Council agreed that attaining the objectives was not feasible and that maximum progress toward their attainment had been achieved. Finally, during the follow-up phase, the Council identified and institutionalized the actions needed to assure the sustainability of the implemented changes. These sustainability plans could focus on both the Council and the continuation of formalized inter-organizational relationships that can facilitate clients' referral to treatment providers where medication-assisted treatment is available.

Research Plan

The nine-site study was structured with an experimental design, and all research centers involved in the study selected two agency partnership pairings of one criminal justice and one treatment organization.[3] These agency pairings were then randomized to either the control (no intervention) or experimental (intervention) group. Only the experimental agency pairing would receive the intervention. Before site randomization took place, all probation and treatment personnel were invited to participate in an inter-agency training that focused on Knowledge, Attitudes, and information regarding medication-assisted treatment. This baseline training was developed and delivered by outside training personnel to all study sites to ensure consistency, quality, and fidelity of the training. The general areas covered in the training were: open discussion of medication-assisted treatment with special consideration of criminal justice perspectives; physiological properties of medications available for opioid and alcohol dependence; evidence of the medications' side effects and effectiveness; advantages of the medications; and individual appropriateness for medication-assisted treatment. The format of the training included exercises and case studies intended to facilitate open discussion about local practices, issues, and concerns related to probationer use of medication-assisted treatment. This training was the only intervention the control sites received.

The data utilized in determining the outcomes of the Delaware component of the CJDATS MATICCE study were primarily qualitative, drawn from in-depth interviews conducted during baseline and follow-up phases, as well as periodic reports generated from Council members. Semi-structured qualitative interviews were conducted with probation staff, treatment counselors, and Council members prior to the start of the intervention (baseline), and at the completion of the intervention (follow-up). Follow-up interviews were designed to capture potential change over time with respect to inter-organizational relationships, communication patterns, enacted changes, and reflections on the intervention process. The semi-structured design of the interviews allowed respondents to elaborate on key themes and issues unanticipated by interviewers.

MATTICE in Delaware—Outcomes and Findings

Across the CJDATS collaborative, the primary goal of the intervention was to facilitate and enhance organizational linkages, with the expectation that improved linkages would ideally increase referrals for probationers who are appropriate candidates for medication-assisted treatment. The needs assessment phase in Delaware revealed that the organizations did not have difficulty with actually referring or connecting probationers to MAT treatment. In fact, several measures had already been taken before the study started that streamlined the process of referring probationers to local MAT providers. However, the system did break down during the coordination and exchange of information while the probationer was involved in treatment. This created a deep chasm between the agencies. As one probation officer notes:

> Well initially … like we said, no lines of communication, they call [us], [we] will call [them], it was just crazy … There was no line of reason; there was no policy or procedure in place. Then, we had a meeting after I say some years ago, and [treatment agency] was offered an opportunity to come to the building because we had space for them to be here to do the initial assessments. That has become one of the best tools. … [but] it's that follow-up care, that long term care, that referral care, like I like to call it, that's not being met. That's where those lines of communication fall apart.

From the flow chart and initial needs assessment, the Council established four goals that directly related to their self-identified areas of highest need concerning continued coordination of substance abuse treatment, and guided their efforts during the implementation phase.

Goal #1: Improve both the release of information process to probation from treatment, and client honesty about probation status while in treatment.

This goal proved to be one of the most important for increasing and improving the effectiveness of communication between criminal justice and community treatment line staff. During the needs assessment phase, the Council found that many probationers, especially when they were not complying with the terms of their probation, did not have a signed release of information document that enabled probation officers and treatment counselors to openly discuss their progress. Without this release, counselors are bound by federal, state, and local privacy laws to protect the confidentiality of their clients. Clients are free to refuse to sign a release of information during their initial assessment at the probation office; however, when these documents are signed, they are often not forwarded to the appropriate office or agency.

> Probation Officer: No I think that there needs to be better communication, I think that historically there's always been a salty taste in everybody's mouth as far as officers are concerned with trying to get

[3] Some sites included two treatment organizations in their control or experimental condition. In Delaware, each of the study conditions had only one treatment organization paired with one criminal justice organization.

