

TheCrimAcademy_65_Kearley

Fri, Jan 27, 2023 8:13AM 44:13

SUMMARY KEYWORDS

drug court, criminology, medication, rct, people, study, treatment, outcomes, substance, experimental design, brook, feasible, maryland, conducted, experimental, recommendations, folks, mortality, baltimore county, participant

SPEAKERS

Jenn Tostlebe, Brook Kearley, Jose Sanchez



Jenn Tostlebe 00:14

Hi everyone. Welcome back to the criminology Academy podcast where we are criminally academic. My name is Jenn Tostlebe



Jose Sanchez 00:21

And my name is Jose Sanchez.



Jenn Tostlebe 00:23

And today we have Dr. Brook Kearley on the podcast to talk with us about experimental criminology.



Jose Sanchez 00:30

Brook Kearley is a research assistant professor at the University of Maryland School of Social Work and research faculty at the Institute for Innovation and Implementation. She was a dissertation fellow of the National Institute of Justice and received her PhD in criminology and criminal justice from the University of Maryland in 2017. Dr. Kearley's research interests include criminal and juvenile justice policy, and program evaluation with a focus on substance use and Delinquency Prevention and Intervention Programs. She has expertise in experimental methods with over 15 years of experience managing randomized field trials and multi site evaluations. Dr. Kearley's recent research has appeared in The Journal of substance abuse treatment, prevention science, and criminology and public policy. It's a pleasure to have you on the podcast. Brooke, thank you so much for joining us today.



 B

Brook Kearley 01:20

Thanks for inviting me.



Jenn Tostlebe 01:22

All right. So for today's episode, we're going to start off by talking about conducting experimental research in criminology and just kind of what even is experimental criminology. Then we're going to move into a paper that was co authored by Brook and her colleagues. And then we're going to wrap up by talking briefly about the Maryland House Bill 116, which was passed in 2019 and requires local correctional facilities to conduct an assessment of mental health and substance use status, among other things that I'm sure Brook will tell us all about. So Jose, why don't you kick us off?

 J

Jose Sanchez 01:58

Alright, so let's start from the top and just kind of go in with a broad, basic question like we like to do here. And can you tell us what exactly experimental criminology is?

 B

Brook Kearley 02:12

So experimental criminology is a discipline within criminology, that uses experimental methods to answer questions about the causes of crime and the efficacy of our responses to crime. Joan McCord had one of the first kind of seminal works in experimental criminology, you might be familiar, she did a long term follow up of the Cambridge Somerville Youth Study. But I'd say work in this area really took off in the 1990s with the establishment of things like the Campbell collaborative, the Academy of experimental criminology, there was the Journal of Experimental criminology that came out around that time, and then also a division of experimental criminology within ASC. So today, I would say, you know, it continues to be an important part of criminology and very much aligns with things like evidence based policy, and that kind of movement toward evidence based policy.



Jenn Tostlebe 03:09

So Jose, and I were talking a little bit and we think that no, a lot of times when people hear experimental criminology or the term experiment, they might be thinking, oh, like a clinical trial, or someone mixing like chemicals together and basically hoping they don't explode.

 B

Brook Kearley 03:27

Right.



Jenn Tostlebe 03:27

And so when, yeah, when it comes to criminology, then what exactly does an experimental

design look like?

B

Brook Kearley 03:38

So, I mean, there's really no single approach to experimental design, I think it depends on, you know, the research question, it depends on the particular area of inquiry. And sometimes it's just random opportunity. And what I mean by that is for like, in the case of the natural experiments, I would say that experimental designs can range from randomized controlled trials, or, you know, we call them RCTs. quasi experimental designs are also included within experimental approaches, you know, especially, particularly, I guess, the ones that pay really careful attention to matching treatment and comparison groups. There's instrumental variable approaches. And then, like I said, these natural experiments, so they all kind of fit under this broad umbrella of experimental design. I would say that the through line through all of the approaches is just this goal of causal inference. So, you know, really being able to draw a causal conclusion based on the relationships that you're observing and are interested in.

