EVIDENCE BASED PRACTICES

for Juvenile Justice Reform in Louisiana

Reference Document

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"Evidence-based practices are moving the fields of juvenile justice and behavioral healthcare from the conclusion of the last century that little to nothing worked to being able to repeatedly and visibly demonstrate positive outcomes for youth and families. Evidence-based practices improve the quality of care provided to youth and their families and promote child, parent, and family growth and development."
Joseph Cocozza, PhD, National Center for Mental Health and Juvenile Justice

EXECUTIVE SUMMARY

Today's research and the current body of literature regarding effective interventions drives the conclusion that in the best interest of Louisiana's youth and their families, the state must give priority to those services that offer young people the highest likelihood of developing into successful adults. This is especially true for those young people who are at risk of being removed from their homes and placed in the care or custody of the juvenile justice, child welfare or mental health systems. When purchasing services or supports for those young people and their families, Louisiana agencies should give the highest priority to services that are community based, that are in the least restrictive setting, and that are shown to be effective by empirical research. Studies on evidence based practices continue to emerge, and results consistently illustrate that they are more effective than traditional intervention methods. There are several reasons to rely on these evidence based practices which include effectiveness, cost/benefit, practice fidelity, and attention to diverse cultural needs. All these and more have been supported by research. Key findings from a number of those studies are described in this document.

We believe that once presented with the evidence, Louisiana will adopt the use of the best scientific research and evidence to shape our services to young people, their families and our communities. We refer to these as "evidence-based programs" and we know that there is consistency in the following guiding principles:

- it is preferable to treat most youth outside of institutional settings;
- it is preferable to offer youth the services they need to reduce delinquency and other destructive behaviors while increasing educational and pro-social skills;
- it is preferable to select interventions that have been proven to consistently achieve better outcomes for youth.

WHAT IS AN EVIDENCE-BASED PROGRAM?

"Evidence-based programs or practice" (also called EBPs) refers to approaches to prevention or treatment (also called intervention) that have documented scientific evidence (i.e. published research) that they work. Related to the interface of mental health issues and juvenile justice issues, we look to see how these practices reduce crime/delinquency, family conflict, substance use, academic failure, behavioral problems, delinquent peer associations, etc. as evidence of their effectiveness. In addition, evidence-based interventions can yield significant cost savings in both financial and human capital. For example, an evidence based program that has been shown to successfully treat delinquent youth in the community and decrease out of home placement may cost between $1,300 and $5,000 per family per year, while incarcerating just one youth will cost over $50,000 per year. Evidence based practices also have a high level of standardization (e.g. manuals or standardized training

Evidence based practices are standardized, replicable practices that are implemented with fidelity and have been researched and demonstrate positive outcomes in repeated studies.

Evidence-based programs have been shown to successfully treat delinquent youth in the community and decrease out of home placement at a cost between $1,300 and $5,000 per family per year, while incarcerating just one youth will cost over $50,000 per year with the likelihood of poorer outcomes for the youth, their family, and community.

materials) and are thus replicable with fidelity to the research supported design. In short, evidence-based programs must be shown to be effective and have the ability to be disseminated and implemented as designed.

WHY EVIDENCE BASED PROGRAMS?

Outcomes associated with evidence based programs include improved public safety demonstrated through reduced rates of re-arrest; improved family functioning and school performance; reduced rates of out-of-home placements; fewer days in more costly and restrictive facilities by receiving services in their homes and communities; higher retention rates of participants with fewer program dropouts; decreased drug use and symptoms of mental illness; and cost effectiveness when compared to other interventions. Evidence based programs also increase provider accountability and systems' accountability by directly linking services delivered to treatment outcomes. Furthermore, research has demonstrated that many practices do not work and some are even harmful. With that information in hand it is only ethical to avoid referring youth to programs with harmful effects and wastefully spending taxpayer dollars.

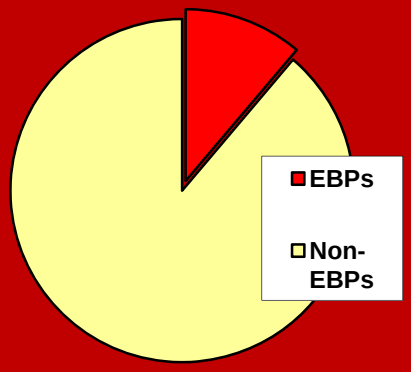
Benefit-to-Cost Ratios of Select Programs (Washington Institute for Public Policy, 2004)		
Program	Cost/Benefit for Every Dollar Spent	Outcomes related to violence, crime/delinquency or substance use
Functional Family Therapy	$13.25	Crime reduction
Life Skills Training	$25.61	Drug and tobacco use reduction
Midwestern Prevention Project	$5.29	Drug use reduction
Multi-Systemic Therapy	$2.64	Crime and drug use reduction
Multidimensional Tx Foster Care	$10.88	Crime and drug use reduction
Nurse Family Partnership	2.88	Crime and violence reduction
DARE (not DARE Plus)	$0.0	None related to violence, crime or substance use
Boot Camps*	$0.0	None related to violence, crime or substance use
Scared Straight	-$203.51	Increase crime

*The Louisiana National Guard Youth Challenge Program is not a traditional boot camp model. Outcomes for the National Guard program are unknown.

