Using a Train-the-Trainer Model to Promote Practice Change among Agencies Serving Justice-Involved Youth[1]

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THERE IS A sizeable gap between the development and testing of innovations in health care and their delivery in routine practice settings. This gap is noted in many behavioral healthcare fields, including substance abuse (McGovern, Fox, Xie, & Drake, 2004; Miller, Sorensen, Selzer, & Brigham, 2006; Nilsen, 2010; Wandersman et al., 2008). While implementation science in recent years has focused on improving the use of evidence-based substance abuse intervention and prevention practices (EBP), very few studies have examined EBP implementation in settings that serve juvenile justice-involved youth (Development Services Group, Inc., 2015), which comprise a large number of youth presenting to substance abuse treatment (e.g., 39.6 percent of youth entering publicly funded treatment in 2017 were referred by the court/criminal justice system; Substance Abuse and Mental Health Services Administration, 2019). Much of the literature addressing EBP implementation in those settings identifies the problem (the gap between science and practice; Development Services Group, Inc. 2015; McKee & Rapp, 2014; Seave, 2011), the challenges to implementation (e.g., EBP design and fit, training challenges, McKee & Rapp, 2014; Seave, 2011), and system-level suggestions for implementation (e.g., state-level implementation; Walker, Bumbarger, & Phillippi Jr., 2015; Welsh & Greenwood, 2015), but do not provide insight into implementation at the direct-care provider level. While it is known that the field is using EBPs (Henderson, Taxman, & Young, 2008), the lack of information about EBP implementation at the provider-level represents a significant gap in the literature.

Research suggests that substance abuse treatment programs serving juvenile justice-involved youth use a variety of EBPs, and the adoption of EBPs is related to a range of factors including organizational mechanisms, training and resources, and network connections, as well as the scope of program changes required to adopt a new innovation (Henderson, Taxman, & Young, 2008). Little is known, however, about the *process* of adopting those practices, specifically regarding how training occurs following an external developer-led training. Examining these factors among providers for juvenile justice-involved youth would help fill the gap in the literature.

It can be reasonably inferred from research findings that agencies that cross-train, thus promoting knowledge/training transfer by training additional staff on EBPs, will have greater likelihood of fully implementing new practices, as new responsibilities are equally shared across staff. One common method of training and dissemination for an EBP is the train-the-trainer (T3) model, where experts or developers train providers in an EBP so they can subsequently train additional providers within their organization. The T3 approach has been shown to serve as an effective dissemination tool in fields such as medicine (Zisblatt, Hayes, Lazure, Hardesty, White, & Alford, 2017), patient education (Shen, Jiang, & Chen, 2018), mental health (Becker, 2017; Greif, Becker, & Hildebrandt, 2015; Hoagwood et al., 2017; Segre, Brock, O'Hara, Gorman, & Engeldinger, 2011), nursing (Wittenberg, Ferrell, Goldsmith, Ragan, & Buller, 2018), child welfare (Brown, Baker, & Wilcox, 2012), child care (Muldoon & Cosbey, 2018), and law enforcement settings

(Molinaro, Fisher, Mosser, & Satin, 2019).

Implementation literature identifies a few facilitating and limiting factors for EBP adoption in substance abuse and juvenile justice settings for which T3 models may be especially well-suited. T3 models could benefit agencies by increasing trainer network contacts and promoting more in-house training opportunities for staff overall, both of which are related to agency EBP adoption (Brown & Flynn, 2002; Knudsen et al., 2005; Henderson, Taxman, & Young, 2008). A pervasive challenge for organizations is getting training directly to the providers who will use the EBP (Seave, 2011). Thus, T3 has the benefit of allowing agencies to offer training on their own schedules to ensure that the service providers who will be implementing the strategies receive the resources they need immediately. In-house trainings have the added benefit of building agency infrastructure and allowing organizations to gradually gain independence from the intervention developer.

