ASSOCIATION FOR THE ADVANCEMENT OF
EVIDENCE-BASED PRACTICE

IMPLEMENTING PROVEN PROGRAMS FOR JUVENILE OFFENDERS

Assessing State Progress

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Advancing Evidence-Based Practice is a nonprofit association of program providers, program developers, researchers, intermediary agencies, government agencies and policymakers all working to promote evidence-based programs for at-risk youth.

Our mission is to promote the development, adoption and effective implementation of evidence-based programs for at-risk youth and families and increase the numbers of youth and families served by such programs.

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EXECUTIVE SUMMARY

Evidence-based practice involves the use of scientific principles to assess the available evidence on program effectiveness and develop principles for best practice in any particular field. In delinquency prevention or intervention this includes: assessment of community and individual client needs; review and assessment of programs that could meet those needs; development and/or implementation of new programs; assignment of youth to particular programs; and monitoring of program fidelity and outcomes. For more than 10 years a number of reliable agencies have been publishing well-scrubbed lists of programs that have been proven to produce substantial reductions in recidivism and crime, while saving taxpayers more than $10 in future correctional costs for every dollar expended.

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There is a long history, stretching from Copernicus and Galileo in the 16th century to professional baseball managers in present day, of practitioners taking a very long time before accepting the practical implications of scientific discoveries. Juvenile justice fits right into this pattern. Although there are sufficient resources currently invested in juvenile justice programs to provide a program that has been proven effective for every youth who could use one, less than 10 percent of youths in need actually receive these programs.

Given this state of affairs, one might expect that most states would be in the process of revising their programs and case disposition processes to increase the participation of youth in programs that have been proven effective. In fact, a few states have responded to this knowledge by taking explicit steps to facilitate the implementation of these proven programs, often as alternatives or replacements for their more traditional programming. Some of these states have set up special resource centers to provide technical assistance to local providers and to monitor their progress in implementing these programs. Some have established local "compacts" for sharing the expected savings in state prison costs with counties who cut their admission rates through the use of evidence-based programs (EBPs). Others have established special funding streams to support the launch of new EBPs. Yet, many others have not taken any but the most rudimentary steps toward embracing this new opportunity in the field of delinquency prevention.

The present study was undertaken to assess how well individual states are doing in providing the best of these EBPs, and whether there are any commonalities between those who were doing the best. The measure of performance we chose for this analysis was the number of "therapist teams" from "proven programs" divided by the total population.

Figure E1 Below shows the number of family therapy teams per million population for all of the states that have begun to implement these programs. It is easy to see that there is a very wide spread between the top five states (Connecticut, Hawaii, Louisiana, Maine and New Mexico) and all others. There is also a big difference between those in the middle range of progress and those who have made very little progress. The top five states share a number of characteristics in common. In all of them, the administration of juvenile justice programs is completely separate from and not subservient to adult corrections and probation. In three of them, juvenile justice is administered at the state level while Louisiana and Hawaii have local probation departments, which is typical of more than half the states in the nation. Four of the top five states started exploring EBPs in the late 1990s. Louisiana is the only one that did not begin taking EBPs to scale until more recently (2006).

Figure E1: Family therapy teams per million population by state, 2011
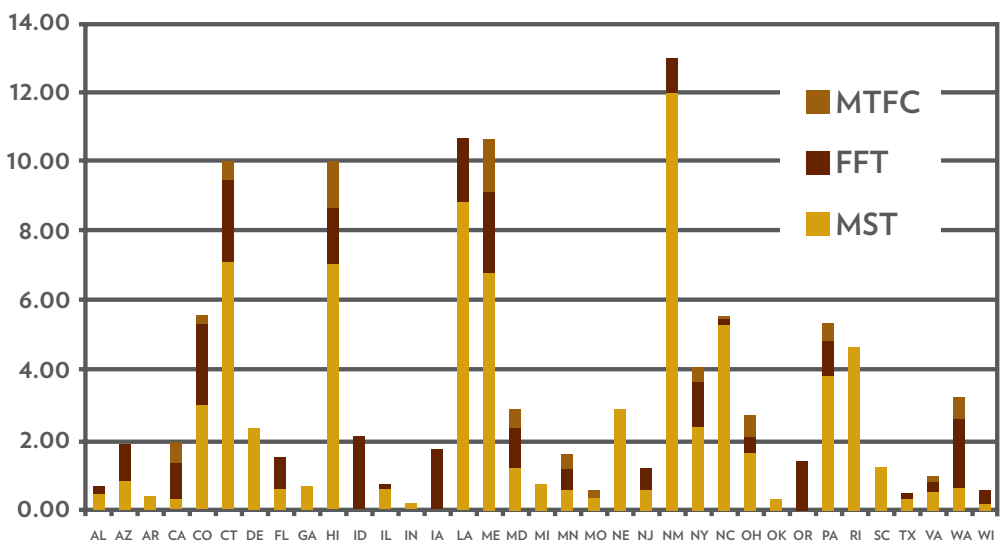
More similarities that are a good indication of how other states should proceed include:

1.) Turning crisis into opportunity: Three of the leading states were being sued by the federal Department of Justice over conditions in their juvenile institutions. In the other two, there was a growing political consensus that many youth being sent to placement did not belong there. All five leading states were able to capitalize on this crisis of confidence by bringing appropriate stakeholders together and identifying capable individuals to take charge.

2.) Structured involvement of all key stakeholders: Effective changes in juvenile justice programming efforts require the cooperation of many state and local agencies, including state departments of children and families, mental health, probation, law enforcement, and school systems. All of the leading states created high-level stakeholder groups to oversee the process of rolling out EBPs. In Connecticut, it was the Governor's Blue Ribbon Commission on Mental Health in 2000; in Maine it was the Juvenile Justice Advisory Group; in New Mexico it was the Behavioral Health Collaborative; in Louisiana it was the Juvenile Justice Implementation Commission; and in Hawaii it was the Empirical Basis to Services Task Force and the local Community Councils.

3.) Emergence of champions: All of the five leading states had widely recognizable champions that varied from key department heads to a behavioral health consultant to the governor to an associate commissioner of corrections. Everybody knew who these champions were, and they were effective in that role.

4.) Development of local expertise: All of the leading states identified at least one person to become fully informed about the available EBP options and made the time available for them to do this, including travel to operational sites and training in specific models.

5.) Pilot testing of new evidence-based programs: All but one of the leading states picked one or two sites in which to test the program models they had selected as the best to suit their needs. The pilot tests were closely monitored and the results were widely shared.

6.) Creation of information resource centers: These centers, sometimes called the Center for Effective Practice (CEP), became the primary bridge between the science of EBPs (e.g., review articles, assessment instruments, training consultants) and the practitioners. CEP staff would sit in on practitioner meetings to better understand their needs, and then develop analytical or informational tools to help address them. Practitioners would ask CEP staff for information about particular problems, or programs they may have heard about, and receive timely, unbiased answers.

7.) Designation of small number of EBPs to be supported by state: All of our leading states started out supporting just one EBP, either Multisystemic Therapy (MST) or Functional Family Therapy (FFT). All of them added additional programs to the list of what they supported, albeit slowly. New Mexico and Hawaii still mainly support MST, with just a few FFT teams currently in operation. Connecticut, while still a heavy MST user, has elected to support more than a half-dozen other proven or promising models.

8.) Special funding for designated evidence-based programs: The availability of funds to support the very important but non-revenue producing pre-implementation aspects of a new EBP can be a challenge. That challenge is reduced if the state can support some of those costs.

9.) Technical assistance to counties for needs assessment, program selection and implementation: Since, in most states, counties are far from uniform in size or demographics, it is seldom likely that a one-size policy reform will fit all. Research has demonstrated that local communities will get better outcomes if they receive proper training in how to assess their needs, select programs and then implement them. It has been proven that the spread of EBPs becomes much more rational and effective when states are able to serve local communities in this way (Hawkins et al., 2008).

Connecticut is an example of where the two state agencies responsible for juvenile offenders, Children and Family Services and the Court Support Services Division, took the lead in investigating programs that could provide evidence-based alternatives to out-of-home placement. This followed a large public uproar over the conditions in some of the placement facilities they used. Connecticut policymakers also discovered the need to create a CEP that could evaluate program performance and help develop new program models.

Maine is an example of a state where a high-level official in the corrections department took the lead, and turned to the state university system for assistance in reviewing the literature and tracking outcomes.

New Mexico represents a third model. It has turned over much of the responsibility for selecting programs and providers to a Behavioral Health Consortium that also monitors their outcomes. As a cost-effective means of meeting their MST training needs, New Mexico turned to Colorado's Center for Effective Interventions, which was already an MST Network Partner supervising programs in Colorado, to provide training and oversight for MST therapists in New Mexico.

Hawaii was another early investigator and adopter of EBPs for at-risk adolescents and families, but through the auspices of the Department of Health and its Center for Adolescent Mental Health. Referrals to these programs come from the schools but not the juvenile courts.

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Louisiana did not become interested in EBPs in an organized way until 2006. Like Connecticut, Louisiana was rocked by scandalous stories (including profiles in the New York Times) about conditions in their juvenile institutions. A federal lawsuit was brought by the U.S. Department of Justice, asserting that the civil rights of juvenile inmates were being violated. Through the influence of some powerful champions in the state, it was agreed that Dr. Debra DePrato, a medical doctor and senior faculty member of the Health Sciences Center at Louisiana State University, and the former director of juvenile justice services in Jefferson Parish, would take over responsibility for medical services and behavioral health within all juvenile institutions in the state.

