sharing child and youth development knowledge
volume 25, number 1
2011

Social Policy Report

Evidence-Based Interventions for Juvenile Offenders and Juvenile Justice Policies that Support Them

Scott W. Henggeler & Sonja K. Schoenwald
Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina

Abstract

In a context where more than 1,000,000 American adolescents are processed by juvenile courts annually and approximately 160,000 are sent to residential placements, this paper examines "what works" and "what doesn't work" in reducing the criminal behavior of juvenile offenders and presents examples of government initiatives that have successfully promoted the adoption, implementation, and sustainability of evidence-based interventions for juvenile offenders. In general, the vast majority of current juvenile justice services has little empirical support or exacerbates antisocial behavior. These include processing by the juvenile justice system (e.g., probation), juvenile transfer laws, surveillance, shock incarceration, and residential placements (e.g., boot camps, group homes, incarceration). On the other hand, several effective treatment programs have been validated in rigorous research. Effective programs address key risk factors (e.g., improving family functioning, decreasing association with deviant peers), are rehabilitative in nature, use behavioral interventions within the youth's natural environment, are well specified, and include intensive support for intervention fidelity. Although only 5% of eligible high-risk offenders are treated with an evidence-based intervention annually, inroads to the larger scale use of evidence-based treatments have been made in recent years through federal (e.g., Office of Juvenile Justice and Delinquency Prevention, Substance Abuse and Mental Health Services Administration) and state (e.g., Washington, Ohio, Connecticut, Florida) policy initiatives. Based on our experience transporting an evidence-based treatment within the context of these initiatives, recommendations are made to facilitate stakeholder efforts to improve the quality and effectiveness of rehabilitative services available to juvenile offenders.

Social Policy Report
Volume 25, Number 1 | 2011
ISSN 1075-7031
www.srcd.org/spr.html

Social Policy Report
is published four times a year by the
Society for Research in
Child Development.

Editorial Team
Samuel L. Odom, Ph.D. (Lead editor)
slodom@unc.edu
Kelly L. Maxwell, Ph.D. (Issue editor)
maxwell@unc.edu
Donna Bryant, Ph.D.
donna.bryant@unc.edu

Director of SRCD Office for Policy and Communications
Martha J. Zaslow, Ph.D.
mzaslow@srcd.org

Managing Editor
Amy D. Glaspie
aglaspie@srcd.org

Governing Council

Greg Duncan
Arnold Sameroff
Ann Masten
Nancy Hill
Oscar Barbarin
Patricia Bauer
Marc H. Bornstein
Jennie Grammer
Melanie Killen
Richard Lerner
Kenneth Rubin
Elizabeth Susman
Thomas Weisner
Susan Lenon, *ex officio*
Lonnie Sherrod, *ex officio*
Martha J. Zaslow, *ex officio*

Policy and Communications Committee

Bonnie Leadbeater
Barbara Fiese
Oscar Barbarin
Brenda Jones Harden
Anna Johnson
Tama Leventhal
Joseph Mahoney
John Murray
Sam Odom
John Ogawa
Cassandra Simmel
Louisa Tarullo
Martha J. Zaslow
Lonnie Sherrod, *ex officio*

Publications Committee

Ann Easterbrooks
Patricia Bauer
Margaret Burchinal
Noel Card
Greg Duncan
Richard Lerner
Susan Goldin-Meadow
Velma McBride Murry
Anne Pick
Jonathan Santo
Lonnie Sherrod
Fons van de Vijver
Karen Brakke, *ex officio*
W. Andrew Collins, *ex officio*
Nancy Eisenberg, *ex officio*
Jeffrey Lockman, *ex officio*

From the Editors

In this issue of *Social Policy Report*, Henggeler and Schoenwald succinctly summarize the research regarding what works—and what doesn't—in treating juvenile offenders. The list of ineffective interventions is disheartening, particularly because of their common use. Yet the strong evidence in support of some community-based interventions such as multisystemic therapy (MST) and the successful implementation of these interventions is suggestive of a shift in policy and practice that supports positive outcomes for youth offenders. Henggeler and Schoenwald use their experiences with MST to explore important issues regarding the uptake of an evidence-based practice in a decision-making context that considers multiple factors, only one of which is empirical evidence of effectiveness. They offer insightful guidance about the complexities in establishing an intervention's effectiveness, implementing it with fidelity, and collaborating with various stakeholders to bridge the science-practice gap.

Peter Panzarella, an administrator from the Connecticut Department of Children and Families, describes the complexities in implementing evidence-based practices at the state level and working with stakeholders from multiple service systems. Samantha Harvell notes in her commentary that the zeitgeist seems right for expanding evidence-based practices in juvenile justice. With limited resources and an increasing appreciation of evidence-based practices, policymakers at all levels—federal, state, and local—are more closely examining interventions for juvenile offenders. Scott Henggeler and Sonja Schoenwald's review of research regarding evidence-based interventions will certainly inform those examinations and discussions. Christopher Slobogin's commentary provides a legal perspective of juvenile justice issues and suggests that a major paradigm shift is needed before community-based interventions will ever become used widely.

Together, the article and commentaries provide a rich description of the multi-layered issues regarding policies and practices for juvenile offenders. The collective picture portrayed is both daunting and hopeful—daunting in the sense of the immense challenges still faced in implementing evidence-based interventions for juvenile offenders even when there is solid evidence of the effectiveness of particular interventions over others, yet hopeful because of the success of interventions like MST that have been implemented well in a variety of policy contexts through strong partnerships between researchers and policymakers.

— Kelly L. Maxwell (Issue Editor)
Samuel L. Odom (Lead editor)
Donna Bryant (Editor)

Evidence-Based Interventions for Juvenile Offenders and Juvenile Justice Policies that Support Them

As Gendreau, Smith, and Theriault (2009) contend, there is a general consensus among research-oriented psychologists and criminologists about "what works" and "what doesn't work" in reducing the criminal behavior of juvenile offenders. Yet this knowledge has had relatively little penetration into the general public, media, politicians, and policymakers. Indeed, Greenwood (2008) concluded that only about 5% of juvenile offenders have the opportunity to benefit from programs with proven effectiveness.

This paper has two broad purposes. The first is to contrast those juvenile justice interventions and policies that have been proven effective with those that have not—and then to describe the likely bases of their relative success or failure. The second purpose is to present examples of federal and state initiatives that have successfully promoted the large-scale adoption, implementation, and sustainability of evidence-based interventions for juvenile offenders. This work illustrates that collaboration among those who develop and implement such interventions and those who develop and implement policy can help bridge the science-service gap.

Extent of Juvenile Arrests and Residential Placements

Law enforcement agencies arrested 2,111,200 juveniles in 2008 (Puzzanchera, 2009). About 25% of the arrests pertained to violent (i.e., robbery, rape, aggravated assault, murder, and manslaughter) or property (i.e., burglary, larceny-theft, motor vehicle theft, and arson) index offenses. Females comprised 30% of the arrested population, and black youth were overrepresented in juvenile arrests (Hispanic ethnicity was included in the white racial category). Of the youth eligible for processing in the juvenile justice system due to their arrest, 66% were referred to juvenile court and 10% were referred directly to criminal (adult) court. A small percentage of youth referred to juvenile court were subsequently waived to criminal court.

The most serious and costly outcome of a court referral following arrest is residential placement (e.g., detention center, wilderness program, residential treatment center, correctional institution, group home). Approximately 160,000 juvenile offenders were placed in 2007 (Puzzanchera & Kang, 2010). National data on length of stay are not available for all juveniles in residential placements, but the median length of stay for youth placed by the juvenile justice system is about 4 months (Snyder & Sickmund, 2006). Although length of stay varies with the seriousness of the offense in the expected direction, crimes against persons (e.g., robbery, assault) had been committed by about only 35% of placed offenders. In fact, about 20% of placed youth had committed technical violations of probation or parole (e.g., not attending school, missing curfew, testing positive for cannabis) or status offenses (e.g., ungovernability, running away). Again, black youth were overrepresented in correctional placements. Hispanic youth were also overrepresented in residential placements, at a rate lower than blacks but higher than non-Hispanic whites.

What Works, What Doesn't, and Why

The following summary is based on conclusions from several excellent comprehensive reviews published during the past decade. These include reviews commissioned by the government such as the Blueprints for Violence Prevention series (Elliott & Mihalic, 2004) and the Surgeon General's report on youth violence (U.S. Public Health Service, 2001), volumes published by leaders in the field of delinquency and criminal justice (e.g., Greenwood, 2006; Howell, 2003), journal reviews (e.g., Eyberg, Nelson, & Boggs, 2008), meta analyses (Drake, Aos, & Miller, 2009; Lipsey, 2009) as well as several more circumscribed reviews of specific types of interventions and policies.

Ineffective Programs and Policies

Until the 1990s the conclusion that "nothing works" (e.g., Lipton, Martinson, & Wilks, 1975) was generally accurate—rigorous research had not supported a myriad of rehabilitation efforts for juvenile offenders. Although effective interventions have been developed and validated during the past 20 years, it remains the case that the vast majority of current services utilized in the juvenile justice system have not proven effective or simply have not been evaluated. Key examples follow.

Processing in the juvenile justice system. Following an arrest, several juvenile justice stakeholders (e.g., juvenile court intake officer, district attorney, judge) can decide whether the youth should be officially processed through the court system, released without referral for services, or diverted from the system to a variety of community-based services. Petrosino, Turpin-Petrosino, and Guckenburg (2010) recently completed a meta-analysis of 29 controlled studies comparing juvenile justice processing with either release without services or processing to a diversion program (diversion programs varied widely in the types of services offered). Overall, analyses showed that juvenile court processing tended to increase criminal behavior, especially when compared with diversion to community services.

Juvenile transfer laws. All states have mechanisms for handling juveniles in criminal court (Adams & Addie, 2010)—through prosecutor discretion laws, statutory exclusion laws for certain types of offenses, and judicial waiver laws; and fewer than half of waived cases involve person offenses. Redding (2010) reviewed six large-scale studies and all found that transfer to adult court was associated with higher recidivism rates among juveniles convicted of person and property offenses when contrasted with counterparts adjudicated in juvenile court. Thus, rather than acting as a deterrent, transferring juveniles for trial and sentencing in adult criminal court had the unintended consequence of increasing their criminal activity.