Naturalistic studies that allow observation of implementation in real-world settings provide an improved understanding of how interventions are used; what is feasible, appropriate, and acceptable to organizations (Proctor, Landsverk, Aarons, Chambers, Glisson, & Millman, 2009); how to promote movement from agency contemplation and preparation for intervention adoption to intervention implementation (Aarons et al., 2011; Becan et al., 2018), and helps inform researchers/intervention developers of how to best package interventions for scaling up/dissemination (Chambers, Glasgow, & Stange, 2013). Therefore, acknowledging the potential impact of T3 on subsequent EBP adoption, the current study uses a naturalistic approach to examine implementation of an EBP using a T3 model among substance abuse treatment agencies. Forty agencies serving youth involved in the juvenile justice system, both community-based and juvenile justice-secure settings, were provided with a standard two-day training on an established motivational enhancement curriculum and followed to monitor additional within-agency training and use. The primary aim is to describe the process and utility of using T3 approaches as an implementation strategy across varying treatment modalities, including implications for agencies serving justice involved youth.

Methods
Procedure
This research is part of a 5-year National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH), and Department of Health and Human Services (DHHS) funded grant to study implementation factors related to the adoption of EBPs in a large sample of adolescent treatment sites across the U.S. The project was structured as two phases. Effectiveness was examined in Phase 1 (Becan, Knight, Crawley, Joe, & Flynn, 2015; Knight, Dansereau, Becan, Rowan-Szal & Flynn, 2015; Knight, Joe, Becan, Crawley, Theisen, & Flynn, 2019). Phase 2 examined implementation of Treatment Readiness and Induction Package (TRIP) in multiple juvenile-justice and community-based sites in the United States (Joe, Becan, Knight, & Flynn, 2017).

The current study is based on Phase 2 data, as collected in 2013. Programs were selected to represent major modalities for adolescents receiving treatment for substance use (including community residential and outpatient programs, and secure juvenile justice facilities). Regional Addiction Technology Transfer Centers (ATTCs) assisted with program recruitment. With the help of four ATTCs (Great Lakes, South Southwest, Pacific Southwest, and Northeast and Caribbean), the full implementation sample included 312 counselors from 52 adolescent treatment facilities located in 4 U.S. states. The Institutional Review Boards (IRBs) for the research center and the treatment programs reviewed and approved study protocols.

All agencies participated in a two-day developer-led regional training (approximately 13 training hours) on the Treatment Readiness and Induction Package (TRIP). Program directors helped to identify 1-2 clinical staff from each participating program to serve as agency representatives and attend the TRIP curriculum training. Agency representatives were selected to support use of train-the-trainer approaches in promoting use and dispersion among staff and clients (Yarber et al., 2015). Specifically, identification of these individuals was informed by the degree to which he/she (1) serves in a clinical role in treatment of adolescents, (2) provides group-based substance use treatment services, (3) either uses or has a willingness to use EBPs, (4) is interested in working to improve their agency's use of EBPs by serving as an in-house trainer, and (5) is anticipated to remain at the agency through the duration of the project (12 months following the training) and, ideally, beyond the project. These individuals were trained in preparing their organization for implementing TRIP.

The TRIP curriculum is derived from Mapping-Enhanced Counseling (MEC; Dansereau & Simpson, 2009), as listed on NREPP (National Registry of Evidence-Based Programs and Practices; Substance Abuse and Mental Health Services Administration [SAMHSA], 2008) with over 80 studies demonstrating its effectiveness, particularly as a means of promoting problem recognition, treatment motivation, thoughtful and objective decision making, and therapeutic engagement (Becan, Knight, Crawley, Joe, & Flynn, 2015; Knight, Dansereau, Becan, Rowan, & Flynn, 2015; Knight et al. 2016). MEC is particularly advantageous for use in adolescent treatment settings (World Health Organization [WHO], 2017), because it helps adolescents recognize impulsivity, which often translates into higher risk-taking, including drug use, illegal activity, and unprotected sex. TRIP is packaged as eight 90-minute group-based sessions (Bartholomew, Dansereau, Knight, Becan, & Flynn, 2011).