> information from [Treatment Agency]. I'm not sure in the past year that's gotten better because I'm not physically directly doing that, but I know that it almost felt like a them and us type of situation where we were trying to call for information, and because the offender maybe didn't sign forty-five different releases of information we were only able to get one piece of information because they have so many variations, at least they did, releases of information for every aspect, urines, methadone, every little thing had a separate release. We're not there when the offender signs the release so if they aren't signing the proper releases and we were calling to try to get information we were being met with a brick wall, I understand HIPAA and I get that, but we're trying to work towards the same goal and it sometimes felt that we were on opposite ends of the pendulum.

As this probation officer notes, an additional barrier to information sharing was a general miscommunication between the agencies about what specific information the probationer was allowing the treatment program to share with their probation officer. Each release of information contained various details about treatment progress that could be communicated back to the probation officer. Even when probationers signed a release of information with the treatment agency, the individual was only granting permission for specific details about treatment progress to be shared, such as group attendance and keeping appointments with the treatment counselor. The release did not grant permission to share other types of information, such as urinalysis results. Thus, even though probation officers were receiving signed release of information forms from the treatment agency, the officers did not understand why counselors were not communicating about other aspects of the probationer's treatment progress that were required under a court order. This resulted in ongoing frustration between the agencies and the general "salty taste" the respondent notes in the above passage.

In order for treatment to improve the release of information process to probation, the Council in Delaware developed three primary changes to existing policy that were successfully carried out during the implementation phase. First, the Council spent a considerable amount of time redesigning the template of the release of information form. The major issue that had been undermining effective collaboration prior to making these changes concerned representatives from probation and treatment exchanging the release form. Quite often, a probationer/client would sign a release at one agency but not at the other, and the agency that had the signed release was not forwarding it to the other agency. This impeded both parties' abilities to do their jobs effectively. For example, when a probation officer would call a counselor to get a progress report on a probationer who was receiving treatment, the treatment staff would not respond for fear of violating the client's legally protected privacy. This situation became particularly problematic when a probationer was not complying with the conditions of probation and did not want the probation officer to have the evidence contained in the treatment progress report, so the probationer/client would refuse to sign a release of information with the treatment provider.

The Council directly addressed this issue by redesigning the release of information form, circulating copies to probation officers, and placing copies of the new form in heavily trafficked communal areas within the probation building. Probation officers were formally notified of the change, encouraged to use it as a new resource, and instructed to remind probationers of the benefits and consequences of not signing a release at both agencies.

The second major change that occurred is that treatment assessors working in the probation office now send weekly referral updates to the treatment program manager. These files include a list of all probationers who have been recommended for medication-assisted treatment and signed release forms for each of them. Because most probationers complete a release of information during their initial assessment at the probation office, exchanging this information has ensured that the release forms now follow the (referred) probationers to treatment. As a result of this action item, counselors are now better able to communicate freely with probation officers regarding the progress of clients.

In addition to ensuring that the release of information has been signed by the probationer and is on file with both agencies, the Council also identified another barrier to maintaining inter-agency coordination. Some probationers may have enrolled into a substance abuse program on their own rather than being referred by a probation-based assessor. To address this issue, treatment counselors decided to ask clients to complete a short questionnaire regarding their criminal justice involvement during their initial orientation session. Since the Council understood that a client's criminal justice status may change during the course of treatment, they asked the counselors to have all clients complete the brief survey every three months. Treatment staff members created this document as part of the implementation phase and distributed the questionnaire to all treatment counselors.

Goal #2: Develop inter-agency trainings on policies, procedures, and missions of other agencies.

Another primary goal of the overall project is to inform criminal justice staff about the effectiveness of medication-assisted treatment for opioid and/or alcohol dependent populations. In the larger study, this was achieved through the training conducted with staff at both the experimental and control sites, where the focus was on treatment philosophy and the characteristics of the medications used during the course of treatment. The Council acknowledged that such training was important, but also deemed it necessary to conduct trainings with treatment staff on the legal expectations and court mandates governing probation officers' work in Delaware. Likewise, probation staff received additional training on health-related confidentiality guidelines that are similarly integral to the treatment staff's work. The Council successfully addressed this need by facilitating two inter-agency trainings—one for probation staff held at their offices, and one for counselors held at the treatment center.

The probation staff training included explanations of: a) methadone dosing policies, b) each phase of treatment, c) conditions of remaining in treatment, d) methadone detoxification procedures, and e) confidentiality parameters around sharing clients' treatment and medical information with people and agencies outside of the treatment agency. The treatment staff training included explanations of: a) the probation office mission statements, b) each level of probation, c) zero tolerance orders, d) conditions of probation, and e) the full range of probation officer duties.