> Although effective interventions have been developed and validated during the past 20 years, it remains the case that the vast majority of current services utilized in the juvenile justice system have not proven effective or simply have not been evaluated.

Surveillance. Surveillance includes probation and parole, which can be intensive or not, and is implemented by professionals within the juvenile justice system. Probation and parole are practiced in virtually every jurisdiction in the nation. Overall, current evidence is mixed regarding the effects of probation and parole on juvenile offending. For example, Drake et al. (2009) found no average effect in their meta-analysis, whereas Lipsey (2009) found a slight favorable effect in his meta-analysis. In a qualitative review, Howell (2003) concluded that intensive supervision, by itself, does not reduce reoffending but can be effective when linked with a therapeutic program. Though not clearly detrimental, in contrast with other interventions and policies described in this section, surveillance is included here because of its widespread use and lack of strong empirical support.

Shock incarceration interventions. Scared Straight is the best known of the shock incarceration programs. Juvenile offenders are brought into adult prison and supposedly "scared" out of their delinquency through threats, bullying, and intimidation by inmates. As detailed in the aforementioned reviews (e.g., Drake et al., 2009; Greenwood, 2006; Howell, 2003), evaluations have shown that such interventions increase the criminal behavior of juvenile offenders.

Residential placement. As indicated previously, about 160,000 youth are placed annually in residential facilities such as boot camps, group homes, detention centers, residential treatment centers, and wilderness camps. The primary intentions of most of these placements are to provide an opportunity for rehabilitation and to protect community safety by removing the youth from home. Residential placements, however, have failed on both counts. Reporting on results from a large-scale survey of youth in residential placement, Sedlak and McPherson (2010) concluded that despite great needs, mental health, substance abuse, and educational services are deficient for many youth. Moreover, across the comprehensive reviews cited previously, the authors have concluded that a wide variety of placement services for

juvenile offenders ultimately increase their criminal activity, and do so at high social and economic cost. Such findings within the juvenile correctional system are consistent with the negative effects of adult incarceration on reoffending (Nagin, Cullen, & Jonson, 2009) as well as with findings for residential treatment of youth in the mental health system (U.S. Department of Health and Human Services, 1999). Given that residential placements will continue to exist, albeit hopefully limited to only the most serious juvenile offenders, a pressing need exists to develop and validate institution-based services or community-institution linked services that better meet the needs of this very high-risk group of adolescents and their communities.

In sum, a number of juvenile justice interventions and policies that are intended to reduce the criminal behavior of delinquents have had the unintended consequence of increasing youth antisocial behavior. As described subsequently, we regard such findings as a logical and expected outcome of the interplay between well-established risk factors for offending and the nature of the interventions provided in the preceding services. Before describing this perspective, however, several programs are presented that have proven effective in reducing the criminal activity of juvenile offenders.

Effective Programs

The Blueprints initiative (http://www.Colorado.edu/cspv/blueprints/modelprograms.html) reviewed research on 600 delinquency, drug, and violence prevention and intervention programs. Only 11 of these met the following criteria for effectiveness: evaluation through an experimental design, evidence of a significant deterrent effect, successful replication at multiple sites, and sustainability of favorable outcomes for at least a year. Of those programs intervening with juvenile offenders, only three met these criteria—functional family therapy, multisystemic therapy, and multidimensional treatment foster care. These same intervention models are cited as effective in virtually all of the comprehensive reviews noted previously. Key features of these three models are discussed next, and more complete descriptions and reviews of corresponding research are provided by Henggeler and Sheidow (in press).

> Functional family therapy, multisystemic therapy, and multidimensional treatment foster care were identified in the Blueprints initiative as effective interventions for juvenile offenders.

Functional family therapy. Functional family therapy (FFT; Alexander & Parsons, 1982) is a family- and community-based treatment that was one of the first evidence-based treatments developed in the field. Six FFT outcome studies (four randomized clinical trials, and two quasi-experimental) have been published, with participants ranging in clinical severity from status offenders to youth presenting serious antisocial behavior. Most of these evaluations demonstrated favorable decreases in antisocial behavior for youths in the FFT conditions (Henggeler & Sheidow, in press). During the past decade, FFT has become one of the most widely transported evidence-based family therapies, with 270 programs worldwide, treating more than 17,500 youth and their families annually (http://www.fftinc.com). In FFT, the presenting problem is viewed as a symptom of dysfunctional family relations. Interventions, therefore, aim to establish and maintain new patterns of family behavior to replace the dysfunctional ones. In addition, FFT integrates behavioral (e.g., communication training) and cognitive behavioral interventions (e.g., assertiveness training, anger management) into treatment protocols—though always maintaining a relational focus. Central to the implementation of FFT is the phase-based nature of intervention protocols, with initial emphases on engaging and motivating family members, followed by extensive efforts at individual- and family-level behavior change, and concluding with interventions to sustain such behavior change. FFT also has an intensive training and certification protocol aimed at maintaining program standards and therapist adherence.

Multisystemic therapy. Multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) is a community- and family-based treatment that focuses on youth with serious clinical problems (e.g., violent juvenile offenders, juvenile sexual offenders, substance abusing juvenile offenders, and youth with serious emotional disturbance) at high

risk for out-of-home placement. MST is one of the most extensively validated (i.e., consistent decreases in reoffending and residential placements) and widely transported evidence-based psychosocial treatments (Henggeler, in press). There are 21 published outcome studies (19 randomized trials and two quasi-experimental studies), the majority conducted with serious juvenile offenders and their families; and the intervention is delivered to more than 17,000 youth and families annually. Consistent with Bronfenbrenner's theory of social ecology (1979), youth are viewed as nested within multiple systems (e.g., family, peer, school, neighborhood) that have direct (e.g., parenting practices) and indirect (e.g., neighborhood context affects parenting practices) influences on behavior. This perspective fits well with research on the development of conduct problems, where antisocial behavior is viewed as multidetermined (Liberman, 2008). Similarly, MST interventions are comprehensive and flexible—with the capacity to address pertinent factors at the individual (e.g., cognitive biases), family (e.g., affective and instrumental relations), peer (e.g., prosocial versus antisocial nature of peer associations), school (e.g., academic performance), and community (e.g., availability of prosocial activities for youth) levels. Importantly, mechanism of change research from several MST clinical trials (Henggeler, in press) has supported the roles of improved family functioning and decreased association with deviant peers in producing favorable outcomes for juvenile offenders. In addition, MST has an intensive quality assurance and improvement system to sustain program standards and treatment fidelity, and numerous aspects of this system have been validated (Schoenwald, 2008), including the link between therapist treatment fidelity and desired youth and family outcomes.

Multidimensional treatment foster care. Multidimensional treatment foster care (MTFC; Chamberlain, 2003) was developed to provide a community-based foster care alternative to state detention and group care facilities, particularly for cases in which other intensive in-home and out-of-home services have failed. Seven research trials (five randomized and two quasi-experimental) have evaluated MTFC for youth with serious antisocial behavior who cannot be maintained in their home, and several adaptations have been examined for youth presenting other types of challenging clinical problems. MTFC programs have been transported to more than 50 sites in the U.S. and internationally (http://www.mtfc.com), treating about 1,300 youths and families annually. MTFC is based on the principles of social learning theory, which include behavioral principles (i.e., learning through overt reward and punishment) and the impact of the natural social context on learning. As with MST and FFT, many of the specific intervention techniques used in MTFC are derived from behavior therapy (e.g., development of behavioral management plans) and cognitive behavioral approaches (e.g., problem solving skills training). Moreover, these interventions are implemented within a social ecological framework that emphasizes the critical role of parental supervision and monitoring in engaging the youth in prosocial peer activities, disengaging him or her from deviant peers, and promoting positive school performance. Foster and biological parents are both intensively involved in implementing these treatment elements. Importantly, these emphases have been supported by mechanism of change research (Eddy & Chamberlain, 2000; Leve & Chamberlain, 2007) showing that MTFC effects on youth antisocial behavior were mediated by improved foster parent supervision and discipline, decreased association with deviant peers, and increased completion of school work. MTFC also includes extensive consultation and technical assistance to sustain program fidelity.

Bases of Success and Failure

The commonalities of effective programs in contrast with the commonalities of ineffective programs and policies provide a useful framework in understanding the bases of success and failure of juvenile justice programs.

Effective programs specifically address key risk factors. Decades of correlational, longitudinal, and experimental research have built a strong case for a multidetermined ecological conceptualization of juvenile offending. Several comprehensive reviews (e.g., Howell, 2003; Liberman, 2008; Loeber, Burke, & Pardini, 2009) have summarized findings that support a relatively consistent array of individual, family, peer, school, and neighborhood constructs as risk factors for antisocial behavior. The evidence-based treatments discussed previously take full advantage of this research—focusing their interventions on key aspects of the youth's social ecology, such as building more effective family functioning, disengaging youth from deviant peer networks, and enhancing youth school performance. On the other hand, ineffective programs and policies largely ignore these risk factors (e.g., minimal attention to building family competency) or, worse, provide services that directly conflict with risk factor research. For example, aggre-

gating antisocial youth together for extended periods of time, as is common in most of the aforementioned juvenile justice interventions, provides ample opportunity for peer contagion and deviancy training (e.g., modeling and rewarding of deviant behavior by peers; Dodge, Dishion, & Lansford, 2006).

Effective programs are rehabilitative in nature and use behavioral intervention techniques within the youth's natural environment. FFT, MST, and MTFC each use behavioral and cognitive behavioral intervention techniques, though often within a systemic conceptual framework, to improve the functioning of the youth and family members. In addition, these treatment models are specifically community-based, with practitioners aiming to ameliorate identified problems where they occur—in home, neighborhood, and school settings. In contrast, ineffective services typically deliver interventions outside the youth's natural environment—in residential facilities, probation offices, prisons, courts, and so forth. Although these interventions might be behavioral in nature (e.g., cognitive behavioral therapy provided by residential therapist), they fail to fully consider the real world context to which the youth will return.