Dr. DePrato's success in that assignment led to her being asked by the state (and the MacArthur Foundation) to help develop more effective community-based services for juveniles and to lead their Models for Change project in Louisiana. Dr. DePrato and her handpicked team (one of her conditions for taking the job) have had a dramatic effect on the availability of proven programs for the youth of Louisiana. That success appears due to: the extensive efforts DePrato and her team put into developing good working relationships with and educating all the key stakeholders, both at the state and local level; and the technical assistance tools developed and disseminated by the team, helping local parishes with the problems of program selection and implementation.

Given the obvious and well documented benefits of evidence-based family therapy programs in our five leading states, there is absolutely no reason why other states, who have to be concerned with the costs and effectiveness of their crime prevention programs, should not have a well-developed plan and be well underway to adopting such programs and taking them to scale.

INTRODUCTION

It has been 15 years since the Blueprints for Violence Prevention program at the University of Colorado first identified 10 programs that met their rigorous standards for being called a proven model program (Elliott, 1997). During this same period, economists developed cost-benefit models that allowed them to estimate, with a fair degree of accuracy, the likely costs and benefits that would accrue if these programs were adopted, in particular settings. These cost-benefit studies suggested that in most states, every dollar invested in one of the more effective programs would result in $7-10 in benefits to taxpayers, mostly in the form of reduced spending on prison construction and operations (Drake et al., 2009; Greenwood, 2006).

If these facts are indeed accurate then one might think that every state would be in the process of revising their service delivery and case disposition processes to take advantage of the opportunity. In fact, a number of states have responded to this knowledge by taking explicit steps to facilitate the implementation of these proven programs, often as alternatives or replacements for their more traditional programming. They have screened the lists of EBPs put forward by various groups and adopted their own list of proven programs they will support. They have established special funding streams to support the launch of new EBPs. They have adopted common assessment instruments so that different localities can compare results.

Some of these states have set up resource centers to provide technical assistance to local providers and to monitor their progress in implementing these programs. Some have established local "compacts" for sharing the expected savings in state prison costs with counties who cut their admission rates through the use of EBPs. Yet, many others have not taken any but the most rudimentary steps toward embracing this new opportunity in the field of delinquency prevention.

Although the arguments in favor of shifting resources to evidence-based practice may sound compelling, the obstacles can be substantial. The first is financial. Prevention programs require coordinated local investment and action involving: juvenile courts, probation, mental health, public health, child welfare, education, and other stakeholders. Most of the direct financial benefits accrue to the state in the form of reduced future prison commitments. In states where the juvenile court and probation are run by the state, this may not be a problem. But in the majority of states where juvenile courts, probation and other social services are funded on a county basis, this will be a big problem until states devise some method of sharing the estimated savings with counties.

In fact, a number of states have responded to this knowledge by taking explicit steps to facilitate the implementation of these proven programs, often as alternatives or replacements for their more traditional programming.

A second obstacle is that other non-EBPs that may have developed strong political ties or local community support may currently claim the funding streams that could fund EBPs.

A third obstacle is the complexity of the coordination and implementation process that is required, which can take up to two years or more, and necessitates the active involvement of many key stakeholders. Some communities get steered away from adopting some of the more complex models because the trainers of these models do not believe there is sufficient local support or administrative infrastructure to support their models. In addition, even when stakeholders and support are garnered, inevitable turnover in organizations means that the foundations built can be tenuous.

One final obstacle may be some confusion between best practice for juveniles and adults. In some jurisdictions, such as California, under so-called realignment legislation, local community corrections programs are being overwhelmed by their need to serve increased numbers of more serious adult offenders who can no longer be sent to prison. Some local agencies in these states appear to believe that the principles that guide community corrections are appropriate for guiding juvenile programming as well. Fortunately, these are all problems for which there are solutions.

This report compares states on the basis of the amount of the best evidence-based programming they are providing, and the efforts they are making to promote evidence-based practices and policies. One of the key goals of this study is to help state policymakers and practitioners identify strategies and techniques that can help expand the quality and availability of EBPs in their jurisdictions.

The next part reviews the coverage and reliability of the evidence base for juvenile justice programs and policies. Part 3 compares the progress of the states, and Part 4 identifies and describes the common steps that each of the leading states has taken to get where they are with respect to evidence-based practice. Part 5 provides a summary of the state case studies, and the final part reviews the lessons that the leading states have to offer to those following in their path.

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EVIDENCE-BASE PRACTICE IN JUVENILE JUSTICE

The most common definition of evidence-based practice comes from Dr. David Sackett, a pioneer in the field. Evidence-based practice is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Sackett, 1996). In delinquency prevention this includes: the assessment of community and individual client needs; the selection of programs to meet those needs; the methods used to develop or implement new programs; and the assignment of youth to particular programs.

Assessment of Needs

Evidence-based practice can guide the assessment of community as well as individual needs. At the community level it involves determining the characteristics, strengths, and needs of the population to be served, as well as the resources and programs currently in place, using quantitative data and the opinions and knowledge of key stakeholders (Billings and Cowley, 1995). At the individual level it should involve the use of one of the many standardized assessment instruments currently available to serve that purpose (Schwalbe, 2007). A systematic assessment – at intake – of overall risk and individual risk factors provides a clear basis for programming and placement decisions as well as a basis for comparing trends in effectiveness for specific population groups over time.

Program Selection

For anyone in a position to decide which programs should be continued or enhanced, which should be discontinued, and which new programs should be adopted, the issue should eventually come down to cost and effectiveness (Howell, 2009; Mears, 2007, 2010). Key questions include: What will specific programs cost to implement or continue in this specific setting? Are we prepared to implement such programs? How effective will they be with the population we have in mind? Do we have the infrastructure to support them? Answers to these questions now come in three distinct categories: brand name, generic and principles.

Brand name programs include models such as FFT (Alexander and Sexton, 2002), MST (Henggeler et al., 1998), MTFC (Chamberlain and Reid, 1998), and Nurse-Family Partnership (NFP; Olds, 2007). These are programs that were developed by a single investigator or team over a number of years and have been proven effective through repeated experimental trials, often supported by millions of dollars in federal grants. Brand name programs have met the selection criteria established by various review groups for identifying proven programs.
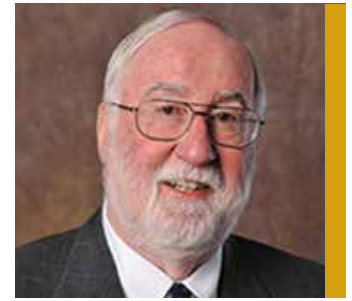
David Lawrence Sackett, OC FRSC (born November 17, 1934) is a Canadian medical doctor and a pioneer in evidence-based medicine. He founded the first department of clinical epidemiology in Canada at McMaster University, and the Oxford Centre for Evidence-Based Medicine. He is well known for his textbooks Clinical Epidemiology and Evidence-Based Medicine. Sackett obtained his medical degree at the University of Illinois, has a doctor of science from the University of Bern and a master of science in Epidemiology from Harvard University. David Sackett altered the routine practice on administering tonsillectomies in the 1950s, and in the 1970s, demonstrated that other methods were often preferable to the common radical mastectomy when treating breast cancer.

The generics are generalized strategies that have been tried by various investigators in different settings. Counseling, intensive supervision and cognitive behavioral therapy (CBT) all fall into this category. Generic methods are identified by meta-analysis and represent the efforts of independent researchers, each testing particular versions of the method.

The third category of what works includes a number of principles that have been found to be true across a variety of strategies. Principles are not programs per se, but techniques or approaches that have proven successful in reducing delinquency. For example, research has shown that focusing on the higher-risk offenders has the most impact on recidivism (Andrews and Dowden, 2006), and increasing fidelity to exemplary models advances positive outcomes (Landenberger and Lipsey, 2005).

There are so many lists of what works currently in circulation that one cannot avoid a decision about which to use. There are currently four reliable sources of information regarding effectiveness for delinquency prevention programs that can be combined to provide all the relevant information needed to make intelligent programming choices: (1) Blueprints for Violence Prevention; (2) meta-analyses conducted by Mark Lipsey; (3) publications by the Washington State Institute for Public Policy (WSIPP); and (4) the international Campbell Collaboration and its Crime and Justice Group's electronic library of systematic reviews, which covers a broader range of topics on crime and justice. These sources stand out because they employ a rigorous scientific standard of evaluation, are comprehensive, and are updated periodically.