We acknowledge that we cannot expect to shift our system overnight, but we believe the system is poised for a bold path of action. That path includes utilizing our state funds to support programs and practices that can produce the best outcomes for the youth in our care. This is already being demonstrated by Louisiana's initial investments in practices such as Cognitive-Behavioral Treatment, Multi-Systemic Therapy, and Functional Family Therapy (all evidence-based practices), but we are just scratching the surface.

In 2007 a survey was done by the LSU Health Sciences Center School of Public Health and the National Center for Mental Health and Juvenile Justice. Seven Louisiana parishes participated with providers describing 152 programs/services actively engaging youth and families affiliated with the juvenile justice system. Of those programs and services, only 17 (11%) could be cross-referenced with a nationally known evidence-based practice.

Only 11% of Louisiana juvenile justice providers surveyed are utilizing an evidence-based practice



leaving youth with a 9 out of 10 chance of receiving a non-proven service.

WHAT CAN LOUISIANA DO TO MOVE FORWARD IN THE ADOPTION AND UTILIZATION OF EVIDENCE-BASED PRACTICES?

To move from our current state of programming in Louisiana to a more effective and reliable intervention delivery system for our juvenile justice and behavioral healthcare systems the following strategies are recommended…

- Prioritize funding for the implementation of the best evidence-based programs
- Include an required evaluation component if continuing to fund unproven programs
- Discontinue funding support for programs evaluated and found ineffective
- Sustain and build capacity for evidence based programs with mainstream funding (e.g. Medicaid, state contracts, etc.)
- Develop a workforce prepared to deliver evidence-based practices
- Assist smaller providers and rural areas in moving providers towards research informed practices (e.g. motivational engagement, cognitive-behavioral treatment, social-ecological approaches) where staffing patterns and/or budget constraints will not allow for the larger evidence-based programs (e.g. Functional Family Therapy, Multisystemic Therapy, etc.)

EVIDENCE BASED PRACTICES FOR JUVENILE JUSTICE REFORM IN LOUISIANA

PROBLEM

Louisiana, like many states, has a juvenile justice system that often fails to afford adolescents the required, effective treatment and assistance to reduce delinquency. Currently over 5,200 youth are served within Louisiana's juvenile justice system annually.[1] A retrospective look at the outcomes of youth who have previously interfaced with Louisiana's juvenile justice system suggests these youth have not fared well. According to the Louisiana Office of Juvenile Justice, 735 youth were in secure care in 2006 and 49.6% of those youth have recidivated. Of the 2297 youth who were in a non-secure, community program, 48.2% recidivated.[2] [NOTE: The newly appointed leadership of the Louisiana Office of Juvenile Justice has taken steps to improve these historically poor outcomes by increasing the use of the evidence-based practices as highlighted in the success stories contained in this report.]

Historically about half of all juvenile offenders continued to commit crime after interfacing with Louisiana's Juvenile Justice System.

National studies and Louisiana studies of juvenile justice involved youth demonstrate that these youth have complex behavioral health needs. As many as 67% of incarcerated male juvenile offenders and 81% of the females have been found to have a diagnosable mental illness in addition to their delinquency issues.[3] Unaddressed mental illness coupled with continued delinquent offending (i.e. high recidivism) may be linked to a reliance on, and support of, programs that have no evidence of effectiveness in reducing delinquency. For example, as recently as 2008, Louisiana continued to fund and support interventions such as "Scared Straight" and boot camp style programs. A meta-analysis of programs similar to "Scared Straight" shows these interventions almost double the odds of youth offending when compared to a non-treated control group.[4] Most of these types of programs rely on intimidation and

instilling fear that is supposed to lead to a change in the youth's behavior; however, more often than not, any lessons or skills learned by youth in these programs fails to generalize to their real world situations.[5] More specifically these programs do not directly address delinquency risk or protective factors.

Alternatively, evidence based programs such as those described in "Blueprints for Violence Prevention" and the "Surgeon General: Model and Promising Practices" address known risk and protective factors for delinquency, substance abuse, and violence on an individual and contextual level. Known risk factors increase the chances of adolescents developing health and behavior problems while protective factors provide a buffer against negative exposures.[6] Evidence based programs have shown positive effects on participants overall mental health and their relationships with family, peers, and community.

SUCCESS STORY

"My son and I needed this program if our relationship was going to continue. We all have tragedy in our lives at one point or another but it's how you handle it that will choose your path. I could not allow the path that my son and I were on to go on any longer.

My husband, my son's father, did a very selfish thing and committed suicide while Kyle was very young. For years we have tried to get past it but it has been hanging over us for a long time. Kyle started to show those pent up feelings more and more with each teenage year and I did not know what to do. As my son grew from a 6 year old boy to a teenager, the lines of communication between us closed with each passing day. My son and I were growing farther and farther apart and he was becoming more delinquent. I knew the situation needed to change.