J

Jose Sanchez 04:40

And so you kind of start to talk about like causal inference and answering some like these causal questions, but what are some of the other main advantages to using an experimental design? Apart from well, at least compared to something with just like a simple pre and post?

B

Brook Kearley 04:55

Yeah, I mean, I would say, and I think most researchers would agree with it. So this is that it really is the best set of tools that we have to establish a causal connection. And by that, you know, I mean reducing kind of those potentially confounding variables, much more effectively than, for example, you know, correlational studies can. So that's a primary advantage. And I think that the reason that experimental criminology has kind of, you know, grown over time, particularly, when it comes to trying to answer policy related questions.

J

Jose Sanchez 05:30

And can you tell us about maybe some of the shortcomings of an experimental design? Or is it just like foolproof or fail proof?

B

Brook Kearley 05:40

Definitely not. Yeah, I mean, in terms of practical concerns, they are often, you know, quite expensive, although they don't have to be, they can be time consuming. And they can just be difficult to do. There are oftentimes a lot of administrative hurdles there are IRB hurdles, there are, you know, all things that take time. There are also sometimes just ethically, you know, there are concerns, they just might not be appropriate, you know, so you wouldn't, for example, randomly assign children to receive, say, a healthy lunch or an unhealthy lunch if you were trying to understand the impacts of nutrition on behavioral incidents, for example. So

there are a variety of concerns. There's also some concerns about the generalizability of experiments, particularly small scale experiments or ones that are conducted in really kind of tightly controlled environments. But I think that a lot of the methodological shortcomings that get raised about experiments are true in other types of designs as well.

 **Jose Sanchez** 06:43

Right. And so you start to kind of talk a little bit about how experimental designs may not always be appropriate, such as you know, we don't want to, like it might be unethical to conduct randomization in certain settings. Are there other times when this type of design may not be the best way to study something?

 **Brook Kearley** 07:04

Sure. I mean, I think that there are plenty of research questions where experimental designs just don't fit, you know, a lot of theory building, you know, a lot of criminology, criminological theory, kind of the base knowledge of our discipline has really come from non experimental sources, observational studies, ethnographic studies, you know, there's, I guess, I would say that experimental designs are sort of a tool in the toolbox, but it's not a fit for every question for sure.



Jenn Tostlebe 07:35

All right, so you mentioned RCTs, or randomized control trials. And these are generally considered like the gold standard of experimental research designs. But it's obviously not appropriate to try and develop an experimental design all the time, as you said, and sometimes, you know, people pointed out that researchers put almost too much trust into RCTs over other methods of investigation. And so really, we just want to start off and ask, you know, what even is a randomized control trial? And then we'll go from there.

 **Brook Kearley** 08:10

Sure. So a randomized controlled trial is really it's just a study design that randomly assigns participants into either what we would call the experimental condition or a control condition. And so as the study is conducted, the assumption is that the only systematic difference between the experimental and control groups is that outcome variable under study. Again, it's trying to kind of isolate any potential causal connection. Now, this isn't always the case. And this is, you know, kind of part of the criticism is that sometimes these groups wind up slightly differently just due to random chance. But still, the assumption is that, you know, those differences are not systematic. And especially if we can measure them upfront, they can also be controlled for in the analysis,



Jenn Tostlebe 09:02

Have you conducted like an RCT, or been involved in an RCT where there have been differences, you know, at the end of the study that were significant, like to a degree? And if so,

differences, you know, at the end of the study that were significant, like to a degree? And if so, how would you handle that?