Effective programs are well specified and include intensive support for intervention fidelity. In a field where "nothing works" was a longstanding conclusion, the purveyors of the effective programs have been determined to sustain the quality and effectiveness of their treatments as transported to community settings. Intervention, training, and quality assurance manuals and protocols are well specified, and therapist and program performance are routinely monitored for fidelity of implementation, youth outcomes, and corrective action if necessary. Although the interventions provided by ineffective programs delivered in juvenile justice contexts might also be manualized, such specification is not necessarily useful in the absence of supportive research.

How Do These Bases of Success Fit with the Conclusions of Other Reviewers?

Several reviewers have used qualitative and quantitative methods to delineate the central features of effective versus ineffective programs for juvenile offenders. As described by Howell (2003), perhaps the most influential has been the work of Canadian researchers—Andrews, Bonta, Gendreau, and Ross with their American colleagues Cullen and Latessa. These investigators have concluded that effective programs follow four general principles.

- *Target known risk factors for offending:* Such is a clear focus of FFT, MST, and MTFC, and as noted previously in the descriptions of these models, mechanism of change research has verified the value of this focus.
- *Interventions should be behavioral in nature:* MTFC is explicitly behavioral, and MST and FFT include behavioral techniques within a broader systems-theory conceptual framework.
- *Interventions should be individualized to the strengths and weaknesses of the offender.* The evidence-based treatments follow this principle and take it one step further—interventions are also individualized to the strengths and weaknesses of the key systems in which the youth is embedded.
- *Interventions should be delivered mainly to high-risk offenders.* MTFC and MST are specifically designed and validated as alternatives to residential placement, and FFT is often provided to repeat offenders.

Purely quantitative analyses have generally drawn similar conclusions. For example, Lipsey (2009) concluded that three factors emerged from his meta-analysis as major correlates of program effectiveness: a therapeutic intervention philosophy, serving high risk offenders, and the quality of implementation. The first two of these factors are similar to those noted above, and, as also noted previously; the three family-based models place tremendous emphasis on providing the types of training and ongoing quality assurance needed to sustain the fidelity of program standards and therapist adherence.

Lipsey draws a conclusion, however, with which we disagree—that treatment programs can be effective within institutional environments. In no case has an institution-based program proven more effective than a community-based program in a rigorous evaluation. Indeed, Magellan Health Services (2008) recently provided a compelling case for minimizing the use of residential programs for youth: (a) clinical gains between admission and discharge are often not sustained when youth return to the real world; (b) many youth in residential treatment show serious adverse effects, perhaps linked with their intensive exposure to disturbed peers (Dodge, 2008); and (c) residential programs are much more costly than community-based counterparts.

In sum, the nature of effective services for juvenile offenders is relatively well established and these contrast considerably with the status quo of the vast majority of

services provided to juvenile offenders across the nation. Indeed, together, the evidence-based treatment programs serve about 35,000 youth and families annually, about 30,000 of whom reside in the U.S. Based on statistics from MST Services (http://www.mstservices.com), the MST purveyor organization, about 50% of referrals to MST programs are from juvenile justice. A similar percentage applies to FFT (James Alexander, personal communication, November 2, 2010), and a slightly smaller percentage to MTFC (Patti Chamberlain, personal communication, November 2, 2010). Thus, about 15,000 youth in the juvenile justice system are treated with an evidence-based treatment annually. If 160,000 juvenile justice youth are placed annually (Puzzanchera & Kang, 2010) and we assume that an equal number are at high risk of placement, then fewer than 5% of eligible high-risk juvenile offenders in the U.S. are treated with an evidence-based treatment annually. As discussed next, however, inroads to the larger scale use of evidence-based treatments have been made in recent years by virtue of both federal and state policy initiatives within and outside of the juvenile justice sector, some of which explicitly called for the use of evidence-based interventions and others that did not.

… fewer than 5% of eligible high-risk juvenile offenders in the U.S. are treated with an evidence-based treatment annually.

Interfaces of Policy and Evidence-Based Intervention Promulgation: Multisystemic Therapy as an Example

Observers of public policy often note that the role of scientific evidence is often limited in the development of public policy. This should not be surprising, given differences in the epistemology of policy-making and science (Hoagwood, 2010). Policy decisions, which often affect sizeable proportions of a population, are driven by political values and agendas, influenced by both irrational and rational factors and by the benefactors of the status quo, and can change quickly as agendas and coalitions shift (Melton, 1997; Morris, 2000). Science values the application of rational methods to derive reliable and valid answers to specific questions, is inherently slower and more conservative than policy-making, and rarely has a large effect on the public until it is proactively translated into knowledge, products, or services that are made accessible in the marketplace.

Some have suggested the influence of science in different realms of policy-making can be accounted for in part by the extent to which the practices of an industry rely on empiricism. For example, Biglan and Taylor (2000) identified the influence of empirical evidence on policymakers as a factor contributing to the favorable effectiveness of efforts to reduce tobacco use relative to those directed toward reducing violent crime. Efforts to control tobacco use emerged in the public health field, which has a history of basing its practices on empirical evidence; and political leaders often defer to health care professionals when formulating public policy relevant to health.

In contrast, the agencies mandated to do something about antisocial behavior may or may not have an empirical tradition. Crime control policies are often set by elected officials without training in empirical methods or a command of the evidence related to crime control. Thus, although scientific evidence that a prevention or intervention program has demonstrated meaningful effects on crime may be one valuable coin of the juvenile justice policy-making realm, it is not *the* coin for at least two reasons: (1) other powerful drivers of decision-making are likely to remain in play even as evidence is introduced; and (2) the bearers of evidence may not be adept at making the evidence relevant to decision makers and stakeholders who are not trained in empirical methods (Melton, 1997; Morris, 2000).

Accordingly, to better align juvenile justice policy and effective interventions, those who generate the evidence need to better understand the context and modus operandi of those who will hopefully use it. How policymakers and system administrators become aware of and use research results in decision-making, and why some organizations are more effective than others at brokering research for policy and practice purposes are topics of interest to both federal and philanthropic research funding organizations such as the W.T. Grant Foundation (2010). Similarly, the academic discipline of policy research focuses explicitly on the uptake, implementation, and impact of specific policies (for example, the impact of Medicaid waivers on access, quality, and cost of health

or mental health care). To our knowledge, such research has not been conducted on the impact of federal and state juvenile justice policies on the availability of evidence-based interventions to youth and families, nor on the extent to which the policies have been informed by evidence. Unfortunately, such a review is also beyond the scope of this paper.

There are, however, several resources that document federal and state legislative, policy, and regulatory activity related to juvenile justice. For example, the National Juvenile Justice Network (NJJN, 2010a; http://www.njjn.org) monitors state juvenile justice legislation. Our review for this paper of the NJJN inventory of legislation enacted between 2005–2010 reveals considerable activities, some focused specifically on reducing incarceration and out-of-home placement of youth, some on increasing the availability of community-based services for such youth, and a very few on increasing the availability of empirically-supported interventions for such youth. In addition, at least two recent policy developments at the federal level may establish a context for a more scientific approach to the treatment of youth in the juvenile justice system: the Juvenile Justice and Delinquency Prevention Reauthorization Act as well as administration policies designed to extend the concept of comparative effectiveness—and associated funding priorities—beyond the realm of health care to other educational and social programs (Lewis, 2010).

The remaining sections of this paper provide examples from the transport and implementation of MST that illustrate the impact state and federal policies can have on the uptake, implementation, and sustainability of evidence-based interventions. We consider implications of this experience for the development of dissemination and implementation strategies that are sufficiently robust and flexible to detect and address policy-related barriers to the adoption and implementation of evidence-based practices for youth.

Evidence-Based Interventions and Juvenile Justice Goals

Policy development and enactment occurs and interacts at multiple levels of the geopolitical context—federal, state, regional, county, and municipal. Within each of these realms the term "juvenile justice system" subsumes distinct agencies that have different functions—police, prosecuting attorneys, defense attorneys, judges, probation and corrections. The overarching goals of the juvenile justice system comprised of these distinct entities relate primarily to securing the safety of the community and deterring juveniles from future illegal acts. The goals of evidence-based interventions typically pertain to the attenuation if not amelioration of the behavioral, emotional, and functional problems of youth with or at high risk of developing a particular disorder or configuration of clinical problems. To the extent an intervention can be shown empirically to deter youth from future criminal acts, it can serve both juvenile justice system and individual health goals.

This simultaneous conferral of both individual and public benefit is a hallmark of public health goals and the strategies used to achieve those goals. A public health perspective assumes that both a specific target population and the general population benefit from a treatment for the target population. This perspective has informed the strategies used to transport MST. The public health benefits demonstrated in randomized trials of MST were significantly decreased recidivism and thereby increased community safety, and decreased out-of-home placements and costs. The demonstrated benefits of MST to the youth and families served included keeping the youth at home while reducing the symptoms and behavior problems that invited trouble with the law. Although we have not empirically evaluated the extent to which making explicit both the individual (youth and family) and public benefit of MST has contributed to its demand, research on public health campaigns suggests this might be the case. Specifically, the success of social marketing strategies designed to influence a variety of health behaviors indicates that tailoring information and activities about an innovation to the interests, attitudes, and beliefs of the distinct groups of potential consumers can improve the uptake of the innovation (Andreasen, 1995; Grier & Brant, 2005).

A reasonable inference from social marketing research is that the benefit of an intervention that matters most to distinct groups of end-users—the youth and family, each agency in the juvenile justice system (courts, prosecution, defense, probation, corrections) and payers—likely varies, and empirical evidence about the effects of the intervention should address these distinct interests. In addition, experts in criminology (Cullen, Myer, & Latessa, 2009) predict that evidence of lasting treatment effects and cost effectiveness or savings will become increasingly necessary in corrections policy and industry as state budget deficits and the adult corrections population simultaneously increase. If, however, the first evidence of effectiveness appears so far out on the time horizon that current stakeholders and their constituents

may not experience the benefit, political will and practical constraints will likely reduce interest in uptake (McCarthy & Kerman, 2010).

It seems reasonable to suggest, then, that to increase the use of evidence and evidence-based interventions in juvenile justice, prevention and treatment researchers would do well to proclaim: (1) the extent to which interventions convey one or more concrete public health benefits (e.g., decreased truancy rates at a school, increased community safety, decreased cost to taxpayer); (2) the expected duration of intervention effects; and (3) cost-related implications (e.g., effectiveness, savings benefit). If the data necessary to do so are not available from efficacy or effectiveness trials of the intervention, then a first step in the transport process is to seek out and collaborate with stakeholders willing to attempt an implementation to generate such data. In this way, researchers and policymakers together begin to build the evidence base about the public health benefit and cost implications of an intervention. We have had the good fortune of engaging in this kind of collaboration with states interested in variants of MST for target populations with which it had not previously been tested (Rowland et al., 2005; Schoenwald, 2010).