For this study, the regional training included hands-on experience applying MEC concepts and delivering the 90-minute modules, and instructions on core and periphery components to allow for adaptation (visit www.ibr.tcu.edu for the full curriculum). Participants practiced use of freestyle maps (drawn "from scratch") and guide maps ("fill in the blank" templates that "guide" thinking around a particular topic) to visually illustrate clients' thoughts, feelings, and actions and how they relate to each other. Use of graphic visualization tools (primarily node-link mapping; Czuchry & Dansereau, 2003); has been shown through cognitive behavioral studies to enhance client and counselor communication and thinking around recovery. The developer-led training explicitly included discussion on intervention and system adaptations, including why adaptations might facilitate implementation, what adaptations could be made, and the possibility of adaptation at the system or organization level. At conclusion of the staff training, the agency representatives had an opportunity to reflect on possible changes in preparation for implementation (e.g., shift in staff responsibilities). Agencies were given the full curriculum, T3 users guide on training other staff (training slides, clinical manual, start-up curriculum materials), and the choice to implement TRIP components within the four months following the training. Research staff provided technical assistance as requested from participating agencies on conducting in-house trainings

and implementing TRIP.

Data collection procedures for this study consist of a 30-minute follow-up clinical staff survey at 4 months after the developer-led staff training which addressed implementation of the EBP at their treatment program. These data were collected electronically using Qualtrics (a secure cloud-based online survey platform). Additionally, one month prior to the training, the program director (or program designee) completed the Survey of Structure and Operations (SSO; Knight, Broome, Simpson, & Flynn, 2008), which included organization-level information modeled on the National Survey of Substance Abuse Treatment Services (N-SSATS, e.g., clinical capacity, length of stay, service modality, clinical and ancillary services and programs).

Sample Descriptions and Inclusion Criteria

Both responses from agency representatives and from non-trainees were vital for this study in determining the degree to which the TRIP curriculum was further disseminated and used beyond those that attended the developer-led training. Agency inclusion criteria for this study were based on completion of the training follow-up survey by at least one agency representative (staff who attended the developer-led training) and by at least one non-agency representative (staff who did not attend the training). Forty-seven agencies had at least one survey from either an agency representative or non-representative, with 39 agencies that had both respondents. Therefore, the final sample for examining use of train-the-trainer approaches at four months post training, included a staff survey from 238 clinical staff (54 agency representatives, 184 non-agency representatives), representing 39 facilities.

Based on the SSO director survey, agencies were classified into 4 treatment modality groups: juvenile justice primary (with 80 patient or more juvenile justice-referred clients; n = 11 agencies; M = 92 percent JJ-referred clients), community residential (n = 12 agencies; M = 33 percent JJ-referred clients), community outpatient (n = 13 agencies; M = 34 percent JJ-referred clients), and agencies providing both community residential and outpatient services (n = 3 agencies; M = 70 percent JJ-referred clients). On average, these programs reported a capacity to serve 127 clients (80 clients for residential, 118 clients for both juvenile justice and outpatient), with 109 days for typical planned length of treatment (95 days for residential, 98 days for outpatient, 154 days for juvenile justice), providing clients approximately 15 hours per week in group sessions (1 hour for juvenile justice, 8 hours for outpatient, 27 hours for residential), and offering motivational interviewing as a therapeutic approach. These programs typically serve male clients (72 percent; 75 percent juvenile justice and residential, 66 percent outpatient); White (45 percent; 39 percent juvenile justice, 50 percent residential, 41 percent outpatient), Hispanic (32 percent; 33 percent juvenile justice, 31 percent residential, 33 percent outpatient), or African American (23 percent; 34 percent juvenile justice, 16 percent residential, 23 percent outpatient); and mostly between the ages of 16-18 (49 percent; 49 percent juvenile justice, 53 percent residential, 43 percent outpatient) or ages 13-15 (32 percent; 44 percent juvenile justice, 30 percent residential, 25 percent outpatient).

Agency staff for this sample were mostly female (63 percent); white (71 percent), Hispanic (14 percent), or African American (14 percent); Master's as highest degree (54 percent); currently certified (47 percent); over 5 years of experience in drug abuse counseling (43 percent); employed in their current job for 1-3 years (33 percent) or over 5 years (31 percent); with a majority facilitating adolescent clinical groups at their agency (67 percent); average age was 42. Demographics of those selected to serve as agency representatives did not vary from the larger staff sample, with one exception. Agency representatives reported slightly more experience in drug abuse counseling (65 percent with 5+ years of experience, compared to 43 percent for non-representatives).