B

Brook Kearley 09:15

Yeah. So I mean, in the study of Functional Family Therapy that was accommodated for gang at risk and gang involved youth in Philadelphia, you know, youth were randomly assigned to the FFT intervention versus another intervention that was typically offered within the court. And we had a baseline interview that we did with the families and so we were able to look at differences at baseline so prior to any intervention, and we did find some significant differences in I think, I'm trying to think of what the variables were off the top of my head, I know it was one group just by chance, the kids in that group had statistically more time in a placement setting prior to the intervention or prior to any involvement in the study. But again, this was just kind of a random difference that we observed. And so because we had that information, we were able to control for that variable in our analyses. So, yeah, I mean, there are definitely times in which by chance, the groups are different, but we would expect that, you know, overall, and generally, they would be approximately equal on the factors.



Jenn Tostlebe 10:35

And then I guess, just given, you know, some of the concerns people have about RCTs, you know, broadly speaking, whether it's appropriate to randomize or whether it's actually, you know, fully accounting for these alternative confounders, what are just some of the considerations to have when trying to decide if an RCT is appropriate for the research questions you're interested in?

B

Brook Kearley 10:58

Yeah, I mean, I think it's a lot of the same issues that we were discussing before. Just things like, is it ethical? Is it feasible? Is it affordable? Is it necessary? You know, those are the kinds of questions that I certainly ask. I've been involved in a lot of RCTs, but I think that's because a lot of the work that I do is really evaluating the efficacy of programs and policies. And so, you know, to answer those questions, oftentimes, it makes sense. And it makes the most sense, but certainly, you know, there are a lot of factors. I would say, if you are working with stakeholders in state agencies and things like that, the biggest thing that you need to really consider is do you have buy in from the leadership down to line staff before you embark on an RCT. And I definitely recommend that people kind of have an initial pilot period to really see if, you know, the work that folks are agreeing to take part in is actually going to be feasible, because again, it's a big lift, and it really requires a lot of participation and coordination. So those are just some of the things to consider.

J

Jose Sanchez 12:10

We start to talk a little bit about some of the challenges or considerations that one has to have when trying to decide if an RCT is appropriate. And Jenn and I have both been involved in RCTs. And we can speak to some of those challenges, like getting that buy in for our evaluation of the

gang intervention in Denver proved to be a little challenging with some parties that, you know, kind of pushed back on. We can't be randomizing because now we're like unethically denying people services. But so can you maybe walk us through a little more: What does implementing a randomized control trial actually look like? So you like you mentioned, you have to kind of get that buy in from not just the administrators, but also the people doing the work on the ground? What are some of the other things that go into actually, kind of getting an RCT off the ground?

B

Brook Kearley 13:02

Yeah, those are really some of the key things. I would say too, because of the randomization elements, you know, the scrutiny of the IRB, is sometimes you know, and understandably, and as it should be, there's more attention, particularly, you know, in our field, we're oftentimes working with vulnerable populations, right, we're working with prisoners, or we're working with children. So even just getting Institutional Review Board approval can sometimes present a challenge with RCTs, I have had a lot of challenges, just when leadership changes within agencies that I'm working with, or even, you know, staff changes, folks that we had been working with, like within the courts or, you know, within our research staff, so those kinds of changes can really be challenging. What are some other challenges? Certainly, you know, if you have an interview element to your project, then there are the challenges that come with tracking and follow up and attrition and making sure that that attrition isn't, you know, unequal in any way or systematically different in terms of the two groups. So, it's a lot of work. But I think that again, for certain questions, it really just gives us the best understanding of the impact of, in my view anyway, of things like a policy or a program.