Blueprints for Violence Prevention. The Blueprints list was developed by a research team headed by Delbert Elliott at the Center for the Study and Prevention of Violence at the University of Colorado (Elliott, 1997; see also Elliott and Mihalic, 2004). For Blueprints to certify a brand name program as proven ("model"), the program must: (1) demonstrate its effects on targeted problem behaviors with a rigorous experimental design; (2) show that its effects persist after youths leave the program; and (3) be successfully replicated at least once. In order for a brand name program to be certified as "promising," the program must only demonstrate effects using a rigorous experimental design at one site. The current Blueprints website (http://www.colorado.edu/cspv/blueprints) lists 11 model programs and 19 promising programs that were identified from a review of more than 800 programs. These 11 proven programs include the Midwestern Prevention Project; Big Brothers Big Sisters of America; FFT; Life Skills Training; MST; NFP; MTFC; Bullying Prevention Program; Promoting Alternative Thinking Strategies; the Incredible Years: Parent, Teacher, and Child Training Series; and Project Towards No Drug Abuse. Many of these programs target school-aged youths before they are involved in the juvenile justice system. FFT, MST and MTFC are three Blueprint models most frequently used with juvenile justice populations. The cost

to support a single team for any of these models is approximately $500,000 per year. Depending on the model a single team can handle 40 (MTFC) to 160 (FFT) cases per year.

Meta-analyses by Mark Lipsey. Lipsey (1992) carried out the first meta-analysis that focused specifically on juvenile justice. In the most basic terms, a meta-analysis combines the results of independent studies with a shared research focus in order to analyze an overall effect, specifically called an effect size. Accordingly, Lipsey's analysis did not identify specific programs but did begin to identify specific strategies and methods that were more likely to be effective than others. Lipsey continued to expand and refine this work to include additional studies and many additional characteristics of each study (see Lipsey, 2006, 2009; Lipsey and Cullen, 2007). Based on the research, he found that effective programs and strategies were those implemented well and targeted on high-risk offenders. He also found that strategies with a therapeutic component, such as counseling and skill building, are more effective than those with a control component, such as surveillance and discipline (Lipsey, 2009). Although various forms of CBT and aggression replacement training (ART) appear to be the most popular generic models, at this time there is no readily available data on how much effort states devote to these programs.

Washington State Institute for Public Policy (WSIPP). The Institute uses the meta-analysis methodology to conduct evaluations of both brand name and generic programs, but also considers the cost of such programs to taxpayers and crime victims, and weighs these costs against estimated benefits. Programs and strategies are not ranked, but effects on recidivism are measured and the number of evaluations is reported. Recidivism, cost to taxpayers and crime victims, and benefits are estimated using data specific to Washington state. In this paper, all cost and benefit information refers to analyses conducted by WSIPP for the state of Washington (Drake et al., 2009). Accordingly, the information can be considered an estimate for the potential costs and dollar benefits for other states.

Campbell Collaboration. Established in 2000, the Campbell Collaboration is named after the influential experimental psychologist Donald Campbell (see Campbell, 1969). Following the example of the international Cochrane Collaboration in medicine, the Campbell Collaboration aims to prepare systematic reviews (incorporating meta-analyses) of high-quality research evidence about what works in education, social work and welfare, and crime and justice. The Crime and Justice Group, consisting of 18 members from 11 countries, oversees the preparation and maintenance of systematic reviews of the highest quality research on the effects of criminological interventions and makes them accessible electronically to practitioners, policymakers, scholars and the general public. As of this writing, the Crime and Justice Group had 32 published systematic reviews, and a number of these have already been updated. Many concern child development and juvenile justice, including
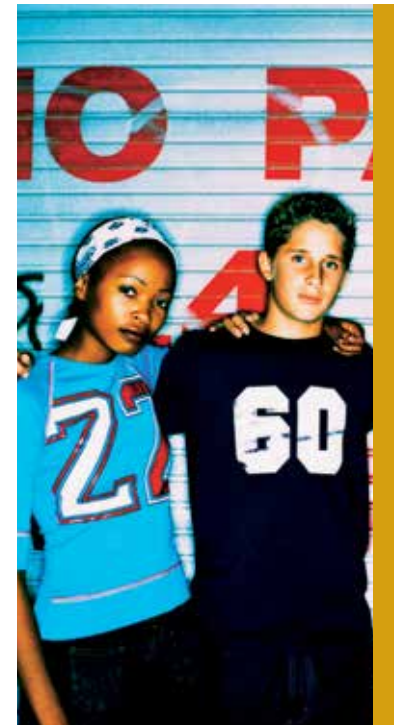
parent training, school-based bullying prevention, mentoring, and CBT for offenders (Welsh and Farrington, 2011). All published reviews are available at the Crime and Justice Group website (www.campbellcollaboration.org/reviews_crime_justice/index.php).

The programs and strategies identified by these four sources represent different types of challenges for jurisdictions when selecting programs. The proven Blueprints programs are all supported by developers with a wealth of experience, training, and technical assistance in implementation and sustainability. FFT and MST have been implemented in well over 200 and 400 sites, respectively (http://fftinc.com; http://mstservices.com). Well-coordinated systems of program monitoring and oversight help ensure that client communities are receiving the outcomes they expect. In fact, it would be inappropriate for a provider to claim they were offering these programs without a direct and sustained linkage to the program developer. For generic programs identified by meta-analysis, potential adopters must first decide which specific model to adopt, based on its design, documentation, demands on an adopting agency, and the availability of technical assistance.

Implementation

The process of implementing EBPs is on the way to becoming a science itself (Fixsen et al., 2009). The literature is clear that implementation is a process that takes 2-4 years to complete in most provider organizations. There are at least six functional stages of implementation, including: exploration, installation, initial implementation, full implementation, innovation, and sustainability (Fixsen et al., 2009). The stages are not linear as each impacts the others in complex ways. For example, sustainability factors are very much a part of exploration and full implementation directly impacts sustainability.

The goal of implementation is to have practitioners (e.g., foster parents, caseworkers, therapists, teachers, physicians) use innovations effectively. Based on the commonalities among successfully implemented programs across many fields, core implementation components have been identified (Fixsen et al., 2009). These components are staff selection, pre-service and in-service training, ongoing coaching and consultation, staff performance evaluation, decision support data systems, facilitative administrative supports, and system interventions. These interactive processes are integrated to maximize their influence on staff behavior and organizational functioning. The interactive core implementation components also compensate for one another in that a weakness in one component can be overcome by strengths in other components.
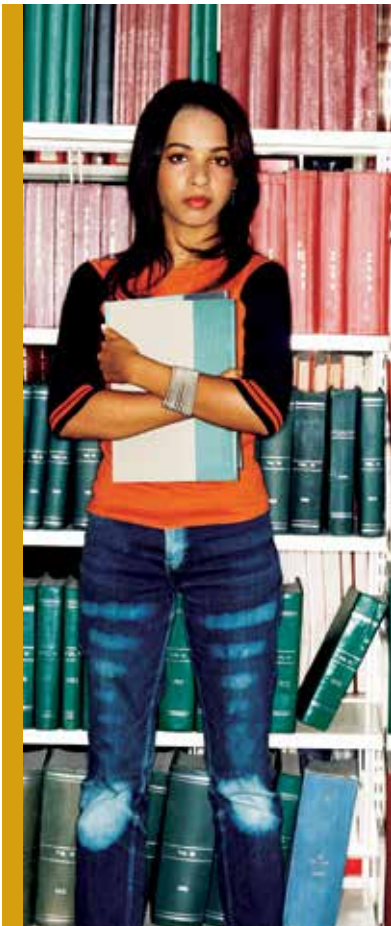
In the early days jurisdictions that were not fully prepared for the challenges that come along with the implementation of EBPs would find themselves overwhelmed by staff turnover, complaints, and competition from other parts of the agency. By now, most of the developers of these proven programs, and the state-level resource centers that work with them, have developed a much better sense of the infrastructure support that has to be in place before implementation can be successful. They have also become much better at coaching jurisdictions through the implementation process.

Program Assignment

It is important to re-emphasize that no one program will be appropriate for all children and youth. The development of guidelines and criteria for deciding which individuals belong in particular programs should be an evidence-based process as well. Prior evaluations of the program model provide evidence to determine the best fit. The risk principle identifies those who should receive priority. In cases where some types of youth could be served by more than one program, it is appropriate to conduct a randomized controlled experiment which can provide evidence regarding where there is the best program match.

COMPARING THE STATES

Availability of EBPs

As the goal of every state's efforts in regard to evidence-based practice ought to be to increase the use of these programs, it would seem that the appropriate outcome measure for these efforts is the number of proven model teams available, or the change in their availability over time.

When we want to measure prevalence of some characteristic or type of behavior within a population, such as homicide, drug use, or teen pregnancy, we usually specify the occurrences as a rate, say per 1,000 children or 100,000 population. Similarly, when we want to measure the availability of some health care service, such as CAT scans or pediatricians, we usually state their availability in terms of CAT scan machines or pediatricians per 100,000 population. This is to provide an "apples to apples" comparison in cases where the denominator varies from state to state. The availability of FFT, MST or MTFC within any jurisdiction can similarly be measured in terms of the number of "therapist teams" available on a per capita basis.

For all three of these models, the team is the basic unit of operation, supervision and training. Each team costs approximately $500,000 per year to support. Figure 1 shows the total number of FFT, MST and MTFC teams per million population in each of the states that have at least one of the EBPs. Obviously there are great differences in their progress.

Figure 2 shows the very same data but with the states sorted from those with the lowest number of teams to those with the highest. In New Mexico, Louisiana, Maine, Hawaii and Connecticut, with availability of these programs averaging more than 10 per million individuals in the population, program availability is more than double that in the four states with the next highest availability (Colorado, North Carolina, Pennsylvania, and Rhode Island). Figure 2 also shows that MST is the most available of these three family-focused proven model programs.