Measures: Staff Training Follow-Up Survey

The follow-up survey (Bartholomew, Joe, Rowan-Szal, & Simpson 2007) asked staff whether they provided training/instruction on TRIP materials to colleagues and other counselors at their agency, as well as frequency with which they used the TRIP curriculum among youth on their caseload. Agency representatives were asked additional questions on agency implementation of the TRIP curriculum, including the typical way in which TRIP is conducted with youth (e.g., group size, session duration, session frequency, open/closed group session, curriculum timing during client's length of stay), the time needed to implement TRIP following the two-day developer-led training, and the degree to which organizational changes were made to facilitate TRIP implementation. A total of 8 organizational changes were included on the representative survey, asking about changes to programming (e.g., TRIP replaced existing program elements), scheduling changes (e.g., lengthened time allocated for group sessions), staffing changes (e.g., realigned staff responsibilities), and physical environmental changes.

The degree to which TRIP is dispersed among agency staff was conceptualized into three generations of training. When agency staff reported no occurrence of an in-house training on the TRIP curriculum, those agencies were classified into the category of "first generation training," whereby TRIP training was exclusively restricted to the staff representatives who attended the developer-led training. Agencies were classified into the category of "second generation training" when staff reported receiving in-house trainings, with agencies classified into "third generation trainings" when staff reported both having received and providing in-house training.

Results

The following section discusses findings from this naturalistic study on ways in which agencies integrated the curriculum into clinical practice, as well as the degree to which TRIP as a motivational enhancement curriculum was dispersed internally through staff trainings and clinical sessions.

Implementation Approach

Strategies needed to prepare for TRIP implementation varied among agency modalities, as well as time to implement TRIP. Leading up to practice adoption, agencies made an average of 2.5 environmental changes to prepare their organization for adopting TRIP. The most frequent change, occurring among 51 percent of the agencies (67 percent of residential, 45 percent of juvenile justice, and 38 percent of outpatient agencies), consisted of replacing existing clinical programming elements with the TRIP curriculum. Other common changes reported by approximately 37 percent of agencies reflect adapting staff responsibilities and client daily schedules, as well as changing in-house terminology to be more consistent with the TRIP curriculum (e.g., "let's map it out"). Agencies seldom reported modifying time allocated for group sessions, sharing/using staff from other locations, or making physical changes to the environment. No programs reported hiring new staff specifically

to conduct TRIP groups, suggesting that TRIP can be adopted following standard shift in staff responsibilities. A majority of agencies implemented TRIP within the first month following the developer-led training (49 percent); with proportionally faster time to implementation for outpatient and residential programs (62 percent and 58 percent agencies respectively, implemented within the first month), compared to slower time to implement for JJ agencies (only 36 percent of JJ agencies implemented within the first month).

Consistent with how TRIP was developed and effectiveness tested, a majority of agencies (93 percent) facilitated the TRIP clinical sessions during the clients' first 30 days of treatment and conducted TRIP as an open-group session (85 percent, allowing clients to enter the TRIP sessions at any point in session rotations). Regardless of modality, agencies typically implemented TRIP one time per week (59 percent), facilitated by one clinician, with an average of 8-10 clients per session.

Additionally, while a majority of residential and outpatient agencies implemented TRIP as an eight 90-minute clinical package (consistent with initial clinical testing), JJ agencies tended to divide the eight 90-minute sessions into two 45-minute segments. Further variations among modalities were exemplified through the proportion of clients who received TRIP. A majority of clients (56 percent) on average received the curriculum, ranging from 45 percent in outpatient settings to 62-63 percent within JJ settings and residential settings.