B

Brook Kearley 14:34

The other thing that I will say is, you know, I think that the ethical concerns are are oftentimes certainly warranted, but almost knee jerk and so there's a lot of work that needs to be done and should be done early on when you're talking with folks at the practitioner level. The reality is, you know, most a agencies look within the criminal justice system, the juvenile justice system, child welfare, all of that. They are implementing programs and policies and essentially experimenting without actually looking at the impacts of these policies, right. So they'll implement a new policy, without any real knowledge, maybe a theoretical assumption, but without any real knowledge of whether that policy or program will be effective or whether it would be harmful. And so I think, you know, some of the ethical concerns are maybe misguided. And then there are also just times when, like, the way that I've been able to do some RCTs in the past is a program is just beginning, right. And so maybe there's just limited enrollment available, but there are, you know, much greater need within the population. That's a perfect example of a time when random assignment is ethical feasible, you know, that you can sort of justify that, because there aren't the resources to support everyone who might benefit. And so why not, then just randomly assign those who would benefit to either their treatment as usual or this program and make sure before the program expands that it really is having the outcomes that you've intended for anticipate? I'm sorry, I may have gotten off of it there. But I hope I answered your question.

J

Jose Sanchez 16:26

Yeah, definitely. Yeah, I'm just like, as we're talking, I'm just, we finally wrapped up RCT in

Denver. And it just kind of bring me back to like, the early days, because we've been doing it. I started working on that since even before I got to Colorado, over four years ago. We've had a pilot study. And then we got a funding to do a randomized control trial, which, you know, we had to kind of, and we'll get into it a little bit when we talk about your paper. But one of the concerns that some people brought were that it was a single blind, not a double blind type of RCT. But when we proposed doing a double blind, we got a massive pushback from the practitioners, or when we're coming up with a design and how to implement it they weren't going to allow us to randomize people after they had been vetted. So yeah, just kind of thinking of, sometimes you kind of just got to work with what you have, and make it but we, you know, we still did our absolute best to make sure that it was the best, most rigorous study that we could have, while also remaining cognizant that it wasn't going to maybe meet the criteria that you would ideally have because practically it wasn't going to be feasible, right? We're getting pushback on certain elements. It's either we adjust to them, or we don't do the study at all.

B

Brook Kearley 17:53

Yeah, I mean, we are doing in criminology, most of the time when we're doing experimental research, it's in the field, right, we're not in a laboratory. We need to listen to we need to respect the concerns, and the issues raised by practitioners and stakeholders who are working in these environments. And, yeah, you just do what's feasible, and you try to do the best that you can, and the most rigorous that you can, given all of the constraints. And that intent to treat is most often, you know, considered the best approach is that in the real world, you know, people get referred to programs all the time and never show up. And so a certain amount of that is kind of consistent with what we see in these real world settings anyway.

J

Jose Sanchez 18:42

Yeah, thankfully, we, for our city in Denver, we had baseline and out of 50, something variables, only two or three of them were significant. So you know, like, probably random by chance. But then also, our sample size wasn't nearly as big as we had hoped, because of COVID. You know, one of the real big challenges that hopefully people don't have to go through but anyways.

B

Brook Kearley 19:11

We can have a whole podcast on COVID. Derailed research. Maybe you have already.



Jenn Tostlebe 19:18

No, we haven't. I think for both because we both were working on projects during that and working on papers related to it. And we're just like, let's move on from COVID.



Jenn Tostlebe 19:29

Well, I think we're in a good place to start moving into the paper. So this was an article

authored by our guest Brook and her colleagues John Cosgrove, Alexandra Wimberly, and Denise Gottfredson. It's titled "The impact of drug court participation on mortality: 15 year outcomes from a randomized control trial." It was published in the Journal of substance abuse treatment in 2019. And to give a quick little summary about the article, in this article, Brook and her colleagues wanted to examine the effects that participating in drug courts had on long term mortality risks. The study was a non blind randomized control trial in which 235 people during 1997 to 1998 were randomized either into the Baltimore City drug treatment court, or traditional court jurisdiction. Participant mortality was then followed up on 15 years post randomization. So Brook, our first question for you about this paper is just kind of what was the motivation behind the article? And what was the gap that you were really trying to address?