Our FFT therapist came to work with us just in time. The first session was the hardest. There were times I doubted everything she did. Then with each session it became easier. I realized with the FFT therapist's help and knowledge that the situation could and would change. She saw us for eleven sessions in our home. The program helped us regroup as a family and learn how to move past this tragedy. I know that things are not completely perfect but they are at least 90% better than what they were. We continue to work on our relationship each day. I am grateful to have my son back." Louisiana Parent

These programs are cost efficient compared to treatment with no tangible outcomes and increased incarceration rates. Implementing evidence based programs has been shown to save tax payer dollars. According to the Washington State Institute for Public Policy, Multi-systemic

Therapy and Family Functional Therapy, both evidence based practices, produce a net benefit of $9,316 and $14,315, respectively for every dollar spent on these programs.[7] According to the 2005 Louisiana Program Accountability Measures Report, based on the rate of recidivism it cost the state of Louisiana on average $40,000 per individual in a residential program.[8] For individuals in a nonresidential programs it cost on average $8,600 per person.[9] Using evidence based programs, according to Dr. Delbert Elliott, Director of the Center for the Study and Prevention of Violence, it would cost $4,500 per youth for Multisystemic Therapy or $1,350 to $3,750 per youth for Functional Family Therapy.[10] Furthermore, these practices have been shown to reduce re-arrests and out-of-home placements by 25-55%; improve family communication and interaction patterns; decrease drug use; and decreased mental health symptoms.[11] Yet, in Louisiana, these types of programs remain largely underutilized, leaving Louisiana youth with only about a one in ten chance of receiving an evidence based practice according to one in-state study of juvenile justice providers in seven parishes.[12] It is believed that the adoption and implementation of evidence based programs throughout the state will better address delinquency and mental health issues of the youth of Louisiana.

An evidence based treatment or service is one which has been rigorously studied through randomized or quasi experimental trials in either academic or community settings and is shown to produce positive outcomes for the youth and families that receive them."

DEFINITION OF EVIDENCE BASED PRACTICE

In order to effectively promote the adoption of evidence based practices, one must understand what is meant by "evidence based". Evidence based practices are defined as a treatment or service which has been rigorously studied through randomized or quasi experimental trials in either academic or community settings and is shown

Evidence based practices target risk areas by addressing and reducing specific delinquency risk factors and maximizing protective factors. Risk factors can be placed into four different categories: individual, family, peer, and school/community.

to produce positive outcomes for the youth and families that receive them. Evidence based practices also have a high level of standardization (e.g. manuals or standardized training materials) and are thus replicable with fidelity to the research supported design.[13] In short, they must be shown to be effective and have the ability to be disseminated and implemented as designed.

CHARACTERISTICS OF EVIDENCE BASED PRACTICES

There are a number of characteristics which are generally consistent among evidence based practices.[14] Evidence based practices…

- are grounded in conceptual modes that emphasize the enhancement of healthy functioning;
- promote child, parent, and family development;
- demonstrate effectiveness in replicated research studies using different samples of youth and/or families;
- should be feasible (i.e. have a reasonable cost and training that is easily available);
- should be based on clear, well articulated theory;
- are consistent with delivery of the treatment over time (i.e. fidelity), thus practice is received as designed;
- are often designed to reach culturally diverse populations;
- and can be used by staff with various professional backgrounds as applicable to the type of intervention.

TARGETING SPECIFIC RISKS AND NEEDS

Service recipients want the care that has been demonstrated to best address the complaint or problem they are experiencing. When we go to a doctor, we expect that the physician is going to utilize the latest, most effective treatments available. For instance, we don't expect our healthcare physician to treat lung cancer with aspirin or foot surgery. The same standard of best

practice should translate to behavioral health. Youth and families experiencing and/or are at risk for delinquency, violence, substance abuse, and other behavioral health problems should be able to expect the best available care known to treat the problem at hand. Through research we know that a number of programs have demonstrated effectiveness with certain risk and/or need areas (see Figure 1).

Figure 1. Risk and Needs addressed by Various Evidence Based Practices

RISK/ NEED AREA	EVIDENCE BASED PRACTICE
Delinquent Behavior	BSFT, MRT, MST, FFT, MDTFC, MDFT
Substance Abuse	BSFT, FBT, FFT, MST, MI, CBT, MDFT
Mental Health / Emotional Disorders	CBT, MI, MDTFC
Violence	MST, MDFT
Family Functioning	BSFT, FBT, MST, FFT
School Attendance	BSFT, FBT, MST, FFT
Conduct Disorders	FBT, BSFT, FFT, CBT, MDFT
BSFT: Brief Strategic Family Therapy, **MRT**: Moral Reconation Therapy, **MST**: Multisystemic Therapy, **FFT**: Family Functional Therapy, **MDTFC**: Multidimensional Treatment Foster Care, **FBT**: Family Behavior Therapy, **MI**: Motivational Interviewing, **CBT**: Cognitive Behavioral Therapy, **MDFT**: Multidimensional Family Therapy.	