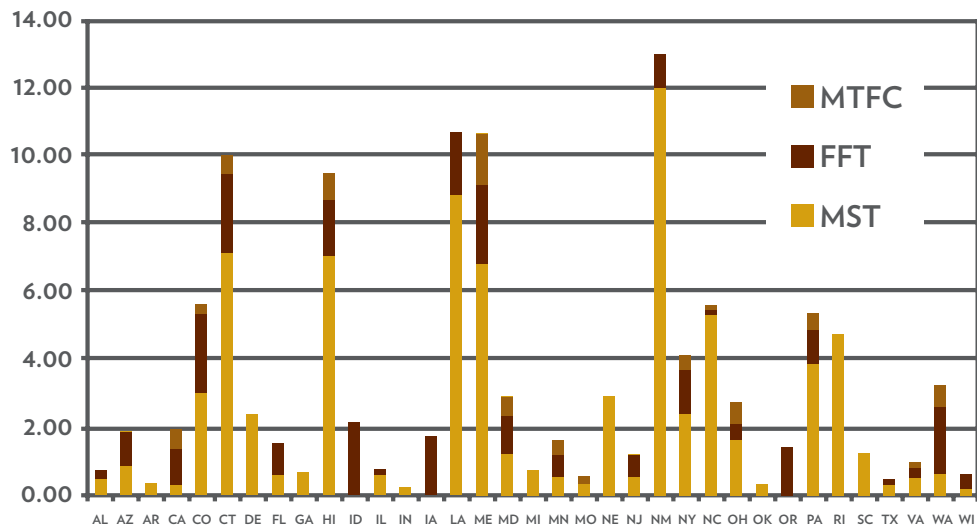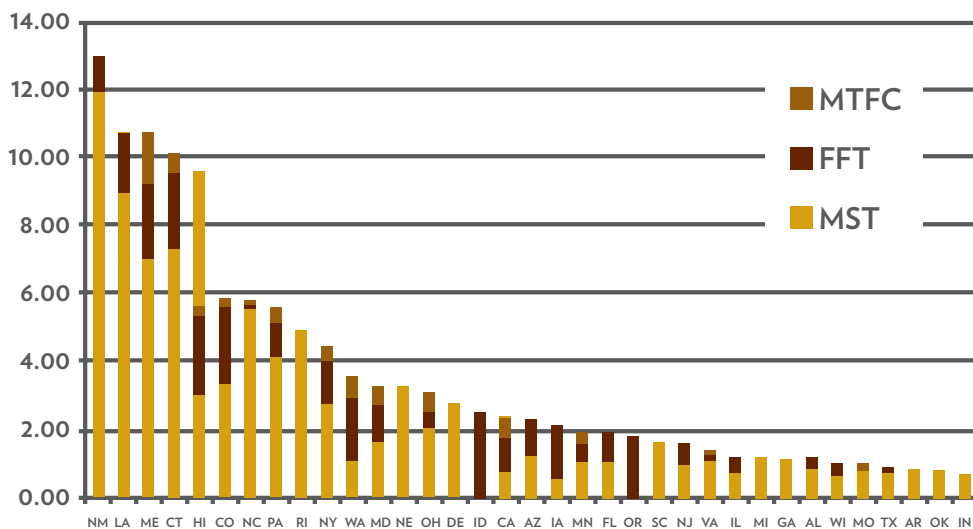**Figure 1: Family therapy teams per million population, by state (2011)**

Figure 2: States rank ordered by family therapy teams per million population (2011)

Effect of EBP Capacity on Juvenile Placements

Since four of the five leading states adopted EBPs to reduce the excessive use of institutional placements for juvenile offenders, we might expect to find that their placement rates would have declined (or declined more) in recent years compared to the rest of the nation. Figures 3 through 7 show the trend in placements for the five leading states in use of EBPs for juvenile offenders compared to the rest of the nation for the period 1997 to 2010.

In Connecticut, there has been a marked decline in the rate of juvenile placements compared to the national average. In Maine, the juvenile placement rate has been well below the national average and far more stable throughout the period under study. Because of this, it is more difficult to say what effect the use of EBPs is having on juvenile placements in the state.
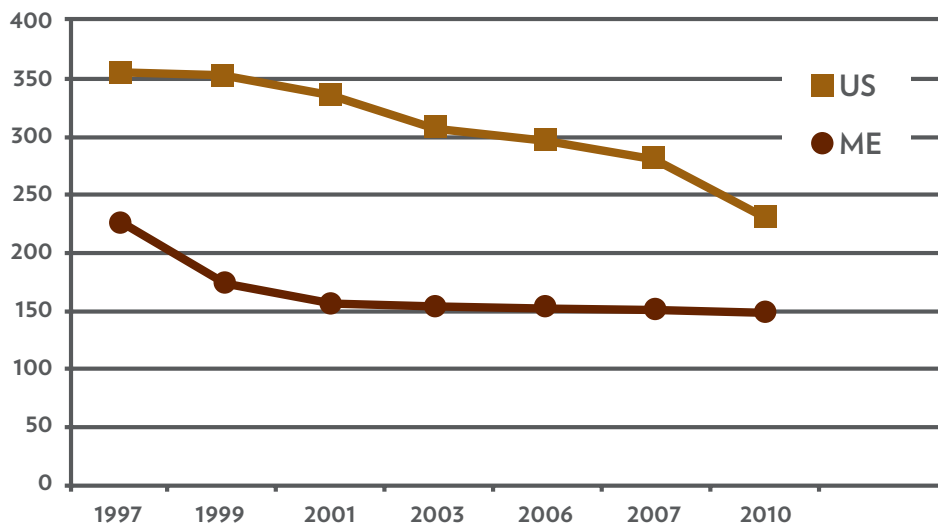
Figure 3: Juvenile placement rates in Connecticut and the U.S., 1997-2010
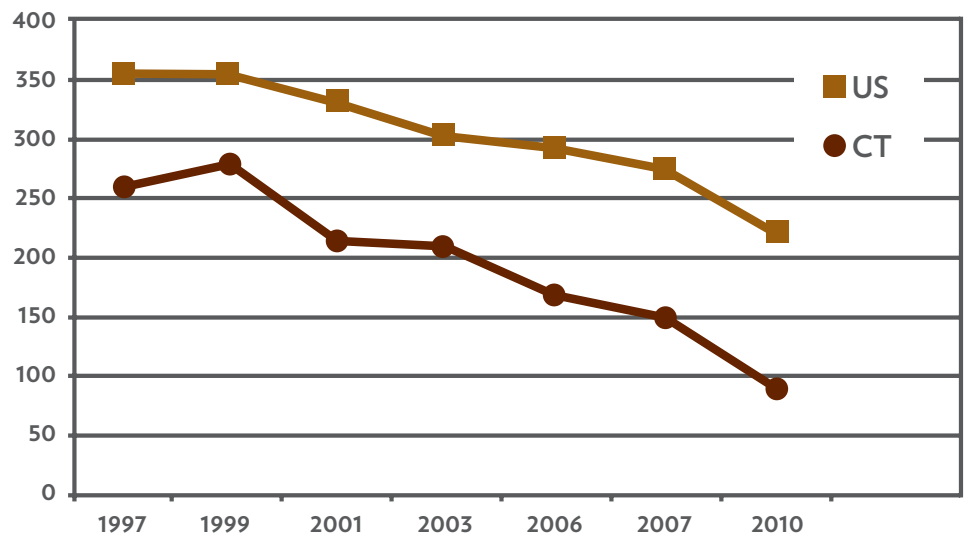
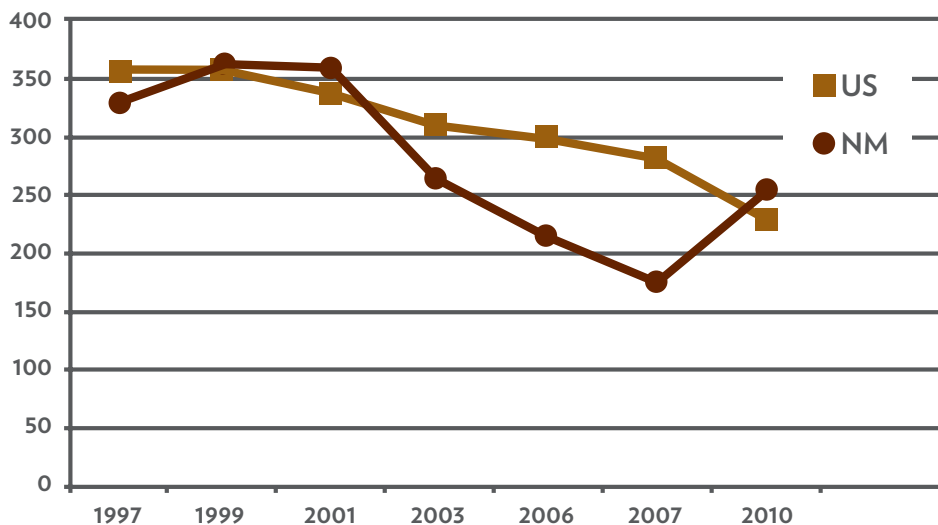*Data were available for 1997, 1999, 2001, 2003, 2006, 2007, and 2010.*

Figure 4: Juvenile placement rates in Maine and the U.S., 1997-2010

Note: Data represent placements per 100,000 juveniles aged 10-17.