Finally, adjudicated youth are typically in the legal if not also physical custody of the juvenile justice system. The system's legal mandate to serve these youth is extremely costly, because "service" often consists of incarceration, residential treatment, and other out-of-home placements. Tight state and county budgets can motivate cost-cutting solutions. To the extent evidence-based interventions are cost effective, they should increasingly be among solutions to government budget problems (Cullen et al., 2009). Although the fragmentation of treatment financing in health and mental health care also characterizes to some degree treatment within juvenile justice systems (Cartwright, Kitsantas, & Rose, 2009), the relatively greater central authority and legal accountability for youth in juvenile justice custody could facilitate more rapid uptake and greater reach of evidence-based interventions once an initial implementation is successfully sustained, although we have not empirically evaluated this proposition. The final section of this paper describes the variation in states' approaches to expanding the use of MST, including variations in the centralization of their efforts (Schoenwald, 2010.)

To the extent evidence-based interventions are cost effective, they should increasingly be among solutions to government budget problems (Cullen et al., 2009).

Match and Mismatch of Intervention and Policy

Laws and the regulations that emanate from them can be used to provide at least a "floor" and "ceiling" for local and individual variations in a practice (Ferlie & Shortell, 2001) and are among mechanisms used to support public health strategies (Thornicroft & Tansella, 1999). Mandates can, for example, terminate funding for demonstrably ineffective programs like boot camps for juvenile offenders. Conversely—with or without changes in law—policies, regulations and budgetary actions often affect clinical practices. In our experience, legal mandates, regulations, and policies affect MST implementation and outcomes through their impact on service parameters, service funding, the definition of the target population eligible for service, and the time and scale on which services are enacted.

Service parameters. Some examples of service parameters affecting implementation are: personnel allowed to deliver the service (physicians, licensed social workers, etc.); medical necessity criteria governing client eligibility for the service; requirements regarding treatment session duration, frequency, and participants; and length of the treatment episode. Sources of such requirements include referral, funding, and collateral agencies. For example, even when a referring juvenile justice agency and Medicaid payer endorse the short duration (4-5 months) of MST, a judge or probation chief may require a youth to stay in treatment for a year-long term of probation—a major aberration of MST protocols.

Funding. Legal mandates activated in the absence of sufficient resources to implement a treatment can corrupt its implementation and sustainability. Four funding issues seem critical to policies designed to support the import and implementation of evidence-based treatments like MST. (1) If it is more profitable for a local provider organization to deliver a treatment of unknown effectiveness (e.g., residential treatment) to a specific target

population than to deliver an evidence-based treatment for that population, odds are low the evidence-based treatment will substantially penetrate that market of service providers. (2) Where evidence exists that model-specific training and implementation support are needed to sustain treatment fidelity and associated client outcomes, funding must be provided for the training and ongoing implementation support. (3) Funding must be adequate to subsume the start-up costs associated with staffing and initial training incurred before services can be delivered and billed. (4) Adequate "fit" is needed between the payment mechanism and demand characteristics of the treatment. For example, fee-for-service billing mechanisms requiring therapists to document 15-minute increments of service fit poorly with several hallmark features of MST: variable and functionally-driven duration of sessions; therapist travel to the homes, schools, and neighborhoods; attendance at court hearings and probation meetings; and frequent telephone contact with the family and others participating in treatment. In contrast, case rates and daily rates better accommodate these features of MST.

Target population. The implementation and outcomes of an evidence-based treatment can degrade when a mismatch exists between the population mandated to receive services and that for which evidence of treatment effectiveness exists. With respect to MST, the potential fit between a target population of interest to stakeholders and MST is sometimes unclear because the criteria used to define the population do not map directly onto the clinical and functional criteria characterizing youth effectively treated with MST. For example, class action suits have been successfully brought against several states as a result of poor detention conditions, overuse of residential placement, lack of services, and so forth. The consent decrees emanating from such suits typically identify on legal grounds a class of youth mandated to receive a particular type or array of services. Examples include youth court ordered to residential placement without prior access to community-based alternatives, or youth with Individualized Education Plans denied mental health services. One approach to such situations is for model developers, purveyors, and stakeholders to examine together the extent of overlap in the class action and intervention populations and strategize about treating only the youth appropriate for the intervention, as routinely undertaken in the transport of MST. An alternative strategy is to collaborate with the interested stakeholders and systems in scientifically testing treatment modifications specified for the target population in question, as we have also done with states such as Hawaii pioneering the greater use of evidence-based practices (Rowland et al., 2005).

Finally, even when an effective intervention such as MST is established for the appropriate target population (i.e., chronic or violent juvenile offenders at high risk of residential placement), net widening to other populations can occur over time for a variety of reasons (e.g., a service organization under contract with juvenile justice to treat offenders with MST is approached by child welfare to serve non-offending but troubled foster children; perceived success of MST with serious offenders prompts judicial referral of first time truancy cases). We suggest the greater population heterogeneity identified as among factors contributing to the dilution of previously demonstrated effects of preventive interventions (Welsh, Sullivan, & Olds, 2010) is not inevitable, but can be effectively managed when the developers and purveyors of the intervention collaborate with policymakers in a particular locale to establish and maintain criteria for program inclusion and monitor the population served and service outcomes.

Time and scale. Legal mandates often embody two sources of potential mismatch with MST implementation: time and scale. Political election cycles are short, and legislative and administrative budgets are established annually; hence, mandates often call for the broad use of a new type of service within a fairly short time period. State juvenile justice or mental health agencies may inform contracted service provider organizations that a new mandate requires bringing new services on line within three to six months. For simpler technologies, such as new medications or brief diagnostic screens, establishing an aggressive timeline for broad penetration within the provider community may suffice to facilitate adequate, large-scale implementation. For interventions such as MST, which require multiple changes in practitioner behavior, model of service delivery, and implementation and outcomes monitoring, multiple and intensive strategies are required to ensure adequate implementation, and wide, rapid deployment may corrupt implementation (Grimshaw et al., 2001).

Cultivating and Sustaining Intervention-Policy Context Compatibility

Identifying and managing the mismatch of the content and contours (e.g., service parameters, funding needed, training protocols) of evidence-based interventions with policies is an ongoing process, in part because policies

and their regulatory interpretations change. The routes from policy to the uptake and effective implementation of programs are varied and, in our experience, require patience, persistence and partnership with stakeholders at all levels of the practice (family, practitioner, program manager, clinic CEO or director) and policy context (courts, probation departments, juvenile justice agencies, funding agencies, collateral service sectors). Scholarly reviews of implementation suggest that, to do this work effectively, it has to be someone's job; and "purveyor" entities can be well suited in that role (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

In the case of MST, a university-licensed organization, MST Services, LLC, and its Network Partners are the purveyors who undertake this work. Among the tools they use and promulgate are the training, clinical supervision, and fidelity monitoring protocols derived from MST effectiveness trials and research on the transport of MST to community settings. These tools are part of a quality assurance and improvement system that includes organizational support; adherence measurement and monitoring at multiple levels of the clinical context (therapist, supervisor, expert consultant); and the collection, synthesis, and reporting of quantitative and qualitative feedback on program implementation and outcomes obtained from MST program participants (families, therapists, supervisors, experts, program managers) and provided to these participants and external stakeholders. With this type of quality assurance and improvement system in place (and evolving on the basis of data and experience), approaches to the adoption and expansion of MST can vary somewhat in accordance to the policy and practice contexts of diverse states and nations, as described next.

> The routes from policy to the uptake and effective implementation of programs are varied and … require patience, persistence and partnership with stakeholders at all levels of the practice …

The Promise of Federal Initiatives and the Process of Successive Approximation: Two Examples

Federal and state juvenile justice and mental health policies designed to promote community-based interventions for youth contain seeds of match and of mismatch between an effective intervention and the practice context. At the federal level, for example, the System of Care (SOC; Stroul & Friedman, 1986) for children with serious emotional disturbances promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the early 1990s provided funding for states to increase family- and community-based service alternatives to restrictive placements for youth. The definition of the target population was sufficiently broad to encompass youths with diverse clinical, functional, and placement histories. SOC values, principles and associated program guidelines made paramount increases in the array and availability of community-based, youth and family-centered services. Although evidence of service effectiveness was not required by the initiative, the combination of SOC funding, principles, and target population motivated some states to seek out MST. Challenges to MST implementation in several SOC sites, however, highlighted the need to more clearly identify—within the broad federal and state definitions of the target population (i.e., youth with serious emotional disturbance)—the population for which MST was appropriate, given its evidence base with serious juvenile offenders at the time. In some instances, the result was mutual agreement to discontinue the MST program altogether. In others, MST was re-focused on delinquent youth, requiring the SOC grantee, typically a department of mental health, to solicit greater juvenile justice system involvement.

Also in the early 1990s, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) focused on identifying and supporting the broader use of *effective* juvenile justice prevention and intervention strategies for delinquent youth. The strategies designed to meet this aim included the commission of a scholarly review of the evidence on prevention and intervention programs for this population, the Blueprints for Violence Prevention (Elliott, 1998); a grant to facilitate the dissemination of these programs; and Juvenile Accountability Block Grants (JABG) that included requirements for measuring the effects of funded activities. These strategies stimulated demand for MST among state and county juvenile justice agencies and the organizations with which they contracted to

treat juvenile offenders. The initial Blueprints dissemination grant program, however, did not include resources to support or monitor model-specific implementation or youth outcomes. The purveyors of MST and other Blueprints models worked together with states, communities, and the Blueprints leadership to revise the dissemination strategy to include implementation support and measurement of fidelity and outcomes.