NOTE: A brief description of each of these evidence based practices is in Appendix A

Evidence based practices target risk areas by addressing and reducing specific delinquency risk factors and maximizing protective factors. Risk factors can be placed into four different categories: individual, family, peer, and school/community. For example impulsive, antisocial behavior, which are both individual risk factors, are strong predictors of adolescent delinquency such as theft, fighting, and vandalism, thus a successful intervention would target and develop skills to decrease impulsivity and not reinforce antisocial behaviors. To address family risk factors, interventions often target parenting skills, parent-child conflict, and abusive/neglectful behavior. Peer risk factors associated with delinquency include association with deviant peers and rejection by peers, thus interventions focus on pro-social associations. Finally, school/community risk factors include poor academic performance, living in a poverty, and access to weapons, thus interventions that are successful increase school affiliation and

success and/or expose youth to mentors and programs that model standards beyond those reinforced in their immediate neighborhood.[15] Research-based screening and assessment instruments, like the Structured Assessment of Violence Risk in Youth (SAVRY) currently being implemented by Louisiana's Office of Juvenile Justice, assist in identifying these risk and protective factors. Below is an abbreviated list of risk and protective factors noting gender differences (Figure 2).

Figure 2. Risk and Protective Factors Associated with Delinquent Behavior

Risk Factors

Individual

- Low intelligence; cognitive, learning, and language problems
- Poor impulse control
- Not taking responsibility for behavior
- Admiration for antisocial behavior
- Perception of others as hostile
- Early onset of delinquency
- Child working more than 20 hours per week
- Poor social skills

Family

- Poverty
- Low education levels
- Conflict and hostility at home
- Ineffective parental discipline and monitoring
- Physical/sexual abuse
- Familial substance abuse and psychiatric problems
- Parental criminal history
- Lack of warmth and affection between parents and child

Peers

- Association with delinquent youth (for older youth / adolescents)
- Peer rejection (for younger children)
- Association with youth who use drugs or alcohol
- Gang membership
- Poor achievement/grades

School:

- Falling behind same-age peers
- Poor attendance

Community

- Availability of drugs and weapons
- Poor support network
- Isolation from neighbors
- Living in 'dangerous' neighborhoods
- Frequent family moves

Factors increasing girls risk more than boys

- *Early puberty*
- *Sexual abuse or maltreatment*
- *Depression and anxiety*
- *Affiliation with delinquent romantic partner*

Protective Factors

- Resilient temperament
- Positive social orientation
- Intelligence
- Positive relationship with adult(s)
- Consistent system of recognition
- Opportunities for active pro-social involvement
- Belief in child's competence to succeed in school, avoid drugs and crime are voiced and clear expectations for rules governing such behavior are stated

Factors highlighted for decreasing girls' risk

- *Perception of the presence of caring adult*
- *School connectedness*
- *School success*
- *Religiosity (placing high importance on religion during adolescence)*

(Adapted from Catalano & Hawkins, 1995; Wasserman et al, 2003; and Zahn, Hawkins, Chiancone & Whitworth, 2008)[16,17,18]

OUTCOMES ASSOCIATED WITH EVIDENCE BASED PRACTICES

There are several reasons to rely on evidence based practices which include effectiveness, cost/benefit, fidelity, and attention to culturally diversity.

Although studies on evidence based practices are continually being conducted, current research has shown certain practices that are reliable and should be utilized to increase the likelihood of positive outcomes. These outcomes include effectiveness, improved cost/benefit, fidelity, and attention to culturally diversity. Each of these has been supported in various studies. Key research findings are summarized below.

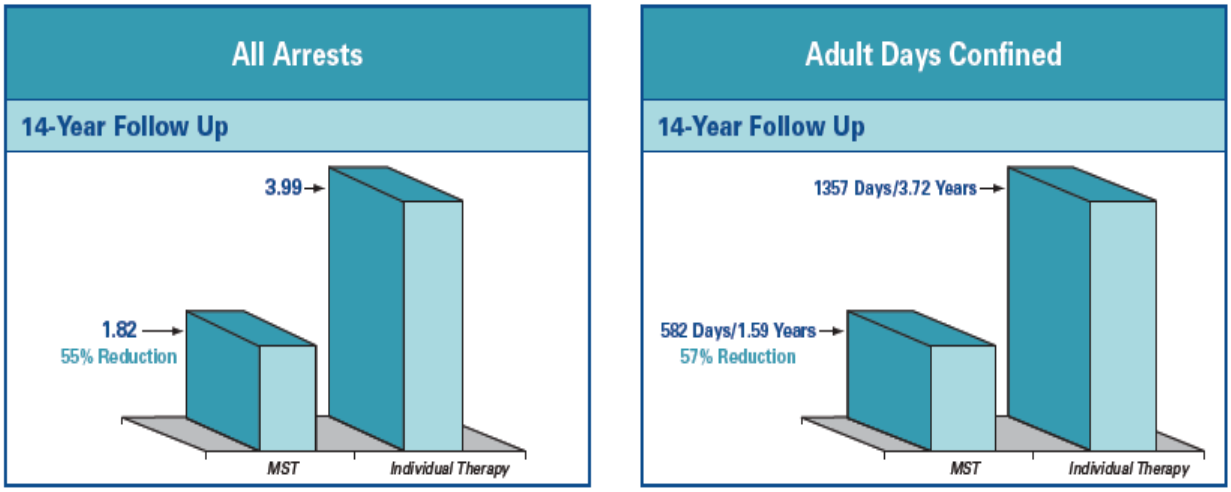
The **effectiveness** of evidence based practices has been demonstrated in numerous instances showing the positive outcomes associated with specific interventions. For instance, Multisystemic therapy, used with violent or substance abusing youth and those who are at risk of such, has shown positive results such as decreased substance abuse, reduced psychiatric symptoms, fewer associations with negative peers, less antisocial and criminal activities, increased school attendance, and improved family relations and functioning in addition to decreasing re-arrest.[19] In one study (illustrated in Figure 3) to determine the long term effects Multisystemic therapy with youth who had been previously arrested, adolescents who