**Figure 5: Juvenile placement rates in New Mexico and the U.S., 1997-2010**

Note: Data represent placements per 100,000 juveniles aged 10-17.

A decline has also been evident in New Mexico, with the exception of the last few years.

In Louisiana, juvenile placement rates have been, for the most part, higher than the national average. The most recent reduction (2007-2010), which coincides with the start of Louisiana's use of EPBs, has not exceeded the national decline for the same period. It could very well be that not enough time has elapsed for any effect of EBP use on juvenile placements to be evident.

Figure 6: Juvenile placement rates in Louisiana and the U.S., 1997-2010
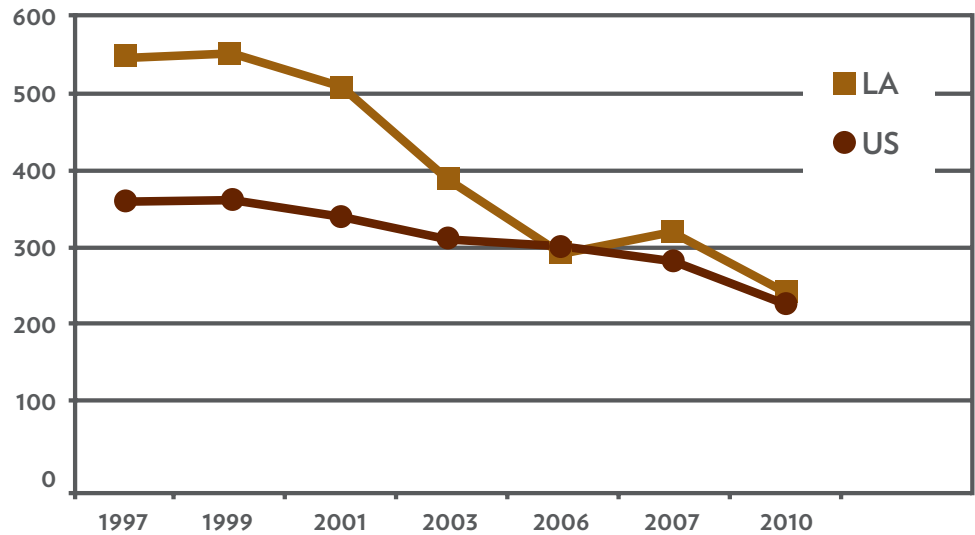
Source: http://www.ojjdp.gov/ojstatbb/ezacjrp/asp/State_Adj.asp
Note: Data represent placements per 100,000 juveniles aged 10-17.

Finally juvenile placement rates in Hawaii have remained well below the national average. Since the MST programs in that state are used primarily for youth with mental health issues, it is not surprising that the scaling up of these programs did not affect the placement rate.

Figure 7. Juvenile placement rates in Hawaii and the U.S., 1997-2010
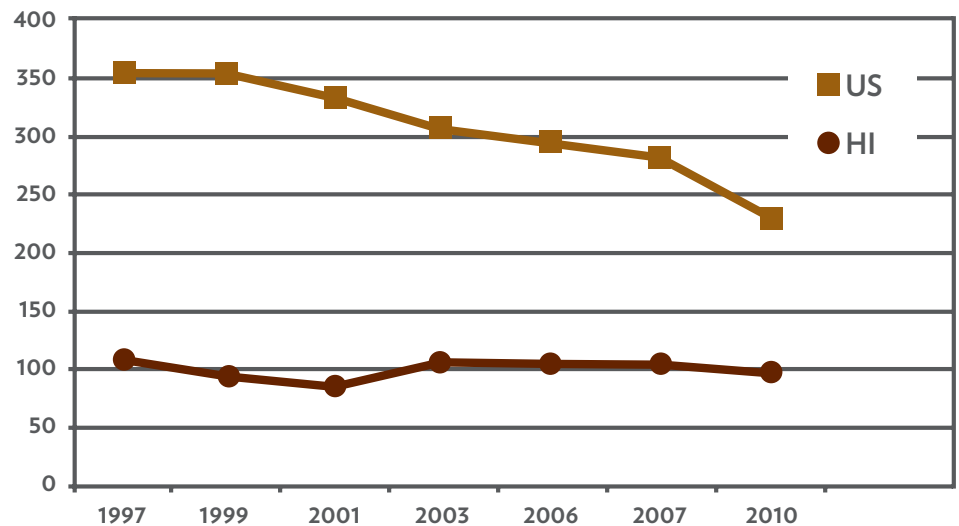

Source: http://www.ojjdp.gov/ojstatbb/ezacjrp/asp/State_Adj.asp'

A recent analysis of placement rate in Pennsylvania found a continuing decline in placement rates for counties that adopted at least one EBP, while placement rates were rising in counties without EBPs (Campbell & Bumbarger, 2012).

Effect of EBP Capacity on Juvenile Arrests

Less can be said about how the use of EPBs in the five leading states has impacted juvenile arrest rates due to the fact that there are many factors that influence juvenile arrest rates that may not be influenced by EBPs (underlying crime rate, police activity, etc.). Figure 8 shows the combined juvenile arrest rate for the four states that focused on juvenile offenders and the national rate for the period 1995-2010.

Figure 8. Combined juvenile arrest rates in the four states that lead in the use of EBP for juvenile offenders, compared to the U.S. and Hawaii, 1995-2010
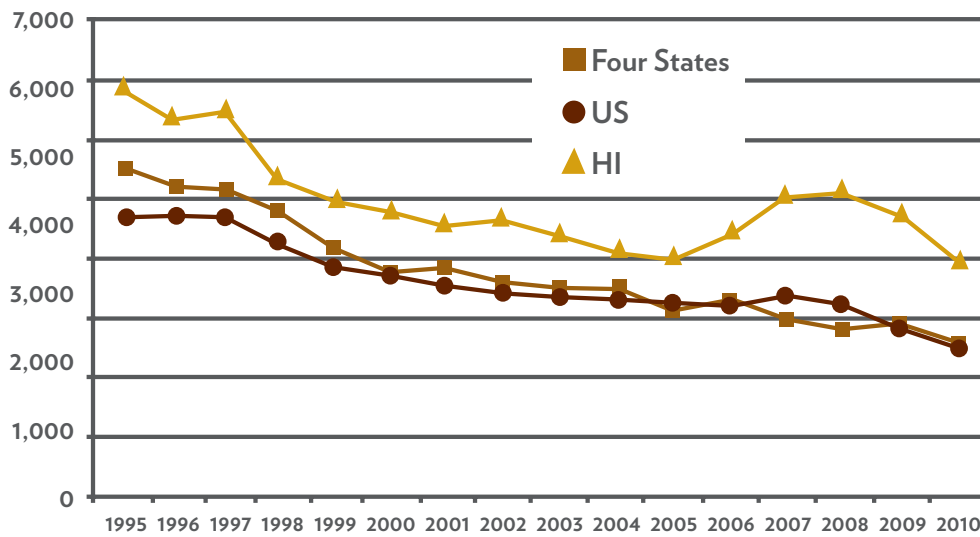
Source: Criminal Justice Information System (FBI), US Census, KidsCount.org
Note: The four states are Connecticut, Louisiana, Maine, and New Mexico. Arrests are weighted by coverage by dividing the estimated population covered by the arrest data by the actual population for each year.

As can be seen in Figure 8, while juvenile arrests appeared to decline over the study period for the country as a whole, on average the four leading juvenile justice states declined slightly more. That is, the U.S. rate declined from around 4,000 to 2,300, while the leading states declined from roughly 4,800 to 2,300. Again, more sophisticated analyses are needed to parse out possible confounding influences on the relationship between the use of EBPs and juvenile arrests. But we can say with some degree of certainty that in the four leading states juvenile arrests have declined sharply in the last decade.
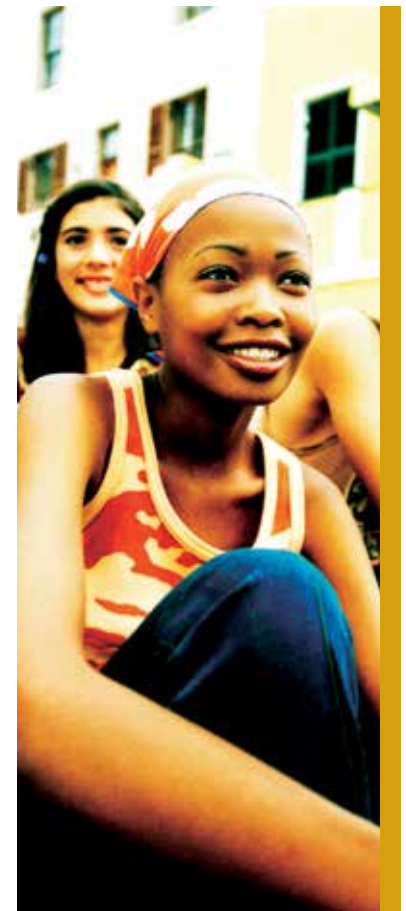
COMMON CHARACTERISTICS OF LEADING STATES

One of the first questions to ask about our leading states is whether their enhanced availability of EBPs is the result of some purposeful effort on the part of the state to expand their use, or whether they are just statistical outliers in which many local sites simply happened to have become interested in EBPs. The answer to this question is very clear in that the expansion of EBPs in all the leading states was the result of direct and clear-cut state action.