When staff were asked how the trainings were received and whether they achieved the intended goal of informing staff about the policies and mission of the other agency, one probation officer replied:

> Probation Officer: I think that, when we brought the training in for [Treatment Provider], that that may have opened some people's eyes to understanding the program a little bit better, understanding the intentions. I think when we opened up the lines of communication a little bit more by way of the progress report, that people, officers

> are a little bit more accepting of trying to communicate with [Treatment Provider].

Although the initial objective of explaining agency-specific policies to staff who do not work for that agency was achieved, the trainings were especially useful for demystifying the staff themselves. Prior to the training, probation officers and treatment staff only had contact by telephone. One probation officer actually pointed out that when the treatment staff came to the probation office to conduct their training, "it kind of removed some of that mystery from who they are."

To further promote this demystification, probation and treatment staff both created and exchanged a list of contact information for each of their offices. Members of the Council created the lists and distributed them throughout both agencies. Before they created the lists, both probation officers and treatment counselors experienced frustration when trying to contact staff from the other agency, because they had to use the main office number and be transferred. Having their calls misdirected was time-consuming and created considerable inter-organizational inefficiency, generally inhibiting information exchange. Providing these contact lists allowed staff at both agencies to identify the appropriate person to speak with and directly contact them.

Goal #3: Streamline the referral process and information exchange between probation and treatment agencies

Delaware's referral process for probationers to access medication-assisted treatment was greatly improved by the presence of treatment assessors at the probation office, but the Council took action to make further improvements in this process. First, the Council ensured that unit supervisors within the probation office took measures to confirm that appropriate paperwork is filled out at the time when clients are referred for alcohol and drug assessments. Probation officers are required to fill out several documents when making assessment referrals for court-related documentation, and unit supervisors are now expected to request copies of appointment slips for their records. Unit supervisors are required to conduct a periodic sample of audits for the probation officers they supervise, and the Council helped put into place further guidelines for ensuring that these appointment slips are included in the audits. When officers failed to complete these forms in the past, it delayed completion of client assessments. It also resulted in incomplete files for probationers, because the file did not reflect that a drug and alcohol assessment had been completed in keeping with the court order.

Second, treatment counselors are now actively identifying clients that have not signed a release of information and encouraging them to do so once they complete the brief criminal justice involvement questionnaire upon being admitted to the treatment program. Counselors now have the appropriate release document, and counselors and probation officers are better able to provide clients with an integrated continuum of care. This was an area of considerable discussion among Council members, because treatment counselors were not comfortable persuading clients to sign a release of information for all aspects of treatment progress for fear of disrupting the therapeutic relationship they are trying to establish. As one counselor notes:

> Respondent: I mean it's just like, our hands are tied, if the client says I can only release this information, that's all we can release and yeah you gonna sit there and say and try and encourage the client, this isn't gonna fly with probation and parole but I never had, even when I was a counselor, I never had a client be violated for not signing a release form. Or you the client is on probation and never once [did I] get a phone call or anything from the probation officer.
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> Interviewer: So then, it doesn't really matter to the counselors [whether the release is signed]?
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> Respondent: Well I mean … I think it's two-fold—we probably need to work a little harder with the clients to coordinate the treatment but I think the probation officers need to force the issue, they have more leverage than we do … We have no leverage, I mean we can't make the clients sign a release form. We're not gonna discharge somebody 'cause they refuse to sign a release form for probation and parole … They just say oh no, I'm not going to sign, okay. So then we're done, as far as I'm concerned. I mean like I said you can bring it up, but some of them are adamant and it's usually the clients that aren't doing well in treatment … And they don't want their probation officer to know that and I don't blame them.

Overall, treatment counselors felt they had little "leverage" to convince a client to allow their probation officer and treatment counselor to discuss their progress. Counselors agreed to provide the release form to clients when they were identified as being on probation, and to discuss with them the therapeutic benefits of allowing the two agencies to discuss their progress, but decided they would not push clients to sign it.

Goal #4: Identify more expedient ways to exchange client information that is confidential.

Due to federal, state, and health-related confidentiality guidelines, exchanging information between agencies has often been a major source of inter-agency conflict. Even after a client has signed a release of information document, sharing client progress can be difficult without a formalized procedure in place. Over the course of the intervention, the Council was able to implement several strategies to accomplish this goal.