State Initiatives to Sustain and Expand the Reach of Evidence-Based Interventions

State initiatives contributing to the diffusion of MST have taken several different forms and illustrate how mandates and policies can catalyze, but not guarantee, the uptake, implementation, and diffusion of evidence-based treatments. State initiatives to transport and disseminate MST reflect approaches that range from relatively centralized to more diffuse (Schoenwald, 2010). In some states, like Washington and Florida, the legislature identified juvenile crime and the associated community safety risks and costs as sufficiently onerous problems to warrant new legislation. In 1997, Washington was the first state to legislate, through the Community Juvenile Accountability Act (CJAA), the use of research-based programs to reduce juvenile crime cost effectively. In a process that paralleled the Blueprints review, the Washington State Institute on Public Policy (WSIPP; www.wsipp.wa.gov) selected programs on the basis of a national research literature review and was contracted to evaluate the performance of the programs as implemented in Washington. Counties chose the programs they wished to implement, and service funding was partially provided by the CJAA, with federal (JABG) and Blueprints dollars contributing to the cause. Some of the chosen programs were not launched because the mechanisms for training and technical assistance had not been developed; others were implemented but yielded poorer outcomes than anticipated and were thus discontinued. Three counties established MST teams as a result of this initiative.

In 2003, the Florida legislature undertook a statewide initiative to import evidence-based treatments for juvenile offenders and evaluate the effects of those treatments in Florida. The legislation was discharged through the state department of juvenile justice in a new program called Redirection. Redirection imported only models whose implementation and outcomes were favorable in Washington and other states, and MST and FFT were imported. At the time, research linking the MST quality assurance system components and youth outcomes as well as specification of infrastructure and program practices had advanced considerably (Schoenwald, Sheidow, & Letourneau, 2004; Schoenwald, Sheidow, Letourneau, & Liao, 2003). Accordingly, the legislature and department of juvenile justice collaborated with purveyors of MST to create the infrastructure, funding, and regulations to support implementation. The regulations were thus more closely aligned than was the case when Washington pioneered the import of MST.

In the intervening years, a number of other states sought to import one or more evidence-based treatments, and then to expand the reach of those treatments throughout the state. States differed, however, in their approach to the task. The states' strategies can be conceptualized on a continuum from centralized to laissez-faire (non-centralized, more privately than publicly funded). Connecticut, for example, pursued a centralized approach to the import and expansion of MST. There, the Department of Children and Families (DCF), responsible for serving youth in state custody, initiated the import of MST as aftercare for juvenile offenders released from out-of-home placements. State-funded evaluations of MST were favorable, and these, along with political pressures to improve services for juvenile offenders not in state custody, prompted the Court Support Services Division (CSSD) of the judicial branch to support statewide expansion of MST. Today, DCF and CSSD jointly fund a private provider organization as the Network Partner to provide the training and quality assurance to all MST programs in the state. The state agencies directly reimburse contracted provider organizations for delivering MST to youth and families.

Ohio provides an example in the middle of the continuum between centralized and laissez-faire strategies to take evidence-based treatments to scale. Although the import of MST was initiated in 1996 as a result of a Governor's office initiative to improve and evaluate services for juvenile offenders, the growth of MST accelerated via the state's establishment in 1999 of Coordinating Centers of Excellence (CCOEs) across all state departments (health, education, welfare, juvenile justice, mental health). The state provided infrastructure funds to support each CCOE, and the CCOE then established its own strategies for identifying practices it wished to import or develop. Within the Department of Mental Health, the Center for Innovative Practices (CIP) was established in 2003. The CIP collaborates with the local mental health boards (which control services and funds), consumer advocacy

groups, universities, and sister agencies to identify and support a variety of clinical practices. As an MST Network Partner, the CIP provides the quality assurance/quality improvement system to MST programs in Ohio; the state, however, does not fund that endeavor. Instead, CIP pays the salaries of the training experts via contracts with provider organizations.

Finally, Colorado presents an example of highly decentralized, non-publicly-funded diffusion of MST. The first MST teams in Colorado were established with funding from the aforementioned federal JABG and Blueprints dissemination programs. The subsequent expansion of programs, however, was spearheaded by private provider organizations. Today, the MST Network Partner in Colorado, the Center for Effective Interventions, supports the majority of MST programs in Colorado, New Mexico, and neighboring states but receives no state or county support or sponsorship for these activities. As occurs in Ohio and Connecticut, state and county agencies contract directly with provider organizations to serve youth and families with MST.

Across domestic and international implementation sites (see Schoenwald, Heiblum, Saldana, & Henggeler, 2008) a variety of controlled, quasi-experimental, benchmarking, and descriptive evaluations have been conducted. The methods and results of state evaluations are often reported in the internal reports of public agencies and rarely reported in peer-reviewed journals. In some states that pursued the larger scale transport of MST, the design and results of evaluations have been made available to the public. For example, a report from The Florida Redirection Project (which encompasses MST and FFT), based on over 2,000 youths and families served, showed the program reduced felony recidivism by 31% and saved millions of dollars in avoided residential placement (Office of Program Policy Analysis & Government Accountability, 2007). The Prevention Research Center at Pennsylvania State University (Chilenski, Bumbarger, Kyler, & Greenberg, 2007) evaluated outcomes of several MST programs that had served over 400 youth and families and found substantial reductions in substance use, delinquency, academic failure, truancy, and out-of-home placements. The Connecticut Center for Effective Practices conducted an extensive qualitative and quantitative evaluation of the MST programs in the state and found reductions in recidivism and out-of-home placement that appear to be sustained over time (Franks, Schroeder, Connell, & Tebes, 2008). Importantly, this evaluation also identified implementation challenges. For example, workforce issues were very difficult to resolve in light of the rapid expansion of MST statewide, and some stakeholders thought the promise of MST might have been oversold.

The results of two MST benchmarking studies (i.e., studies comparing the strength of effects of community-based implementation with that of previous clinical trials) found that MST outcomes (i.e., reducing antisocial behavior and out-of-home placement) in the second year of program operations in Norway matched or surpassed those achieved during the first year (Ogden, Hagen, & Andersen, 2007); and Curtis and colleagues (Curtis, Ronan, Heiblum, & Crellin, 2009) compared pre-post findings from MST programs in New Zealand with results from clinical trials conducted in the U.S. and found clinical outcomes were consistent with those achieved across previous MST studies. On the other hand, some study results have been equivocal. In Sweden, for example, some aspects of implementation (duration of treatment, adherence) differed relative to U.S. and Norwegian trials, and the short-term outcomes of MST were similar to those of youth receiving alternative services (Sundell et al., 2008).

A comparative evaluation has not been conducted of the implementation and outcomes of state or national dissemination efforts as a function of variation in geopolitical factors or dissemination strategy pursued. Evidence from a prospective, 45-site study of the implementation and outcomes of MST in North America, however, indicates neither therapist variables nor agency type (public, private) influences MST adherence or youth outcomes (Schoenwald, Chapman, Sheidow, & Carter, 2009). The observed small effects of organizational variables such as organizational structure and climate on outcomes are attenuated once therapist adherence is taken into account. This study, however, involved neither proactive dissemination nor assessment of service system variation beyond sources of referral and funding (both of which affected reasons for case closure, but not long-term outcomes).

Taken together, the experience of transporting and implementing MST in a range of service systems, communities, and nations, along with the evidence amassing from evaluations of MST implementation and outcomes, prompt some observations. Strategies to achieve the larger scale implementation of evidence-based interventions will likely need to be multi-faceted and address juvenile justice and collateral system policies and practices, service organization policies and practice, practitioners, and consumer populations. This observation is consistent with the conclusions drawn in the aforementioned

> Researchers will likely need to be more involved in the translation process and its evaluation if they want juvenile justice policies to better support the use of effective interventions.

reviews of efforts to improve health care (Ferlie & Shortell, 2001) and increase the use of evidence-based medicine (Grimshaw et al., 2001). The starting point of interest in the adoption of a particular intervention is likely to vary across locales. A state senator, the director of a state department of juvenile justice, a service organization contracted by that system to provide treatment to youth, or a consumer advocacy group may be the first to express interest in an intervention or to respond to a proactive effort to cultivate interest. Regardless of the starting point, the development and implementation of a particular intervention program in a particular locale—and of expansion of the intervention program to additional locales operating within the auspices of the same general system (i.e., state, county)—seem ultimately to require cultivating and maintaining partnerships with individuals and organizations within and across the practice context while maintaining a collective focus on achieving youth outcomes shown to affect community safety.

Conclusions

This paper provided a review of the features of effective and ineffective interventions for juvenile offenders and their families, identified attributes of public policy-making and scientific inquiry to be addressed in the design of strategies to transport and implement effective interventions in juvenile justice systems, and illustrated how the larger scale use of effective treatments can be accomplished within the context of federal policies that may (OJJDP) or may not (SAMHSA) explicitly promote evidence-based practice and of state policies and initiatives that can take a variety of forms. To become more potent influences in the quest to align juvenile justice policy and evidence, the following recommendations are offered to the research and practice community.

1. Understand that the epistemology of policy-making and science often differs with respect to purpose, values, and process (Hoagwood, 2010). Policies are borne of political values and align with political agendas, can change frequently, and can have great impact on the domain of activity in question (health, juvenile justice, education). Science values the use of rational methods to derive reliable and valid answers to specific questions, is inherently slower and more conservative than policy-making, and is unlikely to have a major public impact until results are translated into language, products, and practices that can be exchanged in the marketplace of ideas, goods, and services. Researchers will likely need to be more involved in the translation process and its evaluation if they want juvenile justice policies to better support the use of effective interventions.
2. Understand the primary goals, values, and attitudes of the different constituents who develop, implement, and experience the effects of juvenile justice policies; and differentiate messages about the benefits of interventions accordingly.
3. Consider using a public health framework to marry the community safety and recidivism prevention goals of juvenile justice agencies with the individual and family goals of consumers and practitioners.
4. Capitalize on the cost savings, cost-effectiveness, or cost-benefit evidence about an intervention. If available data about an intervention do not speak to these issues, generate them, potentially in collaboration with willing early adopter systems and organizations.
5. Include in the design and evaluation of dissemination and implementation protocols strategies to cultivate and maintain collaboration with the stakeholders who affect policies and are relevant during the phases of program development, implementation, and sustainability, recognizing that these stakeholders change over time due to election cycles.
6. Be opportunistic regarding the initial transport and implementation of an intervention.
    a. Identify states or jurisdictions that have already enacted legislation, policies, or regulations that support the use of one or more evidence-based interventions. Explore their interest and willingness to collaborate in the identification of

populations still in need of effective intervention and of programs that could be transported on a pilot basis. Some of these states are identified in this paper, others in publications and web-based materials generated by such organizations as the National Juvenile Justice Network.

b. Identify agencies collateral to juvenile justice systems that share the responsibility for serving juvenile justice involved youth. State and county mental health agencies, for example, have an explicit public health mandate (whereas juvenile justice agencies do not), are often contracted by juvenile justice agencies to provide services to youth, and may have among their ranks a larger number of stakeholders familiar with the empirical traditions that inform health care.

c. Review the recommendations and tactical strategies of juvenile justice advocacy groups and organizations for influencing laws, policies, and regulations. There are complimentary actions for researchers in many of these tactics. For example, the NJJN (2010b) recommends to advocates the tactic of reframing cost as investment in public safety and crime reduction, and this tactic echoes the need for researchers to align intervention effects with the goals of juvenile justice agencies and to generate evidence of the longer-term effects and cost effectiveness of the intervention.