Implementation is now seen as the art and science of incorporating innovations into typical human service settings to benefit children, families, adults and communities.

For many years the effort to move "science to service" has been seen as a passive process that involves "diffusion" and "dissemination of information" that makes its way into the hands of enlightened champions, leaders and practitioners who then put these innovations into practice (Rogers, 1995; Simpson, 2002). In this approach, researchers do their part by publishing their findings in the appropriate journals. It is then up to public officials and practitioners to do their part by reading the literature and making use of the innovations in their work with clients. This passive process is well accepted and serves as the foundation for most federal and state policies related to making use of EBPs and other human service innovations (Fixsen and Blase, 2009).

However, new evidence is accumulating regarding a more purposeful, active and effective approach to the process of incorporating science into practice. Implementation is now seen as the art and science of incorporating innovations into typical human service settings to benefit children, families, adults, and communities. The term "innovation" is used here to include programs and practices that have a strong research base (e.g., EBPs) as well as other programs and practices that have potential benefit to consumers, communities or provider organizations (e.g., data-based decision support systems, electronic record systems, targeted fundraising approaches, skill-based hiring methods).

From an implementation point of view, doing more and better research on a program or practice itself does not lead to more successful implementation. Once models and best practices are identified, practitioners are faced with the challenge of implementing programs properly. A poorly implemented program can lead to failure as easily as a poorly designed one (Mihalic et al., 2004).

Several comprehensive reviews of the implementation evaluation literature and current successful practices were recently completed that produced new ways of seeing how to make better use of science in typical human service settings (Blase and Fixsen, 2003; Blase et al., 2005; Wallace et al., 2008).

Results from the synthesis of the implementation and best practices literature yielded two major theoretical frameworks that can guide practice and research efforts to move science to service more effectively and efficiently. The first framework describes the stages of implementation. The second framework describes the core components of implementation. These stages and core components of implementation can serve as milestones to help us better understand the process as states attempt to expand the use of EBPs in local communities.

Our case studies allow us to gain a better understanding of the steps that must take place during each of these stages. During the exploration and adoption phase the state needs to make a careful assessment of the problem(s) it is trying solve (e.g., overuse of placements, lack of community alternatives, lack of programs for status offenders) and the options available for solving them. During this phase states will also need to develop or gain access to critical areas of expertise such as: the strength of various evaluation designs; the reliability of various program rating schemes; or the requirements and operational details of candidate EBPs. The purpose of exploration is to assess the potential match among community needs, accessible EBPs, and community resources and to make a decision about whether to proceed with implementation or not.

After a decision is made to begin implementing an EBPs, there are tasks that need to be accomplished before the first client is seen. These activities define the installation stage of implementation. Resources are being consumed in active preparation for actually doing things differently, in keeping with the tenets of the EBP. Structural supports necessary to initiate the program are put in place. These activities and their associated "startup costs" are necessary first steps to begin any new human service endeavor, including the implementation of an EBP or practice in a new community setting.

Activities during the installation phase of statewide rollout of an EBP might include:

- The identification, recruitment and education of key stakeholders
- Ensuring the availability of funding streams
- Acquiring program materials
- Policy development
- The creation of incentives for local participation
- Creating referral mechanisms, reporting frameworks and outcome expectations
- Realignment of current staff
- Hiring new staff members
- Securing appropriate space
- Staff training
- Purchase of needed technology (e.g., cell phones, computers, software)
- Funding of un-reimbursed time in meetings with stakeholders and time for staff while they are in training

In most of our leading states this installation phase involved some pivotal piece of legislation that established the conditions under which implementation of EBPs could thrive.

The third stage in the implementation process is initial implementation. Implementation requires change. The change may be more or less dramatic for an individual or an organization. In any case, change does not occur simultaneously or evenly in all parts of a practice or an organization at once (Kitson et al., 1998). Implementation requires changes in the overall practice environment. Changes in skill levels, organizational capacity, organizational culture, and so on require education, practice and time to mature. Joyce and Showers (2002) describe how they help practitioners through the "initial awkward stage" of initial implementation. Fisher (1983) stated it clearly when he described "the real world of applied psychology [as] an environment full of personnel rules, social stressors, union stewards, anxious administrators, political pressures, inter-professional rivalry, staff turnover, and diamond-hard inertia" (p. 249).

During the initial stage of implementation the compelling forces of fear of change, inertia and investment in the status quo combine with the inherently difficult and complex work of implementing something new. All of this occurs at a time when the program is struggling to begin and when confidence in the decision to adopt the program is being tested. In two of our leading states (Connecticut and New Mexico), initial installation involved pilot tests of selected models in just one or two locations. In another, the person leading the statewide effort had implemented the selected program (MST) some years previously, and was thus well acquainted with the details of implementation.

Full implementation of an innovation can occur once the new learning becomes integrated into practitioner, organizational, and community practices, policies, and procedures. At this point, the implemented program becomes fully operational with full staffing complements, full client loads, and all of the realities of "doing business" impinging on the newly implemented EBP. While this description is more applicable to an individual service provider it also applies to a statewide rollout as well. The initial implementation provides an opportunity to identify and fix problems in communication and leadership channels between local and state officials, and in the fit between the model and local operating conditions. During full implementation state officials can use what they have learned during the pilot test to help spread the EBP to local communities even more effectively.

Each attempted implementation of an EBP presents an opportunity to learn more about the program itself and the conditions under which it can be used with fidelity and "positive effectiveness." Some of the changes at an implementation site will be undesirable and will be defined as program drift and a threat to fidelity (Adams, 1994; Mowbray et al., 2003). Others will be desirable changes and will be defined as innovations that need to be included in the "standard model" (Winter and Szulanski, 2001). When attempting to discriminate between drift and innovation, the Dissemination Working Group (1999) advised first implementing the practice or program with fidelity before attempting to innovate. In that way, it is clear that "innovation" is not an attempt to escape the scrutiny of fidelity assessments and that the innovation is based on a skillful performance of the program or practice. In addition, Winter and Szulanski (2001) noted that adaptations made after a model had been implemented with fidelity were more successful than modifications made before full implementation.

After the intensity of establishing a fully implemented EBP in a new community, the implementation site needs to be sustained in subsequent years. Skilled practitioners and other trained staff leave and their replacements must be trained. Leaders, funding streams and program requirements change; new social problems arise; and partners come and go. External systems change with some frequency, political alliances are only temporary, and champions move on to other causes. It is during this sustainability phase in which the newly implemented EBP is making its greatest contribution while also facing the challenges of drift and shifting of management attention to newer innovations.

During the initial stage of implementation the compelling forces of fear of change, inertia and investment in the status quo combine with the inherently difficult and complex work of implementing something new.

While this framework was developed specifically for the purpose of focusing on the implementation of new programs in a service organization it can also be used to help us understand the process of implementing EBP-friendly policies at the state level as well. Of our four leading states, New Mexico is the highest with 13 teams per million population and Connecticut is the lowest with 9.4 teams per million. The states with the greatest number of teams are the most populous ones (Pennsylvania and California).

In three of our four top states the juvenile justice system is administered entirely by the state, rather than local counties, which makes it easier to bring about statewide change.

Another commonality was that policymakers in all of the top states became moved to action by their deep concerns with the number and quality of out-of-home placements in their state in the late 1990s. Four out of five had large-scale reform underway by the start of the new decade. In Connecticut and New Mexico this took the form of test implementations of MST in pilot sites. In Maine it was the piloting of a new risk and needs instrument. In Hawaii it was the formation of the Empirical Basis to Services (EBS) Task Force within Child and Adolescent Mental Health Division. Reforms in Louisiana did not begin until the selection of Debra DePrato and Louisiana State University as the primary force for reforming community-based services for juveniles in 2006.

All of the five leading states had widely recognizable champions that varied from key department heads, to behavioral health consultants, to the governor of one, to an associate commissioner of corrections in another. All of the leading states created high-level stakeholder groups to oversee the process of rolling out EBPs. In Connecticut, it was the Governor's Blue Ribbon Commission on Mental Health in 2000. In Maine, it was the Juvenile Justice Advisory Group. In New Mexico, it was the Behavioral Health Collaborative, In Hawaii, it was the EBS Task Force and the local Community Councils, and in Louisiana it was the Juvenile Justice Implementation Commission.

SUMMARY OF STATE CASE STUDIES

The purpose of the state case studies, conducted as part of this research, was to determine what characteristics or activities appeared to set the leading five states apart from all the rest, and which of their activities appeared most conducive to the spread of proven EBPs for juveniles and their families. The following summaries were written to help readers put the individual state activities described in our report into the political and organizational context in which they occurred. More detailed case studies for selected states are available in Appendices B-G.

Connecticut

Connecticut was the first leading state we studied and helped establish the framework from which all other states were viewed. It is a wealthy state with one of the highest household incomes, but contains deep pockets of poverty in the decaying parts of its old mill towns. It is a state in which juvenile justice and child welfare services are run at the state level.