Perhaps one of the Delaware Council's most notable accomplishments was the creation and adoption of a new progress report document that includes pertinent information about client progress in treatment and overall probation compliance. This document now includes information such as: 1) current level of supervision, 2) current offense, 3) zero tolerance status, 4) supervising officer contact information, 5) diagnoses, 6) phase of treatment, 7) medication status, 8) group/individual session attendance, 9) urinalysis information, and 10) confirmation or non-confirmation of client enrollment in treatment. Once a client has been given a referral to the treatment program by the treatment assessors at the probation office, officers will be asked to complete and fax the progress report to the treatment agency. Once this document arrives at the treatment site, the counselor assigned to the client will complete the treatment section of the progress report (items 6-10 above) within 72 hours of receipt and return the completed progress report form to the originating officer. To facilitate much-needed compliance by agency management, Council members met with the unit supervisors at the probation office to seek their endorsement. Council members representing both agencies then sent numerous emails to their staff explaining the new progress report and procedures for exchanging information regarding clients.

Before these changes went into effect, antagonism had developed between the two agencies because officers would initiate contact with treatment counselors, but counselors were unable to return their correspondence without a signed release of information. When officers were finally able to make contact with treatment personnel regarding the status of a probationer, counselors were unable to confirm or deny that

the individual was in treatment due to federal, state, and health-related privacy guidelines. In addition, treatment staff at the treatment clinic generally work earlier shifts than standard business hours (5 a.m. to 2 p.m.), and half of the probation officers at the experimental site work a "second shift" from 2 p.m. to 10 p.m. These shift differences further complicated the officers' ability to maintain contact with treatment staff. Given the difficulty in establishing quick phone contact, the Council decided to make correspondence by fax the primary method of contact. As one probation officer notes:

> Respondent: … we have the issues, um, that we couldn't overcome as far as timing issues with them coming in at 5 o'clock in the morning. And a lot of our officers working a second shift where they're not coming in till 2 o'clock in the afternoon … so, you know, having used the form I think it's the best way to communicate and it's, I think, the most common way now that officers are communicating.

A treatment counselor similarly notes:

> Respondent: I think it cuts out a lot of [expletive] as far as you know, oh I can't get a hold of the counselor or the counselor's not calling me back, blah blah blah blah blah … because you can just fax the piece of paper. So, I mean I—I think it's made communication more efficient. Because they're right. I mean—a lot of our counselors, a lot of them work 5 to 1, 6 to 2, and they[probation officers] come in and they're working at least 8 to 4, or you know, second shift.

The Council was able to address these concerns when drafting the new progress report form in two primary ways. First, they included a box nested within the treatment section of the form that states, "I cannot confirm or deny this client is in treatment." If there is no release of information on file for the probationer, treatment staff can check this box and return it to the officer within the 72-hour time frame. Having this new option for communicating about this aspect of the client's case helped assure officers that the fax had reached the appropriate office and counselors were not ignoring their correspondence. Second, by formalizing the preferred method of correspondence between the agencies, officers that were assigned to work during the later shift no longer had to be concerned with how to reach treatment staff by phone. These two strategies alleviated a tremendous amount of tension that had been building up between the agencies for many years.

Sustainability

Ultimately, the Delaware component of the CJDATS MATICCE study was successful. The PEC was able to move through all phases of the organizational linkage intervention by completing the needs assessment with four priority need areas, identifying a corresponding strategic planning report with four goals to address the need areas, and successfully implementing all objectives related to their goals. However, one of the larger aims of the MATICCE study was for the local pharmacological exchange councils to maintain a sustainable structure and implement practices so that issues that develop after the study concludes can be addressed through the change team process. The Council was also tasked with establishing a series of sustainability goals that would guide their activities once the research center withdrew from the council. In Delaware, these goals included:

- Offering the intervention materials to the control group agency pairing;
- Assisting the control group organizations in establishing their own PEC, which would include training new members in the OLI manual; and
- Continuing to meet on an as-needed basis to address inter-agency problems.

Ultimately, while the PEC achieved all of its goals, none of the sustainability goals came to fruition.

As the project phases unraveled, it became apparent to both the research team and Council participants that the study design did not allow for equitable study benefits to both organizations—specifically for the treatment agency. Although executives from the treatment organization gave their enthusiastic support to Council activities, this support and expressed interest in the intervention was motivated mostly by long-term goals for formal and informal agency collaboration. These benefits have an indirect effect on management and line staff, but are directly related to achieving executive-level goals related to leading and steering a successful treatment agency. Since the individual Council participants were not agency executives, their full participation and investment was compromised by the fact that solutions surrounding the release of information and ongoing information exchange were unilaterally advantageous to probation personnel.