Agency Level Dispersion: Generations of Training by Modality and Practice Use

The degree to which TRIP is dispersed among agency staff varied widely (see Table 1, next page). In total, only 7 facilities (18 percent of 39 agencies) reported no knowledge/training transfer beyond the agency representatives who attended the developer-led training (first-generation training), with only 2 facilities (5 percent of 39 agencies) who reported no TRIP curriculum use. The remaining 32 agencies, reported knowledge/training transfer as facilitated by agency representative trainees alone (second generation trainings, 16 facilities, 41 percent of agencies), or facilitated by both agency representative and in-house trainees (third generation training; 16 facilities, 41 percent of agencies). Generally juvenile justice and outpatient agencies dispersed the

TRIP curriculum through second generations of training (46 percent and 54 percent respectively), with residential agencies typically dispersing across three generations (42 percent). Regarding practice use, in general, most agencies (66.7 percent) jointly used agency representatives and in-house trainees to administer the TRIP curriculum to clients; with some variation by modality, ranging from 42 percent of residential agencies, 64 percent of juvenile justice, and 85 percent of outpatient settings who used both sets of trainees to implement TRIP.

Staff Level Dispersion: Representative and In-House Training and Use

While the above section discussed how agencies collectively disperse new curricula (e.g., description of generations of training), the current section will discuss the degree to which clinical staff are exposed to EBPs through in-house training. Regardless of modality, a majority of agency representatives (83 percent) provided an in-house training; with a moderate variation by modality from 79-80 percent of juvenile justice and outpatient to 94 percent of residential representatives providing an in-house training (see Figure 1, next page). In total, the train-the-trainer approach resulted in an additional 82 staff trained (46 percent of staff received an in-house training); with variation by modality, ranging from 38-39 percent trained staff for juvenile justice and residential agencies to 49 percent of trained staff for outpatient agencies. Among the in-house trainees, 18 percent provided an additional in-house training; ranging from additional knowledge transfer among 13-14 percent juvenile justice and outpatient in-house trainees to 31 percent of in-house residential trainees (see Figure 2, next page).

Regarding curriculum use, a majority of trained staff used the curriculum, regardless of training source or serving as a trainer. Specifically, 85 percent of agency representatives used the TRIP curriculum; with variation by modality ranging from 88 percent and 67 percent for residential and juvenile justice representatives respectively, to 95 percent of outpatient representatives. Approximately 70 percent of agency representatives both trained and used the intervention. Likewise, 85 percent of in-house trainees used TRIP; with moderate variation by modality, ranging from 86-87 percent for juvenile justice and residential settings to 96 percent for outpatient settings. Unlike agency representatives, a majority (66 percent) of in-house trained staff

used the intervention; however, they did not provide additional training,

This naturalistic study offers further insight into the relationship between training transfer and how TRIP is implemented. Specifically, findings suggest that with each generation of training, proportionally more clients received the intervention, with 65 percent and 59 percent of clients reportedly receiving TRIP for agencies classified as second- and third-generation trainings, respectively; compared to a lower 20 percent of clients receiving the intervention for agencies classified as first generation. Thus, initially supporting that dispersion (conducting in-house trainings) acts as a facilitator to widespread adoption. Further, findings suggest that agencies who more widely disperse EBPs also implement faster than agencies who report no knowledge/training transfer beyond those who attend a developer-led training. In fact, while 50 percent of agencies classified as third-generation trainings and 56 percent of agencies in second-generation trainings started TRIP within the first month, only 28 percent of agencies classified as first-generation training implemented it during the first month (43 percent implemented it during the second month).

Discussion

This study offers a novel examination of the utility and process of using train-the-trainer (T3) on implementation of best practices among substance abuse programs that serve juvenile justice-involved youth, and adds to the literature on T3 effectiveness. Results show that T3 approaches were widely used within this sample of agencies, resulting in widespread training and practice use. In general, regardless of treatment modality, T3 served as a means for agency representatives (those sent to developer-led trainings) to share knowledge with other agency staff through subsequent in-house trainings. In-house trainings resulted in 46 percent more staff being trained in the EBP, most (80 percent) of whom used the curriculum. The impact of these in-house trainings is evidenced by a 32 percent increase in youth who received the EBP. These data demonstrate the potential ease in transferring knowledge and future self-sustainment/independence from developers to sustain EBPs.