The move toward evidence-based practice in Connecticut began in 1999 with a crisis of confidence in the juvenile corrections system. Conditions within juvenile institutions being used at the time were found to be scandalous and secure placements overused. A special Blue Ribbon Commission was established to bring all the key stakeholders together, gather all the facts, and explore options. Meanwhile, the two agencies responsible for the care of juveniles in the state, the Court Support Services Division (CSSD) and the Department of Children and Families (DCF), had been investigating possible alternatives to residential care and identified MST as the program model offering the best chances of success.

After undertaking a carefully monitored pilot project supervised by MST Services, there was sufficient satisfaction with the process and outcomes to launch an ambitious plan to take MST up to scale throughout the state, including the establishment of several Centers of Excellence to assist communities in implementing the new programs, adapting their systems to support them, and monitoring their results. Reform legislation facilitating the shift to community-based care was passed in 2001.

After expanding MST statewide, DCF also invested in several other proven program models, including FFT, Multidimensional Family Therapy, Brief Strategic Family Therapy (BSFT), and MTFC. The state has since developed and tested some new models where no existing model was found to meet their needs.

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New Mexico

The Land of Enchantment became interested in MST for the same reasons that attracted Connecticut and at about the same time. Key stakeholders decided that MST offered a defensible and more effective program option for many youths that were currently being sent to placement. Rather than develop their own internal expertise, New Mexico policymakers relied on their behavioral health contractor to set up and monitor two pilot programs, and then take the program to scale. The behavioral health contractor and MST Services decided that it would be cheaper and easier for the state to contract with Colorado's CEP, which was already an MST Network Partner supervising programs in Colorado, to provide training and oversight for MST therapists in New Mexico. In the 12 years since they started, three different companies have held the behavioral health contract with the state. The primary institutional memory and key relationships are between the CEP and the local providers, who all meet together on a bimonthly basis. New Mexico has demonstrated that it is possible to provide high-quality family interventions to most of the population even in a sparsely settled state.

Maine

The use and evaluation of evidence-based practice in Maine's juvenile justice system cannot easily be traced to any one event or act of legislation. However, the success that Maine has achieved in utilizing EBPs has been greatly facilitated by the tradition of collaboration and strong leadership that exists in the state. The primary motivation for moving to EBPs began in the mid-1990s during a fiscal crisis in which cost-savings were needed and leadership began to recognize that the current approach was ineffective. Several major stakeholders and groups have led the way for Maine, including: the Juvenile Justice Advisory Group; Maine Department of Corrections (MDOC); the Juvenile Justice Task Force; the judiciary; the Maine School of Law; and the Muskie School of Public Service at the University of Southern Maine. The work of these groups has relied on substantial buy-in and support from the legislature, and cross-agency collaboration that has been found in the state for many years. These elements have gone a long way toward developing an evidence-based culture in Maine.

The first Blueprint program to be adopted in Maine was MST in 2001. Unfortunately, after completion of initial training and recruitment this early program was not operated with fidelity and was thus discontinued but other agencies were willing to take up the work and as a result, MST has been in use continually since 2001. FFT began in 2003 when the Catholic Charities of Maine proposed to use it for their most high-risk juveniles. Seizing the opportunity to

try another model MDOC agreed. FFT flourished and began to achieve excellent results very quickly. EBPs such as FFT have been able to continue thanks to the willingness of other agencies to make referrals outside of MDOC. Another evidence-based initiative, the Problematic Sexual Behavior program, was initiated in the early 2000s in part as the result of collaboration.

Hawaii

Evidence-based family therapy came to Hawaii early in the 21st century, as it did with many of other lead states, again with motivation provided by a consent decree, but with the other party being, youth who needed the services, rather than the federal government. The early MST programs were part of major reform of mental health services for adolescents based on evidence-based practices. With more than 10 teams per million population, involvement with MST is currently limited to youth refereed for mental health services, primarily by the schools, not by the juvenile court.

In 1994, U.S. District Judge David Ezra ruled Hawaii was in violation of the Individuals with Disabilities in Education Act. In a consent decree settling the lawsuit, the state agreed to create an expansive system to provide those services over the next six years. The Felix Consent Decree set out benchmarks for improvement by the state. A major outcome of this ruling—due to a "leadership-initiated response to improve service quality and efficiency"— was to identify and implement evidence-based services in the system of care. To help accomplish this goal, the Hawaii Department of Health Child and Adolescent Mental Health Division (CAMHD) established the CAMHD Empirical Basis to Services (EBS) Task Force. This task force continues to drive the evidence-based services initiative, and is further summarized in Chorpita et. al (2002). The initiative identifies empirically supported programs (such as MST) while also seeking out common components of evidence-based services that can be duplicated in routine care. The initiative provides course definition and treatment selection; implements specific evidence based services; encourages the use of evidence-based services; provides large-scale training, performance standards and practice guidelines; and utilizes information systems, performance measures, and feedback tools. Chorpita et al (2002) provide a summary of evidence-based services identified by the task force, and Daleiden and Chorpita (2005) discuss strategies used by CAMHD to manage evidence-based clinical decision making.
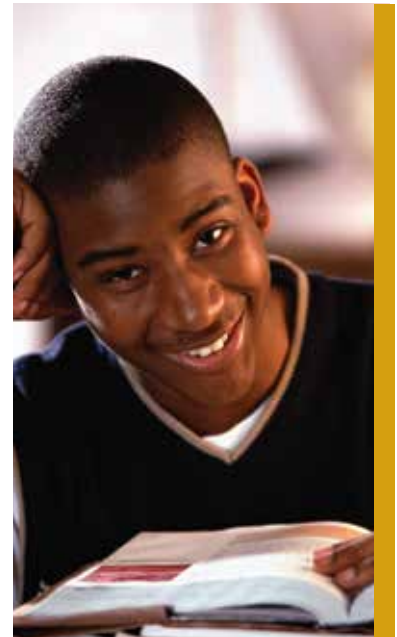
Louisiana

The Pelican State may be the most interesting case for those states that are just beginning to experiment with EBPs. Unlike the three states described above, Louisiana only recently embarked on this effort. Like Connecticut, Louisiana was rocked by scandalous stories about conditions in their juvenile institutions. A federal lawsuit was brought by the U.S. Department of Justice, asserting that the civil rights of juvenile inmates were being violated. Through the influence of some powerful champions, it was agreed that Dr. Debra DePrato, a faculty member of the Health Sciences Center at Louisiana State University, and the former director of juvenile justice services in Jefferson Parish, would take over responsibility for medical services and behavioral health within all juvenile institutions in Louisiana.

Dr. DePrato's outstanding success in completing that assignment lead to her being asked by the state to help develop more effective community-based services for juveniles, and by the MacArthur Foundation to lead their Models for Change project in the state. Despite interruptions caused by Hurricane Katrina, Dr. DePrato and her handpicked team have had a dramatic effect on the availability of proven programs for the youth of Louisiana. That success appears due to: the extensive efforts DePrato and her team put into developing good working relationships with and educating all the key stakeholders, both at the state and local level; and the technical assistance tools developed and disseminated by the team, helping local parishes with the problems of program selection and implementation.

Pennsylvania

The Keystone State was one of the first to initiate a program to bring about evidence-based practice in juvenile justice. This began with funding from then Governor Tom Ridge and with the backing of the Pennsylvania Commission on Crime and Delinquency (PCCD), which controls block grant funding, and the powerful Juvenile Court Judges Commission, which sets policy for the juvenile courts. The Commonwealth had been an early user of EBPs as defined by the Communities That Care program that was utilized throughout the state, and was an early supporter of the Blueprints effort. Unlike the other leading states, the Commonwealth decided to support all of the Blueprint model programs rather than just those aimed at delinquents. In order to assist local communities with program selection, implementation, and fidelity, and to publicize the results of their work, PCCD established the Evidence-Based Prevention and Intervention Support Center (EPISCenter), located at Pennsylvania State University. The center also provides technical assistance to local communities and monitors their results.

Washington

The Evergreen State was attracted to EBPs after disappointing results from their experimentation with intensive supervision probation, and as a way of reducing the rate of growth in spending they were projecting for the prison system. In the late 1990s, the Washington State Institute for Public Policy (WSIPP) had been assigned the task of reviewing the program effectiveness literature and projecting the impacts of programs to reflect actual reductions in crime and savings to taxpayers and potential crime victims. Following a series of reports identifying a number of cost-effective programs, since 2006 the state has been providing funding for a carefully selected portfolio of programs that they believe has reduced their need for prison capacity (Drake et al., 2009).

Florida

The Sunshine State is known for its oranges, Walt Disney World and its penchant for locking up kids. A historically conservative state (due to both retirees who prefer the low tax burden and Cuban immigrants who fled the Communist regime of Fidel Castro), Floridians have long held a "get tough" on crime mentality, which led to an explosion of prison construction in the 1990s. A decade later, Florida's leaders found the cost of locking up all these supposed "super-predators" unsustainable and began looking for other options.

A 2001 report from the Office of Program Policy Analysis and Government Accountability (OPPAGA), Florida's version of WSIPP, found that 46 percent of youth in Florida's prisons were there due to non-law violations of probations. By 2004, the Florida legislature had developed a pilot project proposal that would be funded by the Department of Juvenile Justice and would utilize 'high fidelity' implementations of FFT and MST in four communities across the state in a quasi-experimental framework. Evidence-Based Associates (EBA), an intermediary organization, was assigned the contract to manage the newly developed "Redirection" project. The decision to hire a "general contractor" to manage the implementation of EBPs statewide was and remains unique; having the legislature champion the reform effort and use its research arm (OPPAGA) to evaluate the pilot project was equally unique and beneficial.