As one treatment staff member explains:

> Respondent: Well, I mean … the thing is though … and I'm gonna say this, but we really don't need anything from probation and parole. You see what I'm saying? 'Cause we really don't. Yea it goes on the treatment plan, yea we address it as one of their treatment issues—if they're compliant with probation, you know … and if they're not compliant … that's gonna affect their treatment here … But do we need anything from probation or parole? No. Really. If the client's doing well and, that can get communicated to probation and parole and they don't kick them out. Um … then that's a positive. But I mean as far as … , some of this stuff. It doesn't really … interfere. It doesn't really change what we do with their treatment …
>
> Interviewer: Does probation and parole need something from you?
>
> R: Sure. They need us if the client is here, they need all that stuff. Doesn't really matter … I mean in the long term, it matters in the client's whole treatment, if they're not compliant with probation and parole because they can be sent to jail. Okay … but as far as us having to have that information … We don't really need any of the information that they have … if we don't have that information, it doesn't really affect the client. Now, if they don't have our information, obviously it affects the client …

This interaction with the research team interviewer is especially revealing of the inequitable gain that treatment personnel experienced in comparison with probation officers during the PEC intervention. Although this respondent considers some benefits to having knowledge of a client's probation status, especially given the threat of incarceration and its potential complication for clients building therapeutic dependence on a medication, it was ultimately irrelevant to the way counselors approach treatment. Given that the release of information and ongoing communication barriers were the primary focus of Council activities, treatment personnel participated in generating solutions to these existing problems but were unable to be as invested in the process and sustainability of the change team given the lack of benefits they would receive as an organizational entity.

When asked directly about the possible inequity in the PEC process, one probation officer notes:

> Interviewer: Okay … The information that is shared between you, especially in regards to the progress report, um, I mean even just the space on the sheet, there seems to be a lot of information that was sent from treatment and not as much sent to treatment. So

as far as the amount or type of information that you're exchanging, do you think that shapes any negativity back and forth?

Respondent: I don't think so because we gave it—we left it up to [Treatment Provider] what information they wanted from us. And that's all they came up with. So if they wanted more, they didn't ask for anymore. We asked for more, because I think that a lot of the things that we were asking for like medications and diagnosis and things of that nature, we asked that because in our opinion, a lot of that can affect officer safety. If we're doing a home visit, and, we find out that they may have a schizophrenia diagnosis, which then changes our way of handling somebody. And that becomes an officer safety issue, because if we're going in to arrest somebody and people are not aware of the mental illness that's there and … something that could trigger it, um, we have a problem …

From the officer's perspective, the treatment agency did not experience inequity in the Council process because they were given the same opportunity as probation staff to add requested information to the progress report form. Treatment staff on the Council remained highly involved in the process and committed to achieving each of the goals, even though almost all of the strategies were targeted at making probation officers' jobs easier. Once the goals of the Council were achieved, however, treatment members were less motivated to maintain the momentum of the group process given the reduced benefits of their continued participation.

Conclusion: Policy Implications

NIDA's commitment to implementation science is helping to provide greater opportunities for criminal justice agencies and substance abuse treatment organizations to establish ongoing collaborations to institute evidence-based practices. Given the fairly recent development of implementation science for criminal justice systems, innovative strategies are still evolving that can help produce long-lasting, equitable research partnerships among many different agencies involved in offering substance abuse treatment services to criminal justice populations. The MATICCE study tested the use of an Organizational Linkage Intervention as an implementation strategy for increasing the availability and use of pharmacotherapy as an evidence-based practice for drug-involved offenders under community supervision. Overall, the strategy was successful and the results of this study support future use of the intervention for bridging organizational service gaps and working relationships.

The structure of the intervention, especially with the inclusion of a Connections Coordinator, may be particularly appropriate for overcoming barriers related to: 1) conflicting goals and needs across organizations and agencies, 2) studies that involved multiple partners or venders, and 3) studies that include organizations and agencies with historically negative dynamics. Issues such as these are fairly common in research involving criminal justice settings, and support the further utility of similar organizational interventions in future studies. The intervention was also initiated and completed without financial assistance to either agency involved in the intervention, making it particularly useful for generating inter-organizational change within systems that are experiencing a strain in resources.

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