Results document interesting differences between modalities with regard to the use of T3. Compared to residential and outpatient agencies, JJ-secure agencies reported a longer lag between initial training of agency

TABLE 1.
Agency Level Dispersion: Generations of Training by Modality and Practice Utilization

	Total Agencies (N=39)			Juvenile Justice (n=11)			Residential (n = 12)			Outpatient (n=13)			Both Residential and Outpatient (n = 3)		
Generation	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
TRIP Used by															
Both Trainees (n=16, 66.7%)		13	13		3	4		2	3		7	4		1	2
Rep. Trainees Only (n=7, 17.9%)	5	1	1	1			3	1	1	1					
Agency Trainees Only (n=4, 10.3%)		2	2		2				1			1			
Neither Trainee (n=2, 5.1%)	2			1			1								
Modality by Generation N(%)	7 (17.9)	16 (41)	16 (41)	2 (18.2)	5 (45.5)	4 (36.4)	4 (33.3)	3 (25)	5 (41.7)	1 (7.7)	7 (53.8)	5 (38.5)	0 (0)	1 (33.3)	2 (66.7)

Note: Generation 1: Agencies where TRIP training was exclusively restricted to staff representatives who attended the developer-led training (no in-house training occurred on TRIP curriculum). Generation 2: Agencies where staff representatives who attended the developer-led training provided an in-house training (however no report of additonal trainings conducted by in-house trained staff). Generation 3: Agencies where staff reported both having received an in-house training from agency representatives, as well as providing additional in-house trainings.

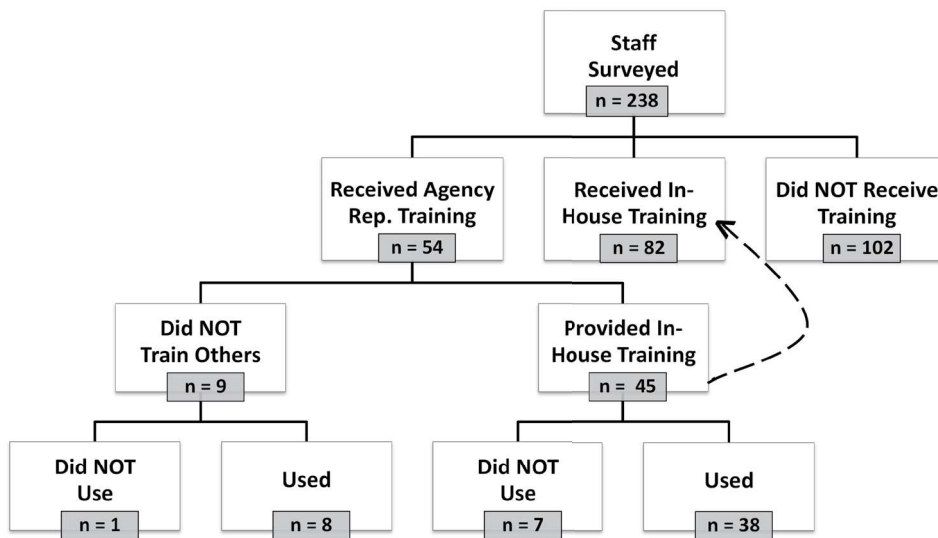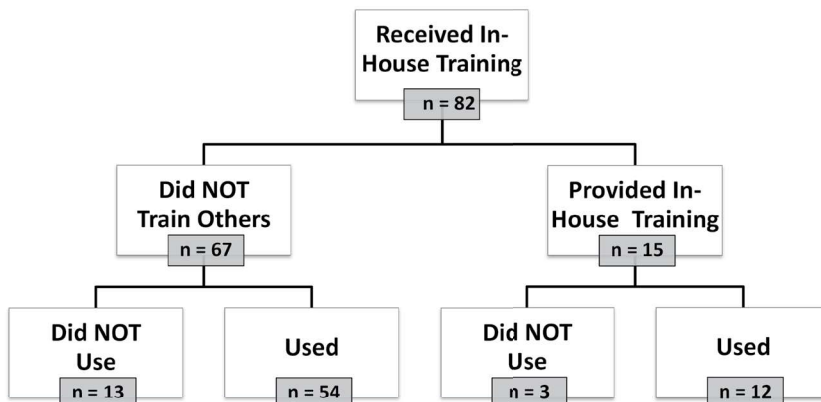Figure 1. Staff Level Dispersion: Representative Training and Utilization