SUCCESS STORY

"MST has made such a difference in our lives. I have learned how to manage myself and my child and we have a much better relationship now because of that. My MST therapist was always there when I needed her, no matter what time. She understood my family's situation and always made me feel like there was hope, no matter how bad it was. My daughter is now off probation and hasn't been in trouble again. Before MST, she had been in detention and was always running away, fighting, stealing, and doing drugs. I thought detention would teach her a lesson, but it had no affect on her. I could not control her and I was afraid she was going to end up in prison for good. She would threaten to hurt me if I tried to stop her. I even went through a time when I thought about just shipping her off to detention for good because I couldn't handle her or deal with the stress. I can't thank my MST therapist enough for what she has done for my family. I would recommend this program to any family in need of some help with their child." – Louisiana Parent

participated in Multisystemic therapy were found to be less likely to recidivate, and, if they were rearrested, they spent fewer days in confinement compared to youth who experienced routine individual therapy.[20]

Figure 3. Fourteen Year Follow-up of Multisystemic Therapy Participants



(Source MST Services at www.mstservices.com)

Other examples of effectiveness come from studies of Functional Family Therapy and Brief Strategic Family Therapy. Both of these family focused interventions are used to help children and adolescents with conduct, delinquency, and other behavior related problems, including alcohol and substance abusing behaviors. Each of these problem behaviors are addressed by the intervention successfully changing family interactions while also considering cultural dynamics that may influence these factors.[21] Brief Strategic Family Therapy has shown positive results such as reduced marijuana use, improved conduct, reduction in associations with antisocial peers, and retention of families in the program.[22] Through more than thirteen published studies, Functional Family Therapy has demonstrated dramatic and significant positive treatment effects, including sustained effects during five year follow-up periods.[23] These findings show lower rates (between 25% and 60% reductions) of reoffending as well as foster care and

institutional placements in comparison to youth assigned to matched alternative treatments.[24] In one study of Functional Family Therapy a positive three-year follow-up effect was demonstrated on siblings of the youth initially referred to the intervention.[25] Taken together, over three decades of data and clinical experience with these interventions by hundreds of therapists and thousands of families have provided strong

SUCCESS STORY

"I was lucky and grew up with both my parents. Around third grade is when I started getting into more and more trouble. I was disrespectful, fighting, and not doing my work. It didn't look like much, but over time it became more serious. Fourth grade was when running away from home and school began. By sixth grade I was already smoking cigarettes and had begun using pot, eventually becoming addicted. By seventh grade I was using other drugs too and I kept getting into more trouble. The school was sick of me causing trouble. I even made teachers cry, which I used to think was funny.

I was full of anger and addictions. My parents were constantly yelling and fighting over me. Sometimes they would have me tested for drugs, but I always found a way to fake the test. I told them I didn't use, and they didn't seem to want to know or care who I was doing it with. I consistently ran away every time things did not go my way, and I had my entire family afraid of me because I would threaten to hurt them. I had no fear of authority. Sometimes my parents would call the cops on me and I would get taken to a group home for a few days or thrown in detention. It was never really a punishment for me because I could meet up with some kids I knew there. In the group home, I made a plan with some of the kids to run away and get high. No one tried to stop us, so we didn't care about the consequences.

The last time I ran away ended up as a night I will never forget. I was 16 years old. I met up with some of my so-called friends to party. We were all high and decided to steal a car to take a joy ride. We ended up wrecking the car and doing a lot of damage. The cops got called and most of my friends bailed, leaving me to get in trouble. I was taken to detention again, but this time it was serious. I had a court date and got sentenced to 90 days.

When I got back home, I found out about MST. My Probation Officer had referred my family to the program. At first I didn't like it at all. Our therapist was always there and it seemed like she was just trying to get in our business. But then she asked what I wanted to change and what my parents wanted to change. She seemed like she really focused on them. I didn't even have to come to some of the meetings. She helped my parents put a behavior plan in place and connect me with good kids to hang out with, not drug users and drop outs. I didn't like it because I didn't want to follow the rules.