Acknowledgements

This manuscript was supported by grants R01DA019892, R01DA017487, and R01DA019708 from the National Institute on Drug Abuse, P20MH0784458 and P30MH074678 from the National Institute of Mental Health, and grant No. 96.2013 from the Annie E. Casey Foundation. This article is dedicated to the memory of Dr. Don Andrews and his important contributions to evidence-based criminal justice.

Correspondence concerning this article should be addressed to Scott W. Henggeler, Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, McClennan Banks Building 4th Floor, 326 Calhoun St. STE MC406, Charleston, South Carolina, 29425. Electronic mail may be sent to henggesw@musc.edu.

Drs. Henggeler and Schoenwald are board members and stockholders of MST Services, LLC, the Medical University of South Carolina-licensed organization that provides training in multisystemic therapy (MST).

References

Adams, B., & Addie, S. (2010). *Fact sheet: Delinquency cases waived to criminal court, 2007*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention

Alexander, J. F., & Parsons, B. V. (1982). *Functional family therapy: Principles and procedures*. Carmel, CA: Brooks/Cole.

Andreasen, A. R. (1995). *Marketing social change: Changing behavior to promote health, social development, and the environment*. San Francisco, CA: Jossey-Bass

Biglan, A., & Taylor, T. K. (2000). Why have we been more successful in reducing tobacco use than violent crime? *American Journal of Community Psychology, 28*, 269-302.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*. Cambridge, MA: Harvard University Press.

Cartwright, W. S., Kitsantas, P., & Rose, S. R. (2009). A demographic-economic model for adolescent substance abuse and crime prevention. *Journal of Comparative Social Welfare, 25*, 157-172. doi:10.1080/17486830902789780

Chamberlain, P. (2003). *Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model*. Washington, DC: American Psychological Association.

Chilenski, S. M., Bumbarger, B. K., Kyler, S., & Greenberg, M. T. (2007). *Reducing youth violence and delinquency in Pennsylvania: PCCD's research-based programs initiative*. Prevention Research Center for the Promotion of Human Development, The Pennsylvania State University.

Cullen, F. T., Myer, A. J., & Latessa, E. J. (2009). Eight lessons from *Moneyball*: The high cost of ignoring evidence-based corrections. *Victims and Offenders, 4,* 197-213. doi:10.1080/15564880802612631

Curtis, N. M., Ronan, K. R., Heiblum, N., & Crellin, K. (2009). Dissemination and effectiveness of multisystemic treatment in New Zealand: A benchmarking study. *Journal of Family Psychology, 23,* 119-129.

Dodge, K. A. (2008). Framing public policy and prevention of chronic violence in American youths. *American Psychologist, 63,* 573-590. doi:10.1037/0003-066X.63.7.573

Dodge, K. A., Dishion, T. J., & Lansford, J. E. (2006). *Deviant peer influences in programs for youth: Problems and solutions*. New York: Guilford Press.

Drake, E. K., Aos, S., & Miller, M. G. (2009). Evidence-based public policy options to reduce crime and criminal justice costs: Implications in Washington State. *Victims and Offenders, 4,* 170-196. doi:10.1080/15564880802612615

Eddy, J. M., & Chamberlain, P. (2000). Family management and deviant peer association as mediators of the impact of treatment condition on youth antisocial behavior. *Journal of Consulting and Clinical Psychology, 68*, 857-863.

Elliott, D. S. (1998). *Blueprints for violence prevention* (Series Ed.). University of Colorado, Center for the Study and Prevention of Violence. Boulder, CO: Blueprints P ublications.

Elliott, D. S., & Mihalic, S. (2004, March). Issues in disseminating and replicating effective prevention programs. *Prevention Science, 5,* 47-52.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology, 37,* 215-237. doi:10.1080/15374410701820117

Ferlie, E. B., & Shortell, S. M. (2001). Improving the quality of health care in the United Kingdom and the United States: A framework for change. *The Milbank Quarterly, 79*, 281-315.

Fixsen, D. L, Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Franks, R. P., Schroeder, J. A., Connell, C. M., & Tebes, J. K. (2008). *Unlocking doors: Multisystemic therapy for Connecticut's high-risk children and youth—An effective home-based alternative treatment*. Farmington: Connecticut Center for Effective Practice, Child Health and Development Institute of Connecticut.

Gendreau, P., Smith, P., & Theriault, Y. L. (2009). Chaos theory and correctional treatment: Common sense, correctional quackery and the law of fartcatchers. *Contemporary Criminal Justice, 25,* 384-396. doi:10.1177/1043986209344552

Greenwood, P. W. (2006). *Changing lives: Delinquency prevention as crime-control policy*. Chicago: The University of Chicago Press.

Greenwood, P. (Fall, 2008). Prevention and intervention programs for juvenile offenders: The benefits of evidence-based practice. *The Future of Children, 18,* 11-36. doi:10.1353/foc.0.0018

Grier, S., & Brant, C. A. (2005). Social marketing in public health. *Annual Review of Public Health, 26,* 319-329.

Grimshaw, J. M., Shirran, L., Thomas, R., Mowatt, G., Fraser, C., Bero, L., O'Brien, M. A. (2001). Changing provider behavior: An overview of systematic reviews of interventions. *Medical Care*, 39, 8 (Suppl 2), pp. II-2–II-45.

Henggeler, S. W. (in press). Efficacy studies to large-scale transport: The development and validation of MST programs. *Annual Review of Clinical Psychology.*

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents* (2nd ed.). New York: Guilford Press.

Henggeler, S. W., & Sheidow, A. J. (in press). Empirically supported family-based treatments for conduct disorder and delinquency. *Journal of Marital and Family Therapy*.

Hoagwood, K. E. (2010, June). *Collaborative research to improve practices for urban families: Taking it to scale in states*. Presentation at the International Symposium on Collaborative Research Approaches, Mount Sinai School of Medicine, New York, NY.

Howell, J. C. (2003). *Preventing and reducing juvenile delinquency: A comprehensive framework*. Thousand Oaks, CA: Sage.

Leve, L. D., & Chamberlain, P. (2007). A randomized evaluation of Multidimensional Treatment Foster Care: Effects on school attendance and homework completion in juvenile justice girls. *Research on Social Work Practice, 17,* 657-663.

Lewis, N. (2010). Prove it or lose it. *Youth Today*, Washington, DC: American Youth Work Center.

Liberman, A. M. (Ed.). (2008). *The long view of crime: A synthesis of longitudinal research*. New York: Springer.

Lipsey, M. W. (2009). The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview. *Victims and Offenders, 4,* 124-147. doi:10.1080/15564880802612573

Lipton, D., Martinson, R., & Wilks, J. (1975). *The effectiveness of correctional treatment: A survey of treatment evaluation studies*. New York: Praeger.

Loeber, R., Burke, J. D., & Pardini, D. A. (2009). Development and etiology of disruptive and delinquent behavior. *Annual Review of Clinical Psychology*, *5*, 291-310.

Magellan Health Services, Children's Services Task Force. (2008). *Perspectives on residential and community-based treatment for youth and families*. Author.

McCarthy, P., & Kerman, B. (2010). Inside the belly of the beast: How bad systems trump good programs. *Administration and Policy in Mental Health and Mental Health Services Research, 3*, 167-172. doi:10.1007/s10488-010-0273-4

Melton, G. B. (1997). Why don't the knuckleheads use common sense? In S.W. Henggeler & A.B. Santos (Eds.), *Innovative services for difficult-to-treat populations* (pp. 351-370). Washington, DC: American Psychiatric Press.

Morris, J. A. (2000). Playing policy pinball: Making policy analysis palatable. *Administration and Policy in Mental Health, 28*, 11-137. doi:10.1023/A:1026607507390

Nagin, D. S., Cullen, F. T., & Jonson, C. L. (2009). Imprisonment and reoffending. In M. Tonry (Ed.), *Crime and justice: A review of research* (Vol. 38, pp. 115-200). Chicago: University of Chicago Press.

National Juvenile Justice Network. (2010a). Retrieved from http://www.nijn.org/legislative_databank_255.html.

National Juvenile Justice Network (2010b). *The real costs and benefits of change: Finding opportunities for reform during difficult fiscal times*. Author.

Office of Program Policy Analysis & Government Accountability (February, 2007). *Redirection pilots meet and exceed residential commitment outcomes; $5.8 million saved*. Tallahassee: Florida Legislature.

Ogden, T., Hagen, K. A., & Andersen, O. (2007). Sustainability of the effectiveness of a programme of multisystemic treatment (MST) across participant groups in the second year of operation. *Journal of Children's Services, 2*, 4-14.

Petrosino, A., Turpin-Petrosino, C., & Guckenburg, S. (2010). Formal system processing of juveniles: Effects on delinquency. *Campbell Systematic Reviews* 2010:1 doi:10.4073/csr.20101

Puzzanchera, C. (December, 2009). *Juvenile Justice Bulletin: Juvenile arrests 2008*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Puzzanchera, C., & Kang, W. (2010). *Easy access to juvenile court statistics: 1985-2007*. Online, Available: http://ojjdp.ncjrs.gov/ojstatbb/ezajsc/.