Figure 2. Staff Level Dispersion: In-House Training and Utilization

representatives and TRIP implementation (greater than 2 months) and were less likely to progress to a third-generation training (where those trained in-house served as trainers to others). Yet despite these differences, JJ agencies reported greater numbers of youth receiving TRIP, suggesting better penetration within the agency. Several reasons could account for these findings, including differences in JJ organizational structure and decision-making policy (e.g., leadership sign-off on planned changes, required approvals by oversight entities), agency size and resources (e.g., saturation of staff in smaller facilities, availability of a "training department" in larger facilities), and attitudes toward innovative practices. Further work is needed to fully understand how these and other factors contribute to greater uptake in JJ settings despite stopping at generation 2.

The delay in implementation followed by greater penetration seen in JJ agencies may reflect the degree to which agencies were prepared to change and/or were investing in deliberate preparation activities. According to program change (e.g., Simpson & Flynn, 2007) and implementation process models (e.g., Aarons, Hurlburt, & Horwitz, 2011), agencies that are successful at implementing an EBP must first prepare the environment. Preparation can involve the shifting of staff responsibilities (as was done in 36 percent of agencies in this sample), targeted efforts to gain buy-in from leadership, identification of change agents who are charged with orchestrating planned changes, identifying potential barriers and solutions, and cultivating a workplace climate that is receptive to change (e.g.,

through staff education, active participation in decision making, use of data to illustrate need for change, offering incentives). Prior work suggests that factors such as staff adaptability and organizational innovation/flexibility can impact JJ staff attitudes regarding best practices for substance use treatment (Knight, Joe, Morse, Smith, Knudsen, Johnson, Wasserman... Wiley, 2018), and intentional efforts to plan how an intervention will be implemented results in greater reach and sustainability (Wiltsey Stirman, Kimberly, Cook, Calloway, Castro, & Charns, 2012).

Results of this study also document that agencies took advantage of the ability to customize the curriculum for their specific agency and client needs. Indeed, engaging in a dynamic adaptation process, where agencies work to carefully adapt an intervention to meet their needs while maintaining integrity and fidelity to core components, is important in ensuring fit and increasing likelihood of sustainment over time (Aarons et al., 2012). Although most agencies implemented the TRIP curriculum as recommended, customizations included breaking each of the 8 sessions into two 45-minute segments to better fit into programming schedules.

While the current study uses sound methodology to document the utility of the train-the-trainer model for promoting uptake of TRIP, several limitations should be noted. First, data on how TRIP was implemented were based on clinician descriptions rather than observations and were therefore subject to recall bias. Second, measures of fidelity to the intervention were not included, so the degree to which TRIP was being implemented as intended cannot be determined. Third, the investigation was limited to one specific practice—the TRIP curriculum—implemented within adolescent treatment settings; therefore, generalizing to other evidence-based practices, other populations, and other settings should be done with caution. Finally, no youth outcomes were measured as part of this study, which precludes inferences regarding the effectiveness of TRIP for intended outcomes (c.f., Becan, Knight, Crawley, Joe, & Flynn, 2015; Knight, Dansereau, Becan, Rowan-Szal, & Flynn, 2015; Knight, Joe, Becan, Crawley, Theisen, & Flynn, 2019).

In conclusion, train-the-trainer approaches are readily adopted within treatment settings that serve justice-involved youth. Further, T3 appears effective for developing internal expertise on an EBP so that agencies need not rely on intervention developers for ongoing

training. Developing such expertise is essential if decisions around customization are to be well-informed, barriers to implementation are to be addressed on an ongoing basis as they arise, and agencies are to be successful in maintaining the EBP as new staff are hired. Future studies identifying organization factors that impact both the uptake and sustainment of EBPs and that provide specific recommendations for how to overcome challenges unique to serving justice-involved populations are needed.

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