A few times, I purposely disobeyed because I figured my parents didn't care enough to do anything and there wouldn't be a consequence. I was wrong. They gave me consequences for everything, but sometimes they gave me some good rewards. My parents worked with me and the therapist to figure out what was "triggering" my substance use. She helped them get along better and quit fighting too.

Our family is totally different now. I am back in school and almost on the honor roll. I am playing football and having a lot of fun. I still get to hang out with my friends, but only the ones who are doing good too. I earned a cell phone and Xbox as rewards for doing good. It is cool to not have all the fighting anymore and I feel proud I am sober. I learned how to handle my anger in a better way and my parents don't scream at me. I just want to say thank you MST for helping us and helping me not end up back in detention."

– Louisiana Youth

empirical support for these family-based interventions with adolescents.

In addition to being effective, evidence based practices are also **cost efficient**. In today's economic downturn, funds for service delivery are limited, so it is more important than ever to maintain cost efficient programs. A number of evidence based programs have demonstrated an ability to reduce the overall cost of services. The Washington State Institute for Public Policy has conducted several studies on the cost/benefit ratio of programs targeting juvenile delinquency. For example, Multisystemic Therapy may cost $4,264 per child, but the benefits of this initial investment far outweigh the cost. For every dollar spent, tax payers save $4.27 by not having to pay for re-arrest, out of home placements, or supervision, thus the overall benefits were shown to total $18,213 per child.[26] The cost per child for Family Functional Therapy in the Washington State study was $2,325. However, for every dollar spent, tax payers ultimately save $13.69; resulting in a total savings of $31,821 per child.[27] Transferring the lessons from the Washington State experience, Louisiana could allocate more money to implementing and sustaining evidence based practices by eliminating programs which are not cost effective.

Evidence based programs are also reliable and replicable because they focus on competent delivery and **fidelity** of program administration. Fidelity means the practices have consistent implementation, delivery, evaluation, and supervision. The programs are administered with little or no change each time. Fidelity maintains and delivers the program as researched and determined to be effective, therefore "evidence based." In a study to determine recidivism rates within eighteen months of treatment, adolescents who were treated with Functional Family Therapy or a control group were compared. As an

additional component of the study, therapists were evaluated and deemed either competent in their delivery of the Functional Family Therapy and or not competent (i.e. were not implementing the program as trained). When compared to the control group in areas such as felony recidivism and violent recidivism, those adolescent who were treated by competent therapists showed reductions in recidivism of 38% and 50% respectively. On the other hand, there were noticeable increases in recidivism when the adolescents were treated by therapists deemed "not competent".[28] This and other similar results show that these programs are most effective when administered by well trained, competent and supervised practitioners. Measures of fidelity are part of the package received when investing in Functional Family Therapy and many other evidence based practices.

Evidence based practices are advantageous because they can be used with **culturally diverse groups**. Many evidence based practices have been studied in culturally and racially diverse communities, as well as rural and urban settings, and have continued to demonstrate successful outcomes. For example, in one Nevada study of Functional Family Therapy that included a sample made up of 30% African American, 20% Hispanic/Latino, and just under 50% Caucasian adolescents (and a very small percentage of American Indian and Asian Americans), no difference in reoffense rates among the different ethnic/racial groups were found.[29] Replication studies, sponsored by the National Institute on Drug Abuse, are underway in numerous culturally diverse sites across the U.S. including both urban and rural settings.

One nuance of the effectiveness of evidence based practices with different cultures is that better outcomes have been demonstrated when there is practitioner-to-client culturally matching. According to a study performed to understand the effects of

caregiver-therapist ethnic similarity on youth outcomes from Multisystemic Therapy, youths whose caregivers were ethnically matched with their therapists demonstrated greater decreases in symptoms, longer treatment engagement (i.e. less drop out), and increased likelihood of discharge for meeting treatment goals relative to youths whose caregivers and therapists were not ethnically matched.[30] In addition, for youths whose caregivers were of mixed ethnic heritage, caregiver-therapist ethnic match was associated with greater improvements in psychosocial functioning.[31] In another study, treatment outcomes of Hispanic and Anglo substance-abusing adolescents in Functional Family Therapy were examined. Results showed that Hispanic adolescents who were ethnically matched with their therapist demonstrated greater decreases in their substance use compared with Hispanic adolescents with Anglo therapists.[32]

Better outcomes have been demonstrated when practitioners are culturally matched with their clients.

CHALLENGES FOR EVIDENCE BASED PRACTICES

Good management and leadership demands that one is honest with both success and the challenges that exist to be addressed. As evidence based practices continue to evolve, there are aspects of these practices that have been criticized and are continuing to be problem solved. Three issues frequently discussed are model adaptations, staff turnover rates, and initial cost which can hinder the implementation of evidence based practices and fidelity in sustaining the practice.