Redding, R. E. (June, 2010). *Juvenile Justice Bulletin: Juvenile transfer laws: An effective deterrent to delinquency?* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Rowland, M. D., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J. P., & Shapiro, S. B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix Class youths. *Journal of Emotional and Behavioral Disorders, 13*, 13-23. doi:10.1177/10634266050130010201

Schoenwald, S. K. (2008). Toward evidence-based transport of evidence-based treatments: MST as an example. *Journal of Child and Adolescent Substance Abuse, 17*, 69-91. doi: 10.1080/15470650802071671

Schoenwald, S. K. (2010). From policy pinball to purposeful partnership: The policy contexts of Multisystemic Therapy transport and dissemination. In. J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents, 2nd edition* (pp. 538-553). New York: Guilford Press.

Schoenwald, S. K., Chapman, J. E., Sheidow, A. J., & Carter, R. E. (2009). Long-term youth criminal outcomes in MST transport: The impact of therapist adherence and organizational climate and structure. *Journal of Clinical Child and Adolescent Psychology, 38*, 91–105. doi: 10.1080/15374410802575388

Schoenwald, S. K., Heiblum, N., Saldana, L., & Henggeler, S. W. (2008). The international implementation of Multisystemic Therapy. *Evaluation & The Health Professions, Special Issue: International Translation of Health Behavior Research Innovations, Part I,* 211-225. doi:10.1177/0163278708315925

Schoenwald, S. K., Sheidow, A. S., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Child and Adolescent Clinical Psychology*, *33*, 94-104.

Schoenwald, S. K., Sheidow, A. J., Letourneau, E. J., & Liao, J. G. (2003). Transportability of Multisystemic Therapy: Evidence for multi-level influences. *Mental Health Services Research, 5,* 223-239.

Sedlak, A. J., & McPherson, K. S. (2010). *Juvenile Justice Bulletin: Conditions of confinement: Findings from the survey of youth in residential placement*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 National Report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Sundell, K., Hansson, K., Lofholm, C. E., Olsson, T., Gustle, L-H., & Kadesjo, C. (2008). The transportability of Multisystemic therapy to Sweden: Short-term results from a randomized trial of conduct-disordered youths. *Journal of Family Psychology, 22*, 550–560.

Thornicroft, G., & Tansella, M. (1999). *The mental health matrix: A manual to improve services*. Cambridge: Cambridge University Press.

U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health.

U.S. Public Health Service. (2001). *Youth violence: A report of the Surgeon General*. Washington, DC: Author.

Welsh, B. C., Sullivan, C. J., & Olds, D. L. (2010). When early crime prevention goes to scale: A new look at the evidence. *Prevention Science, 11*, 115-125. doi: 10.1007/s11121-009-0159-4.

William T. Grant Foundation. (2010). *Current research interests*. New York: Author.

Commentary

Supporting Evidence-Based Juvenile Justice Practice from the Top

Progress and Possibilities at the Federal Level

Samantha Harvell
former Vice President for Early Childhood and Juvenile Justice Policy
First Focus

TIn our world of scarce resources and increasing focus on government accountability, policymakers almost always aim to identify "what works" and direct resources to programs with proven effectiveness in reaching their desired outcomes. To that end, the authors of this paper have made a significant contribution in outlining what we know about what does and does not work in reducing juvenile delinquency and highlighting both federal and state initiatives that have effectively promoted the adoption and implementation of multisystemic therapy (MST), one of the most well-researched, effective programs. I do believe, however, that there is more to say about recent federal efforts to incentivize and expand the use of evidence-based practice with juvenile offender populations and at-risk youth as well as opportunities on the horizon at the federal level.

Though it is without question primarily a state and local issue, the federal government does play a role in setting and shaping juvenile justice policy. The primary federal legislation with jurisdiction over this field is the Juvenile Justice and Delinquency Prevention Act (JJDPA, 2002), originally passed in 1974 and most recently reauthorized in 2002. The JJDPA authorizes funds for states that comply with four core requirements: not holding status offenders[1] in secure facilities; with few exceptions, not detaining children and youth in adult facilities; separating children held in adult facilities for short periods of time from adults by "sight and sound;" and assessing and addressing the disproportionate contact of youth of color at key points in the juvenile justice process. In short, the JJDPA aims to provide children and families involved with the justice system a minimum federal standard for the care and custody of youth. States who remain in compliance with these requirements receive funds annually to support their efforts to carry out the purposes of the JJDPA.

The JJDPA is currently overdue for reauthorization, but progress in the 111th Congress suggests that federal policymakers recognize the need to incentivize and expand the use of evidence-based practice with juvenile offender and at-risk populations. In the 111TH Congress that just ended in December, the Senate Judiciary Committee marked up and passed a JJDPA reauthorization bill with bipartisan support. The bill defined criteria for both evidence-based and promising programs, authorized a mental health and substance abuse incentive grant program with the explicit goal of increasing the use of evidence-based or promising prevention and intervention programs, and authorized a National Commission on Public Safety Through Crime Prevention charged with carrying out a comprehensive study of the research on effective crime and delinquency prevention and intervention strategies. As of this writing, it is unclear whether the bill will be taken up and passed by the full Senate and the House. What is clear is that federal policymakers are listening to the science and understand the importance of identifying and investing in what works.

In addition to progress with the JJDPA, there are many other indicators that policymakers at the federal level are increasingly embracing the importance of evidence-based practice with juvenile offender populations. For example, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) program plan, which outlines the agency's priorities for funding, identified the promotion of evidence-based practice as one of its four guiding principles. Further, the recently enacted health care

[1]Note, a status offense is one that would not be considered criminal if perpetrated by an adult, (e.g., running away from home, truancy, or incorrigibility).

reform bill, the Patient Protection and Affordable Care Act, established a $1.5 billion federal grant program supporting home visiting programs serving families with or expecting young children. This funding stream will direct significant resources to proven programs including the Nurse-Family Partnership Program (NFP). NFP is one of only 11 Blueprints Model Programs, referenced in the article, that meet a very high standard of proven effectiveness in preventing criminal activity and violence.

Arguably, the importance of outcome evaluation and focus on evidence-based and promising practice will intensify in the coming months as policymakers at all levels face increasingly tight budgets. In fact, given the lingering impacts of the recent recession, the next few years may be the most fruitful for advancing significant cost-saving reforms in juvenile justice and promoting the use of effective programs and practices with juvenile offender and at-risk populations. Henggeler and Schoenwald's article could not be timelier. I hope researchers and practitioners will see it as the call to action that it is, take the recommendations to heart, and make sure that their work is seen and heard by policymakers at all levels. Though it may not seem like it at times, they are listening.

References

Juvenile Justice and Delinquency Prevention Act (2002), 42 U.S.C. 56011.

National Juvenile Justice Network. (2010). *The real costs and benefits of change: Finding opportunities for reform during difficult fiscal times.* Washington, DC: Author. Retrieved from: http://www.njjn.org/publications_and_teleconference_437.html

Patient Protection and Affordable Care Act (2010) Public Law No. 111-148.

Commentary

A Prevention Model of Juvenile Justice

Christopher Slobogin
Vanderbilt University

Henggeler and Schoenwald's article could not be more timely. Just last year the Supreme Court decided Graham v. Florida (2010), which held that imposition of a sentence of life without parole on juveniles who have committed crimes other than murder violates the Eighth Amendment's prohibition on cruel and unusual punishment. One reason the Court gave for this holding—perhaps the most important reason—is that life without parole deprives juveniles of a "meaningful opportunity to obtain release based on demonstrated maturity and rehabilitation" (p. 2030). If juveniles who are transferred out of the juvenile justice system and tried as adults deserve a chance to show they are rehabilitated, certainly the same can be said of juveniles who remain in juvenile court (roughly 70-90% of all young offenders). The evidence presented by Henggeler and Schoenwald strongly suggests that community-based programs like multisystemic therapy (MST) are superior to incarceration as a cost-effective means of rehabilitating juvenile offenders and assuring that they do not reoffend.

Nonetheless, the legal system and policymakers are likely to resist such community-based treatments for at least two reasons. First, dispositions for serious crimes, whether in the adult or juvenile system, are meant to impose "punishment" and hold offenders "accountable" for their actions. To many legal professionals and lay people, punishment and accountability can only occur through some sort of detention in prison, jail, or at least a boot camp. Second, many believe that community-based programs are insufficiently protective of the public; after all, programs like MST allow a juvenile who has just offended to remain on

the streets. Particularly when the juvenile has committed a violent crime or a serious property theft, an MST-type disposition will be hard to justify on empirical grounds alone.

If the goal is to ensure that MST-type programs are the disposition of choice in those cases where it is most likely to reduce recidivism, arguments that make clear why community-based programs make legal sense are needed as well. In a book soon to be published by Oxford University Press, Mark Fondacaro and I try to provide these arguments. The title of the book, Juveniles at Risk: A Plea for Preventive Justice signals our basic point: the goal of any effort to deal with juvenile offenders should be prevention and risk management, not punishment. Such a system would not be focused on backward-looking assessments of culpability for crimes committed but rather on forward-looking assessments of the risk posed by the juvenile offender and the interventions needed to reduce that risk.

The jurisprudential benefits of a preventive system are significant. The courts have held that when government deprives people of liberty it must do so in the least drastic manner necessary to achieve its aim. When the aim is punishment, at best that principle means that sanctions must be proportionate; if life without parole is permissible punishment for juvenile murderers, as Graham held, a 30- or 40-year sentence is a proportionate sanction for those who commit other serious felonies. In a preventive regime, however, imprisonment of any type would be impermissible when less drastic alternatives such as MST are equally or more effective at reducing recidivism. Detention would be a last resort. Further, transfer to adult court would never be necessary because juvenile detention facilities are capable of housing dangerous offenders. While adult-type dispositions may be indicated for serious crimes if the objective is to assure juveniles get what they “deserve,” they are irrelevant in a prevention-oriented regime.

The latter point also provides a stronger rationale for maintaining a separate juvenile justice system. That system could easily be threatened if punishment remains the goal and the next juvenile crime wave convinces policymakers that the best way to punish adolescents is to try them as adults. If instead the juvenile system is preventive in orientation, the public and legislators can honestly be told that a separate juvenile justice system is necessary because its priorities are so dissimilar from the adult system.