B

Brook Kearley 20:45

Sure. So this paper was part of a larger long term follow up study that I conducted of the Baltimore City drug treatment court, Denise Gottfredson, who's my mentor at Maryland conducted an initial RCT of the court. And she found positive impacts on recidivism, engagement and treatment, and some self reported measures of substance use. And I was really interested in knowing whether an intervention like a drug court could significantly alter a person's life course trajectory. So, you know, drug courts are part of this, like larger umbrella of problem solving courts. And they're really meant to address the underlying problem in this case, you know, substance misuse. So I was curious if we would find a lasting impact of program participation on these people's lives. And in terms of the gaps, there really haven't been, I mean, at the time that I was conducting this research, there hadn't been any, you know, follow up of a drug court that was, I think, over three and a half to five years. So, you know, it really was one of the first long term studies. And it was also one of the first if not the first to look at mortality as an outcome of interest.

J

Jose Sanchez 22:04

As Jenn mentioned, in sort of the summary of the paper, this was a non blind study, can you tell us the difference between a single blind, a double blind and a non blind and how this might impact the study?

B

Brook Kearley 22:19

So a single blind usually means that the research participant is not told of their treatment assignment. Whereas double blind is when both the research participant and research team and others who might be involved in the study are also unaware of that treatment assignment. In a non blind study, all parties are aware of the participants treatment assignment. And I think, you know, for our study, it just wasn't feasible to keep the results blinded from any of the parties, the participant was going into a drug court if they were assigned to a drug court. And, of course, all of the legal staff had to be aware of that study staff was involved in going to court proceedings and doing follow ups. And it was just not feasible, as we were talking about earlier to, you know, to blind the results. So, I mean, in terms of, did you want me to talk about potential impacts of that?



J Jose Sanchez 23:15

Or? Yeah, just briefly, any, like, what might be the impacts of, like, non-blind.

B Brook Kearley 23:21

I think that, you know, bias can be introduced in these instances when the parties are non-blinded. And the concern is really, that either the participant may respond or perform differently, or the research staff may, you know, respond differently. And so those potentials have, you know, a potential biasing effect on outcomes, but they can be minimized, certainly, and just knowledge and awareness of them, at least, you know, within the research staff can sometimes be helpful in just trying to minimize those.



Jenn Tostlebe 23:55

Alright, so since we're talking about drug courts, we haven't spent a lot of time on the podcast on drug courts. And so can you just describe what the key differences were between the services provided for those in the Baltimore City Drug Treatment Court versus those in the control group?

B Brook Kearley 24:14

Sure. So, you know, the control group just received traditional adjudication through the court system, and the drug treatment court group, they had 1) a less adversarial court team. So, you know, drug court teams tend to work together much more closely. There's more involvement with a single drug court judge who typically has training in addiction science, has a more focused specialization in kind of an understanding of substance use and addiction. There's more emphasis on substance use disorder treatment. This particular drug court was a post-adjudication court. So typically, you know, any jail stays that would have resulted from their offense was suspended and so long as they were compliant with the conditions. So those were some of the primary differences. Both groups, you know, had probation supervision, both groups had access to substance use disorder treatment. So it wasn't that those in the traditional adjudication group, you know, couldn't receive that treatment. It's just that drug courts are specifically designed to support individuals with substance use disorder. So there's kind of more of a particular emphasis there.

J Jose Sanchez 25:34

Alright, so I think we can start moving towards, like the result of the paper. And so the main question that you had was whether there were going to be any differences in mortality between those in the treatment group versus the control group. And so just to kind of finish laying that foundation, what was it that you were expecting or hypothesizing that you are going to see, resulting from this study?