Since evidence based practice implementers usually try to ensure the programs are delivered with fidelity, there is little room for adaptation. Most evidence based practices have a highly structured approach that many practitioners are not willing to

adopt or they try to fit certain parts of the practice into existing programs and thus do not practice the intervention as it has been shown to be effective. Regardless of the level of caution used to maintain fidelity, programs may lose fidelity to the original model over time as they lower supervision standards or fail to keep up with training. Programs may also attempt to alter the model in order to implement it differently to fit their unique settings.[33] Continuous outcome monitoring and reporting as part of contracted service requirements can help to address some of these issues.

Another challenge for evidence based practices has been workforce turnover rates. Turnover rates for workers trained in evidence based practices can be high.[34] This may be due to time dedicated to training and supervision required of the practitioners which is seen as a burden given their workload or a financial cost to the organization that has to cover these indirect costs and loss of service delivery income during training. It may also be attributed to the method of service delivery itself (e.g. in-home services, frequency of contact, etc.) which few practitioners are prepared for during their formal years of college education. Organizations should be aware of the level of training and supervision required to maintain evidence based practices and hire staff with realistic expectations regarding the work setting and practice demands. Although a challenge, evidence based practices provide an opportunity for practitioners to learn new skills beyond their college education and previous practice experience. Planning for turnover, training, and ongoing supportive supervision upfront can help lower the impact of staff changes.

Finally, initial cost, frequently not considered in comparison to the long term savings and benefits, are discussed as a challenge in implementing evidence based

practices. Most evidence based practices are well packaged for dissemination and implementation, but the necessary training and acquisition of these program materials comes with a financial cost. For example, in 2008, the Louisiana Office of Juvenile Justice assisted in the implementation of the first five Functional Family Therapy teams in Louisiana. Each site cost approximately $55,000 to be trained and licensed (this includes training, outside supervision by consultants, and travel costs but not the salary of each of the practitioner which differed between sites). For that initial investment by the state, these sites in Alexandria, Lake Charles, Jefferson Parish, and the 16th Judicial District, each have teams consisting of 3 to 5 trained practitioners that treated over 270 justice-involved youth during the 2008-2009 fiscal year. Preliminary data indicate an 84% retention rate of youth in the program with only 6% of those youth rearrested to date. Planning for upfront costs, training time, supervision time, etc. is thus critical to also afford youth with better treatment and outcomes.

INEFFECTIVE PROGRAMS

Evidence based practices, like all programs, present real challenges in implementation and sustainability; however, when compared to numerous other programs for adolescents, research has also made clear that states continue to fund and support less effective and even ineffective, harmful programs through tax payer dollars. Research has shown programs and practices such as transfer to adult court, Scared Straight, and boot camps fail to produce changes in delinquency offense rates and related delinquency risk factors. In some instances, these programs not only fail to produce change in delinquent behavior, they have actually been associated with increases in delinquency,

substance/alcohol abuse, aggressiveness, symptoms associated with mental illnesses, and overall cost to the system.[35, 36, 37, 38]

IMPLEMENTATION OF EVIDENCE BASED PRACTICES

Once an individual or organization determines evidence based practices are preferred, there are several factors which must be taken into consideration for a program to be successfully implemented. These include assessing needs, organizational effectiveness, qualifications of the staff, program integration, funding, and training and technical assistance. Each of these is briefly reviewed below.

Before an evidence based practice is implemented, the need for the program must be assessed since different programs target different issues.[39] Those who want to implement a program must consider the risk factors and needs of the target population (e.g. substance use, aggression, family conflict, etc.). In addition, there should be research to see if similar programs are already implemented and possibly simply being underutilized in the region. Once the needs of the target population have been successfully assessed, the appropriate program to address the identified needs should be researched. There are a number of resources to aid in this research including, but not limited to the following:

- Louisiana State University Health Sciences Center (Community Based EBP Project- Sponsored by the MacArthur Foundation Models for Change in Juvenile Justice initiative). Stephen Phillippi, PhD sphill2@lsuhsc.edu
- Hyde, PS; Falls, K; Morris, JA: and Schoenwald, SK (2003) Turning *Knowledge into Practice*. Available free at www.tacinc.org
- Blueprints for Violence Prevention http://www.colorado.edu/cspv/blueprints/
- OJJDP Model Programs Guide http://ojjdp.ncjrs.org/programs/mpg.html
- SAMHSA Nat'l Registry of Evidence-Based Programs and Services (NREP) http://www.modelprograms.samhsa.gov

Choosing the most appropriate program can increase acceptance by stakeholders and ultimately gain the tangible results desired for the target population.

Sites and organizations must also be assessed to determine the effectiveness of the organization, qualification of the staff, program integration, and training and technical assistance needed.[40]

- **Organizational Effectiveness:** An effective organization includes administrative support, agency stability, a shared vision, and interagency links. Support by administration is needed to lead and motivate those involved in implementing the program. In addition, administrators must be onboard for the necessary acquisition and allocation of funds to support the program. Agency stability, for example a low turnover rate of staff or history of financial soundness, should be considered. An effective organization also has a shared vision. Staff should be in general accord with the goals, objectives, and outcomes of the program. Finally, the organization should have sufficient interagency links in order to get referrals, assistance with treatment, assistance with grant writing to obtain funds, and the capability to publicize the program.
- **Qualified Staff:** Not only does a program need agency leadership's support, it also needs the support of the staff. It is common to find that staff are enthused during the beginning stages of implementation of an evidence based practice but lose motivation when faced with the challenge of sustaining new efforts. Change is difficult, especially when asking existing staff to alter their routine. Staff must be committed to long term change and supported by leadership in what it takes to sustain that change.[41] Staff preferably have experience working with the targeted

population and must have the necessary credentials as defined by the selected program or practice.