Community-based programs like MST are probably the best means of dealing with juvenile crime. But until legal arguments for requiring such programs are developed, legislators and court systems are not likely to adopt them as the linchpin of juvenile justice. A prevention jurisprudence could help them see the light.

References

Graham v. Florida, 130 S.Ct. 2011 (2010)

Slobogin, C. & Fondacaro, M. R. (in press). *Juveniles at risk: A plea for preventive justice*. New York: Oxford University Press.

Commentary

One State's Experience

The Perspective of a Connecticut Administrator

Peter Panzarella
Connecticut Department of Children and Families

As Henggeler and Schoenwald point out in their article, most of the current juvenile justice services, such as as residential care and surveillance programs, lack the evidence that they reduce crime as compared to community programs. Although the continued use of these services could spring from a desire to maintain the status quo, unspoken concerns about public safety may motivate the continued reliance on out-of-home treatment programs for juvenile offenders. Community programs are much more effective, but they can raise the perceived risk level for public safety. Long-term gains for the entire community can be overshadowed by a single negative case event, creating accusations that public officials are not concerned about the general public's safety.

Functional family therapy, multisystemic therapy (MST), and multidimensional treatment foster care are all programs with proven track records that have created systems for large-scale implementation that produce outcomes similar to those found in their research studies. Although some fields (e.g., business, medicine) have the infrastructure to translate evidence into practice, the field of juvenile justice does not. Instead of emphasizing fidelity to a model, quality of services or outcomes, the field of juvenile justice tends to focus more on process measures and funded capacity, safety, and risk factors. Evidence-based interventions not only challenge how services are delivered but also challenge the factors driving procurement, contract bidding, data systems and budgeting to support the services. Without evidence-based practices as a driver of the public policy infrastructure, juvenile justice services are at risk of becoming or remaining "boutique programs" that do not penetrate on a scale that makes a real difference at a systems level. Implementation on a small scale raises ethical questions about how youth and families can have equal access to evidence-based interventions.

The issues of youth substance abuse, mental health, family conflict, violence and child maltreatment are highly related to involvement in multiple systems that often do not coordinate care. Many mental health and substance abuse service systems were based on a medical model of delivering services to an individual at a clinic rather than looking at the needs of the family using an ecological approach. These services then become either irrelevant or ineffective for the juveniles with mental health or substance use disorders. The public health perspective identified in the article, which benefits individuals and the public, has been helpful in broadening the context of policies and is needed to bring systems together.

In 1997, Connecticut started including evidence-based interventions across children's mental health, substance abuse and crime prevention and intervention programs using state and federal funds. MST was one of the first programs to be disseminated statewide through a series of small pilot projects with local evaluations. Results of these pilot evaluations were positive, but the pilot programs reached only a small portion of high-risk youth. In order to go to scale there was a need for a state infrastructure and a change in procurement policies to include a new system for measuring implementation, fidelity and quality assurance.

Connecticut took a centralized approach to implementing MST because the state is geographically small, has no county government, and had as goals the coordination of public funding to reduce system fragmentation. This came about after a considerable effort to build collaboration around intensive community-based, evidence-based or promising practices within the child and youth service needs of mental health, substance abuse and juvenile

justice. Connecticut supports 26 MST teams, five of which are for special populations and/or pilot research projects (e.g., National Institute of Drug Abuse clinical trial of MST Connecticut Family model for child welfare with parental substance abuse). There is one centralized system to manage the ongoing quality assurance and research projects. Collaboration and joint funding of the MST quality assurance system by the Department of Children and Families (DCF) and the Judicial Branch Court Support Services was essential in developing state infrastructure to sustain and build a platform to implement to scale.

Implementing evidence-based practices resulted in a significant increase in the number of youths treated with evidence-based interventions in their home and a significant reduction in DCF delinquency commitments and the need for long-term residential placements. The CT DCF MST average cost per day is about $72, compared to about $247 a day for DCF long-term residential adolescent substance abuse treatment. We are now examining how to partner with the research community to expand evidence-based practices in other areas of children and adolescent behavioral health and child welfare services.

About the Authors

Scott W. Henggeler received his Ph.D. in clinical psychology from the University of Virginia in 1977. Currently, he is Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina and Director of the Family Services Research Center (FSRC). The mission of the FSRC is to develop, validate, and study the dissemination of clinically effective and cost effective mental health and substance abuse services for children presenting serious clinical problems and their families. As such, FSRC projects have included numerous community-based randomized trials with challenging clinical populations (e.g., violent and chronic juvenile offenders, youths presenting psychiatric emergencies, substance abusing juvenile offenders, maltreating families), and transportability studies for multisystemic therapy and other evidence-based treatments are being conducted in multiple states and nations. The FSRC has received the Annie E. Casey Families Count Award, GAINS Center National Achievement Award, and the Points of Light Foundation President's Award in recognition of excellence in community service directed at solving community problems. Dr. Henggeler has published more than 250 journal articles, book chapters, and books; and has received grants from NIMH, NIDA, NIAAA, OJJDP, CSAT, the Annie E. Casey Foundation, and others. He is Associate Editor of the Journal of Consulting and Clinical Psychology, has been on the editorial boards of more than 10 journals, and is on the Board of the National Association of Drug Court Professionals.

Sonja K. Schoenwald, Ph.D., is Professor of Psychiatry & Behavioral Sciences at the Medical University of South Carolina and was Associate Director of the Family Services Research Center there from 1994–2004. Dr. Schoenwald is among the leading clinical services researchers in the country on issues relating to the transportability, implementation, and dissemination of effective community-based treatments for youth with serious clinical problems and their families. She pioneered the development, refinement, and empirical testing of the quality assurance protocols used to transport multisystemic therapy for juvenile offenders and their families to diverse communities. In addition, Dr. Schoenwald is working with leading treatment, services, and organizational researchers and community stakeholders on research focused on refining and taking to scale a variety of evidence-based treatments for youth and families in the mental health, education, and child welfare service sectors. Dr. Schoenwald has published numerous peer-reviewed papers and book chapters and has co-authored three books and several treatment manuals and monographs for diverse stakeholder groups focused on supporting the implementation of effective treatments in communities nationally and internationally.

Samantha Harvell, Ph.D., is the former Vice President for Early Childhood and Juvenile Justice Policy at First Focus, a national children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. In this role, she led the organization's efforts to identify, develop, and implement policy solutions to cross-cutting challenges in early childhood and adolescent health, education, welfare, and safety. Samantha received her Ph.D. in developmental psychology and M.P.P. in education, family, and social policy from Georgetown University. She also served as an SRCD/AAAS Congressional Fellow in the U.S. Senate, working on education and child and family policy in the Office of Senator Jeff Bingaman (NM).

Christopher Slobogin, J.D., LL.M. received his law degrees from the University of Virginia Law School and his undergraduate degree from Princeton University. He currently occupies the Milton Underwood Chair at Vanderbilt University Law School and has also taught at Stanford, Virginia, Southern California and Hastings Law Schools. He has published over 100 books and articles on criminal law, juvenile justice and mental health issues, including the forthcoming work, *Juveniles at Risk: A Plea for Preventive Justice* (Oxford University Press).

Peter Panzarella, MA, MS, LADC, LPC has served as the Director of Substance Abuse Services for the Connecticut Department of Children and Families (DCF) since 1995. DCF is an integrated state children's agency with responsibility and programs for the child welfare, juvenile justice and children's mental health and adolescent substance abuse treatment. Prior to the Director position, Peter worked over 15 years in the field of addiction treatment and mental health as a clinician, clinical supervisor, and clinical/program manager. He has written and received numerous federal grants to implement evidence-based and promising practices for adolescents, families and drug exposed infants. He has re-directed and manages state funding that supports implementation and quality assurance for evidence-based practices such as multisystemic therapy and multi-dimensional family therapy in Connecticut. He is actively involved in the Connecticut Alcohol and Drug Policy Council. He is licensed as an Alcohol/Drug and Professional Counselor in Connecticut. He has two Master's Degrees, a Master's in Arts in clinical/community psychology from Lesley University and a Master's in Science in administration from State University of New York College at Buffalo. He received a Bachelor of Science in Psychology from State University of New York College at Buffalo. In 2007, Peter received a special recognition award for collaboration from the National Center on Substance Abuse and Child Welfare, Health and Human Services and an award for government facilitation of implementing evidenced-based practices by the Joint Meeting on Adolescent Treatment Effectiveness.

Social Policy Report is a quarterly publication of the Society for Research in Child Development. The *Report* provides a forum for scholarly reviews and discussions of development research and its implications for the policies affecting children. Copyright of the articles published in the *SPR* is maintained by SRCD. Statements appearing in the *SPR* are the views of the author(s) and do not imply endorsement by the Editors or by SRCD.

Purpose

Social Policy Report (ISSN 1075-7031) is published four times a year by the Society for Research in Child Development. Its purpose is twofold: (1) to provide policymakers with objective reviews of research findings on topics of current national interest, and (2) to inform the SRCD membership about current policy issues relating to children and about the state of relevant research.

Content

The *Report* provides a forum for scholarly reviews and discussions of developmental research and its implications for policies affecting children. The Society recognizes that few policy issues are noncontroversial, that authors may well have a "point of view," but the *SPR* is not intended to be a vehicle for authors to advocate particular positions on issues. Presentations should be balanced, accurate, and inclusive. The publication nonetheless includes the disclaimer that the views expressed do not necessarily reflect those of the Society or the editors.

Procedures for Submission and Manuscript Preparation

Articles originate from a variety of sources. Some are solicited, but authors interested in submitting a manuscript are urged to propose timely topics to the lead editor (slodom@unc.edu). Manuscripts vary in length ranging from 20 to 30 pages of double-spaced text (approximately 8,000 to 14,000 words) plus references. Authors are asked to submit manuscripts electronically, if possible, but hard copy may be submitted with disk. Manuscripts should adhere to APA style and include text, references, and a brief biographical statement limited to the author's current position and special activities related to the topic.

Reviews are typically obtained from academic or policy specialists with relevant expertise and different perspectives. Authors then make revisions based on these reviews and the editors' queries, working closely with the editors to arrive at the final form for publication.

The Committee on Policy & Communications, which founded the *Social Policy Report*, serves as an advisory body to all activities related to its publication.