B Brook Kearley 25:58

Sure. So we hypothesized that we would see significant differences in mortality with the drug court group having lower overall mortality than the control group. And we did not observe that. We found no significant differences between the two groups in terms of mortality outcomes. So you know, that was shocking. The other thing that was kind of, frankly, more shocking is just, you know, unfortunately, over 20% of the participants in our study died during that 15 year period, at an average age of, you know, 46 years old. And most of those deaths were substance use related. So just that finding in itself to me was so profound. And I remember someone on my dissertation committee, because was part of my dissertation said, Well, you know, we already know this, like, what's the contribution here, and I said, you know, this is a preventable, treatable behavioral health issue, and 20% of the people in our study died. So that to me was just really impactful, startling, and I really held on to that. I think, when we started to look at the reasons why we didn't observe differences in mortality, between the two conditions is that for both groups, and this is, you know, years before the kind of national opioid epidemic, Baltimore has a history of, you know, heroin and opioid use disorder. And so this is not a new challenge to Baltimore. So I would say, I don't have the paper in front of me, but probably 90% of our study population, had heroin or an opioid as a primary or a secondary substance of misuse. And when we've looked at the kind of treatment that was available to both groups, including those in the drug court, we found less than 7% had access to a medication for opioid use disorder, which, you know, we now understand is sort of the gold standard for opioid use disorder treatment in terms of reducing the likelihood of a fatal or non fatal overdose. So, you know, at the time when this study was rolling out, there were folks in the drug court group who, you know, were struggling in the same way that folks in sort of the traditional adjudication group were struggling because, you know, recovery is a process and relapse is a part of that process. And so I think what we were seeing is that, because these individuals in both groups really didn't have access to all of the treatment options that would, you know, potentially be beneficial to them, we just didn't see a real impact on mortality.



Jenn Tostlebe 29:05

When I think of drug treatment court, I just kind of assume, I guess that it's like the plethora of treatments like no matter what your problem is, basically, we have, you know, something that can help you. And so to think that, you know, it's 90% prevalent in the sample versus seven, I think you said 7% treatment option that just seems so drastically different. I can see what you're saying and see that that could be a big possible reason for the finding.

B

Brook Kearley 29:37

Yeah. And, you know, I mean, it's taken, it is still an issue. I think in even within the treatment community, you know, even within the recovery community of people who have used drugs, there are some stigmatizing beliefs about medications for opioid use disorder, things like methadone. I will say buprenorphine, thing wasn't, I don't even think it was FDA approved at the time of the study. So, you know, the options were limited pretty much to methadone, I believe at the time. But still, it's been there's been a lot of work, and just a lot of discussion happening within the addiction science and the treatment community to really dispel some of these myths about medication because we know from I mean, there's been systematic reviews, and all kinds of studies come out to show the beneficial impacts of medication, but people oftentimes still consider it as you know, trading one drug for another and not really being in recovery if you're using a medication. So it's definitely been a barrier.



Jenn Tostlebe 30:47

Alright, so I think I can guess some of the potential implications you're going to say, but based off of these findings, you know, what are some of the things that you say would be implications for research policy and practice?

B

Brook Kearley 31:01

Yeah, so definitely, you know, to improve these outcomes, I think increasing access, obviously, you know, the decision to use a medication or not, is really up to the individual and how they want to proceed with their recovery. But certainly providing that access and ensuring that they understand both the benefits and the risks of medication are really important. I think increasing access and training in the administration of Naloxone, which is essentially a substance that reverses the effects of an overdose. So it can bring someone out of an active overdose, increasing that access and training both to people within the correctional, you know, providers and criminal justice providers, but also to individuals themselves that are living with an opioid use disorder. I think another implication is really offering training opportunities to drug court professionals with the goal of reducing that kind of stigmatizing language and practice that has been in place for decades, and really emphasizing the use of best practice in the treatment of substance use disorder. And in this case, in particular, opioid use disorder.

J

Jose Sanchez 32:22

So speaking about policy, during our email exchanges, you actually sent us a paper that you prepared for Baltimore County regarding HB 116 and opioid overdoses. And so we'd like to talk to you about that a little bit. Can you describe to us what HB 116 is?