The initial results were positive and follow-up recidivism data showed clear benefits for the youth assigned to EBPs in Redirection versus alternative residential or electronic monitoring conditions. Based on continued success in reducing recidivism and creating alternatives to residential placement for high-risk youth, Redirection received supplemental funding to expand the program in each of the succeeding legislative sessions until 2008, when the program peaked at 1,500 youth per year in 21 EBPs (MST, FFT, and BSFT). Given its initial success, it is not clear why the program has not been expanded to cover more youth and families.
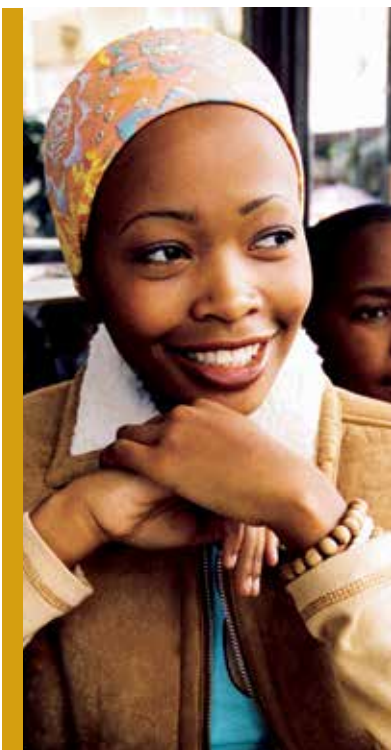
California

The Golden State found itself in the same position and at the same time as Connecticut of being sued by the federal justice department over conditions of confinement within their institutions. Rather than accept the verdict of the justice department and the many experts who had testified at numerous hearings about the ineffectiveness and lack of leadership demonstrated by the California juvenile justice system, state government chose to litigate the matter and oppose the court appointed master at every turn. After more than a decade of defensive wrangling, the state finally decided to withdraw from the juvenile justice field almost entirely, leaving local probation departments to solve the programming issues they had been unable to, and without the help of any leadership or technical assistance. Since this new mandate to develop more effective juvenile justice programs was imposed, which occurred just a year before the state realigned the adult criminal justice system (by requiring the county to supervise less serious felons and parole violators who had usually been sent to prison), it is not surprising to find little progress in evidence-based practice in juvenile justice. A few counties are making use of the Blueprint programs but most are staying with simpler classroom-based models like CBT or ART.

LESSONS FOR POTENTIAL CHAMPIONS AND FACILITATORS IN OTHER STATES

Evidence-based practice in delinquency prevention has come a long way in the past 15 years. This progress has been aided by the development, documentation and dissemination of a number proven program models by university-based development teams and the efforts of a number of organizations and individual researchers to provide authoritative and up-to-date lists of those programs that appear to be effective, not to mention the strength of the evidence supporting this judgment. Some of this progress can also be attributed to the application of cost-benefit models with findings showing that substantial monetary benefits can accrue to the government and taxpayers in the short-term. Nothing captures the attention of a politician or policymaker quite like a government program that pays for itself. Leaders in state and local government across the country have also played some role in championing evidence-based practice, ushering in a possible new era that values "getting smart" on crime over "getting tough."

Make no mistake, evidence-based practice in delinquency prevention still has a long way to go. There are many challenges, including scarce financial resources, institutional support for pet projects, and the complexity of the coordination and implementation process. Moreover, the rhetoric surrounding evidence-based practice continues to outweigh the reality, with far too many decision-makers and advocates using their own interpretation regarding what constitutes "evidence-based."

There is also cause for concern about the uptake of legitimate EBPs. In juvenile justice, it is estimated that only about 5 percent of youth who should be eligible for EBPs participate in one (Hennigan et al., 2007). One reason for this poor participation rate is the general lack of accountability for performance within the juvenile justice and community corrections systems, or even any ability to measure outcomes. Only rarely does a jurisdiction take delinquency prevention and intervention seriously enough to measure the outcome of its efforts.

State governments are a vital link to advancing evidence-based practice and ensuring that efforts at the local level can flourish. Our research has identified five states that clearly lead all others in promoting evidence-based practice in delinquency prevention. Case studies of these states show a modest yet growing investment in a number of evidence-based programs, including FFT, MST and MTFC. Their experiences offer a number of lessons for policymakers, practitioners, and advocates for youth in other states.

Leaders in state and local government across the country have also played some role in championing evidence-based practice, ushering in a possible new era that values "getting smart" on crime over "getting tough."

All of our five leading states, and many of the other top performers, entered the exploration phase and began looking at EBPs because they were seriously dissatisfied with the quality of their existing programs, particularly the perceived overuse of residential placements. In New Mexico and Maine, there were concerns that many of the youths being sent to placements did not belong there and could be treated in the community. In Connecticut, there were concerns about scandalous conditions in their juvenile facilities and over-reliance on incarceration. In Louisiana, interest in EBPs began with concerns about the quality of medical and behavioral health in juvenile institutions, which eventually led to concern about programs in the community.

During their exploration phase all of our leading states took the opportunity to develop their own local expertise. Specific individuals were given the task of reviewing the "what works" literature and visiting sites that had already adopted models of interest. They also took the time to recruit and involve key stakeholders who would be required to assist with statewide implementation while sharing their expertise with local communities.

For most of the leading states the installation phase involved: arranging for training from the model purveyor; selecting the site(s) for pilot testing; and training of affected personnel.

Initial implementation was usually in pilot sites selected to provide a realistic local test of the selected model. It was usually during this pilot test period that states established or created formal relationships with some institute or center for excellence which would serve as the evaluator for the pilot and technical expert, technical assistance provider, and quality assurance monitor as models moved to scale. In all the leading states, statewide support began with a single EBP (e.g. MST) with support for additional models added over time. The following seven lessons are distilled from this study.

Lesson 1 - is that the expansion of EBPs throughout a state does not happen by accident. All of the leading states were actively involved in facilitating and directing the expansion of EBPs, as are those on the next level down as well.

Lesson 2 - is juvenile EBPs are separate and much more advanced than community corrections EBPs for adults. In all of the leading states responsibility for juvenile programming was completely independent and separate from the adult system.

Lesson 3 - confirms the wisdom of pulling together a collaborative group, representing all the key stakeholders, as early in the process as possible, particularly when it comes to identifying community needs and program options. This is a strategy that has also been proven effective as part of Communities That Care.

Lesson 4 - is that once they had established the pattern of working with stakeholders to identify ineffective programs or under-served segments of their client population, it was only natural for one of the resource centers to review the evidence regarding the most effective intervention method for working with those particular clients.

Lesson 5 - is about the importance of establishing an institute or center for best practice that can provide friendly technical assistance to counties and ensure a steady stream of reporting to stakeholders on how their programs are performing. These intermediary centers are the primary source of guidance and support for local practitioners, and their primary contact with the research community.

Lesson 6 - is about how long it will take the state to move through the process of statewide expansion, proceeding from early exploration to achieving desired outcomes on a statewide basis. Many states require a year or more to reach the pilot testing phase, another two years to get the pilot test right, and additional years to expand programs across the state.

Lesson 7 - concerns the value of adopting proven model programs from Blueprints rather than relying on programs identified by less reliable rating systems. The ability of these programs to consistently perform above expectations is one of the factors that convinced local policymakers to move toward evidence-based practice.

Any jurisdiction will have its hands full for at least a year after implementing a new EBP. There is a steep learning curve. Any organization identified as a resource center for evidence-based practice has to start by identifying a fairly small list of proven programs it is prepared to support. Developing expertise with several new evidence-based programs, all at the same time, is difficult and not recommended. Additional programs can be added to the list over time, as demand requires.

With a growing knowledge base, state and local governments should be optimistic about the potential of evidence-based practice to prove its value in delinquency and mental health prevention and intervention. Drawing upon the lessons learned in the leading states, remaining open minded to new evaluation findings and the needs of communities will go a long way toward addressing the need for greater accountability, effectiveness, efficiency and sustainability in how we deal with young people who come in conflict with the law.
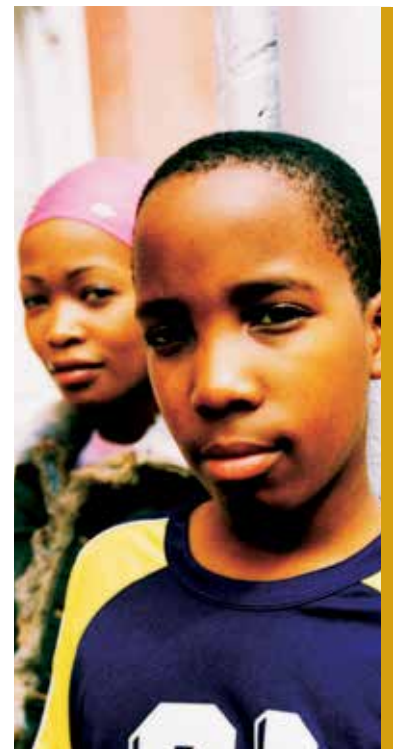
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