- **Program integration:** Program integration means linking the goals and objectives of the selected evidence based practice to the goals and objectives of the agency and its staff. Matching is critical as an evidence based practice should fit within the scope of the agency's mission and work.
- **Training and technical assistance:** Training of program staff as well as stakeholders is essential to provide information on the evidence-based practice, its proper application, correct implementation, and expectations for utilization. Training also helps to build confidence within staff and clearly identify the standards necessary for proper implementation and fidelity.

CONCLUSION

Evidence based practices are services and treatment that have been rigorously studied and shown to produce positive outcomes for the youth and families that receive them. They have been disseminated successfully in numerous cities and states and are practices that are available for implementation throughout Louisiana right now. Knowledge, support, and funding for these programs are crucial. Given current appropriations, the cost to implement, expand, or sustain evidence based practices may even be realized by the state redirecting funds from programs that fail to produce outcomes or have already been demonstrated to be ineffective. Research and innovative programming has afforded the opportunity for us to clearly state that there are preferred and effective practices available to youth and families involved in the juvenile justice system. Conversely, failure to provide access to those services and practices that are

known to exist, or worse, dooming youth to programs that do not work, should be considered unethical and unacceptable for those entrusted to our systems of care.

APPENDIX A

Brief Descriptions of Evidence Based Practices listed in Figure 1.

(NOTE: This is not meant to be an exhaustive list of evidence-based practices)

Program	Description
Brief Strategic Family Therapy (BSFT)	Designed to prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, aggressive/violent behavior, and association with antisocial peers; improve prosocial behaviors; and improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases.
Cognitive-Behavioral Therapy (CBT)	CBT works to reduce behavioral and emotional problems, while increasing positive, adaptive behaviors. Interventions typically come in the form of challenging thinking patterns, teaching skills, and establishing a system of reinforcement for desired behavior. Success in intervening and changing one targeted behavior is then generalized to assist in targeting other problems and issues.
Family Behavior Therapy (FBT)	Treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth. Participants attend sessions with at least one significant other, typically a parent. Treatment consists procedures to teach skills and reinforce behaviors that are associated with abstinence from drugs, spending less time with individuals and situations that involve drug use and other problem behaviors, decreasing urges to act impulsively, establishing social relationships with others who do not use substances and avoiding substance abusers, and training skills associated with getting a job and/or attending school.
Functional Family Therapy (FFT)	Targets youth ages 11-18 at risk for and/or manifesting delinquency violence, substance use, Oppositional Defiant Disorder, or Conduct Disorders and their families. Focuses on family relations and communication; builds on strengths as motivation for change. Flexibly delivered to clients in-home, clinic, school, juvenile court, or other community settings.
Moral Reconation Therapy (MRT)	Seeks to decrease recidivism by increasing moral reasoning. Uses structured group exercises and prescribed homework assignments. Focuses on seven issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and

	habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Participants meet in groups once or twice weekly.
Motivational Interviewing / Motivational Enhancement Therapy (MI / MET)	Goal-directed, client-centered approach for eliciting behavioral change by helping clients explore and resolve ambivalence related to specific change. Applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Community-based assessment & treatment centers have incorporated MI into the initial intake/orientation sessions to improve program retention.
Multisystemic Therapy (MST)	Targets chronic, violent, and substance abusing delinquents age 12-18 at high risk for out of home placement. Focuses on the entire ecology of the youth including family, school, peer, and community relations. Strives for behavior change in the youth's natural environment, using the strengths of each system (e.g. family peers, school, neighborhood, etc.) to facilitate change.
Multidimensional Family Therapy (MDFT)	Family-based outpatient or day treatment program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk other problem behaviors such as conduct disorder and delinquency. Helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems. Targets (1) the youth's interpersonal functioning with parents and peers, (2) parenting practices and level of adult functioning, (3) parent-adolescent interactions, and (4) communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).
Multidimensional Therapeutic Foster Care (MDTFC)	Targets juveniles ages 12-17 with histories of chronic and severe delinquent behavior and/or severe mental health problems at risk of incarceration or psychiatric hospitalization who need residential placement. Recruits and supports host families with program goal to return youth to permanency placement (e.g. biological family). Emphasizes behavior management methods with the youth in a structured, therapeutic living environment while also working with the parents during weekly group meetings.

(Source: Descriptions adapted from Phillippi & Schroeder, 2006, Phillippi & DePrato, 2009, and information at http://www.colorado.edu/cspv/blueprints/index.html; and http://www.nrepp.samhsa.gov)

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