B

Brook Kearley 32:42

Sure. So HB 116, House Bill 116, which is now it officially went into law in January of 2023. So it is now the corrections based opioid use disorder examination and treatment act. And what that Act does is it requires that every local detention center in the state of Maryland, so these are jails, not prisons, at least at this point. But all local jails must provide universal screening for both behavioral health and substance use disorder, it must provide access to all three formularies of medication for opioid use disorder. And for individuals who screen positive for opioid use disorder, there are also some provisions that require, you know, that there are your support, offered reentry planning offered, and just different kind of access to behavioral health supports while they're in the detention center. So, this is a huge, I think, step in the right direction. I am under no illusions that our study had any impact on this decision in Maryland. But I think that just the overwhelming, you know, number of studies and anecdotal reports and evidence that was coming, you know, from all different sources, really, I think, impressed upon the legislature in Maryland that they needed to address this issue. People who are coming in and out of correctional facilities are some of the most vulnerable to opioid related deaths. So, you know, for example, in the first two weeks following reentry from prison or jail, returning citizens overdose from opioids at a rate that's 40 times higher than the general population. So,

you know, I think when our governor was looking at the opioid epidemic, both nationally and in the state, he and other lawmakers realized that if you really want to address this issue, you have to pay attention to those vulnerable folks who are cycling in and out of jail.



Jenn Tostlebe 34:59

Yeah, absolutely. Okay, so the report that you wrote is aimed really toward the Baltimore County Detention Center, and how they can stay in compliance with House Bill 116. And so can you walk us through just some of the key recommendations that you made to them in this report?

B

Brook Kearley 35:18

Sure. So we organized our reports really just like sort of provision to provision we started, you know, just providing some definition, making sure that we all have a shared understanding, you know, what the House bill was requiring, making sure that everyone was understanding, you know, what the three FDA approved medications for opioid use are, and then providing recommendations on access to behavioral health treatment access to reentry planning, we don't know how high or in the high level or in the weeds you'd like me to get. But so I think, you know, outside of just meeting kind of the requirements of the provisions, we really tried to provide guidance on best practice with regard to say, a diversion protocols, right. So as these medications are coming into the facility, one of the primary concerns for a lot of folks within the detention centers was around diversion. And so we provided some recommendations on how to minimize the potential for diversion. In terms of reentry planning, we provided some recommendations that they begin that process, at the very start of the individuals entry into the facility, that they had a peer be a part of that process from the beginning to really foster that engagement, that the peer then try to reestablish contact before an individual left the detention center so that they could help in the event that, you know, there was any kind of need for assistance with access to communit sources of medication. So within the OTPs, or the different clinics. We had recommendations to that were just really around, how do you support and sustain a program like this. And so some of our recommendations, were really focused on data, and having a kind of continuous quality improvement process in place so that you're constantly looking at data to make sure that you're both in compliance, but that the quality of care, the standard of care, and the outcomes that one would expect from a program like this are actually being achieved. We had some recommendations around workforce development, similar to the recommendations that I mentioned from the drug court paper, you know, really just providing that specialized training to folks and having kind of a tiered training approach. So that anyone working in the facility receives kind of a minimal amount of training just on medications, the efficacy of medications, and understanding of addiction and understanding of recovery. And then having more focused and specific trainings for, you know, people who would be part of the actual care team, folks, that would be part of correctional officers that might be involved in bringing people to the medication lines. So there were some Workforce Development recommendations. And then we had just some sustainability planning recommendations really around, you know, how do you best support this program, long term. Is funding that's available through the state to implement this law? But there's a lot of additional sources of support that are available through national state and even, you know, some private

foundations to really bolster and improve the quality of the program. So those were high level. I mean, the whole report is essentially one long recommendation. Those are some of the key takeaways.



Jenn Tostlebe 39:02

Awesome.



Jose Sanchez 39:04

Has there been any discussions on evaluating the implementation and effects of House Bill 116?



Brook Kearley 39:12

Yes, so right now, every jail in the state, although they're legally obligated to provide all three formularies, every jail is in a different place in terms of their implementation. But beginning in January of this year, every jail is now required to provide data up to the state to the state's Behavioral Health Administration, on some of those key factors that we were recommending, you know, that they collect. So just key utilization things like how many referrals, you know, what were the status of those referrals, how many folks ended up receiving a medication, the kind of medication, the outcomes of this medication. So, that's in place. That data is going to the state. We'll be working with Baltimore County County--we meaning myself, my colleague, Alexandra Wimberly, some other folks within school of medicine, who are doing some work in a few of the other jurisdictions. There is no--at this point that I'm aware of--a coordinated state level evaluation that's taking place. Again, I think, because folks are in different places in their implementation. But I would love to be involved, if that does come to fruition. And we're certainly, you know, providing that for Baltimore County.



Jenn Tostlebe 40:30

Awesome. Yeah, this house bill sounds really cool and a big deal. So I hope that is successful. And it can kind of provide like a pathway for other states to jump on.



Brook Kearley 40:43

I'm really excited. I'm just excited to see this shift. You know, it's sad to me that it took the national epidemic for people to really pay attention and to have some empathy for a condition that I think has touched all of our lives in some way. So just to see this shift in not only in just, you know, the provision of medication, but just in the way that folks think about addiction, I think that we're seeing kind of a softening and a lessening of the kind of stigmatizing beliefs that have been so ingrained for so long and kind of similar to other mental health conditions. So I'm really excited about it. You know, we'll see ultimately what the outcomes are. But yeah, it's good stuff.



Jenn Tostlebe 41:30

Yeah. All right. Well, awesome. That is all of the questions that we have for you today. Thank you so much for jumping on here and sharing all about your work and about experimental criminology!

B

Brook Kearley 41:43

It was a lot of fun for me, sorry about my dogs!



Jenn Tostlebe 41:46

No worries. Is there anything, you know, kind of related to these topics that maybe if people want more information, they could be on the lookout for? Any publications or reports?

B

Brook Kearley 41:57

So yes, so within the School of Social works, website, we have a number of publications, both peer reviewed publications, but also white papers and other policy papers that are attached to our it's called the B-Well lab. So it's our behavioral health wing. So work on this project and other projects related to substance use disorder, a lot of work related to the impacts of peers, peer mentorship, on outcomes in things like, you know, jail based programming. Anyway, if you would like to go to our website, there's all the, you know, typical social media as well for those. And yes, that would be a one stop shop.



Jenn Tostlebe 42:45

And then just last thing, where can people find you if they want to reach out is email best or Twitter?

B

Brook Kearley 42:52

Yes. You know, I'm not very good about checking LinkedIn. And I'm not very good about checking my ResearchGate profile. I would say, people should just email me or give me a call, but email is probably best.





Jenn Tostlebe 43:06


Alright, awesome. Thank you again, so much, Brook. It was great talking to you and kind of catching up.





Insa Sanchez 43:16


 **Jose Sanchez** 43:10
Yeah.

 **Brook Kearley** 43:16
Yeah. Great to talk with you too. Bye. Good luck to both of you on your dissertations. Not that you need luck. Just I wish you the best in your progress.


 **Jenn Tostlebe** 43:26
Thank you!


 **Brook Kearley** 43:27
All right. Bye. Bye.

 **Jose Sanchez** 43:28
Bye.

 **Jenn Tostlebe** 43:29
Hey, thanks for listening.

 **Jose Sanchez** 43:31
Don't forget to leave us a review on Apple podcasts or iTunes. Or let us know what you think of the episode by leaving us a comment on our website, thecriminologyacademy.com.

 **Jenn Tostlebe** 43:40
You can also follow us on Twitter, Instagram and Facebook @TheCrimAcademy.

 **Jose Sanchez** 43:52
Or email us at thecrimacademy@gmail.com

 **Jenn Tostlebe** 43:56
See you next time!

