

Progress Toward Evidence-Based Practices in DCS Funded Juvenile Justice Programs

REPORT TO GOVERNOR PHIL BREDESEN
AND
THE TENNESSEE GENERAL ASSEMBLY
PURSUANT TO PUBLIC CHAPTER 585

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EXECUTIVE SUMMARY

Introduction

Public Chapter 585 was enacted into law in 2007. Known as the “evidence-based law,” this legislation requires the Department of Children’s Services (“DCS” or “the Department”) to begin a multi-year process of implementing practices and programs that have been scientifically proven to reduce juvenile delinquency or are supported by research or theory to reduce delinquency. The Department is also required to determine which of its current programs meet the statutory requirements and to submit a report and explanation to support the report to the Governor, the Senate General Welfare, Health and Human Resources Committee, the House Children and Family Affairs Committee, and the Select Committee on Children and Youth of the General Assembly by January 1, 2009. This report is respectfully submitted in compliance with Public Chapter 585.

Summary of PC 585

Public Chapter 585 (which has been codified at T.C.A. 37-5-121) provides that the Departments of Tennessee State Government only expend state funds on juvenile justice programs or programs related to the prevention, treatment or care of delinquent juveniles that are evidence-based. “Evidence-based” is defined as a program or practice that is governed by a manual or protocol that specifies the nature, quality and amount of service that constitutes the program; and, that scientific research using at least two separate client samples has demonstrated improvement in the client outcomes that are central to the program. Pilot projects are allowed for evaluation purposes of programs that are supported by research or theory but which lack the required number of research samples that meet the definition for being evidence-based.

After a review of existing practice within Tennessee by private providers and by programs operated in DCS Group Homes and Youth Development Centers, it is the opinion of DCS that the working definition provided by the legislature will significantly improve the consistency and quality of the treatment of juvenile justice youth and yet is an attainable goal within the timeframes set forth by law.

DCS is required to provide language in any contracts serving Juvenile Justice Youth that the contractor will use only evidence-based services; and, the Department shall provide monitoring, through existing quality assurance methods to ensure that applicable program manuals or protocols are being followed. Additionally, DCS will work with the provider network on the development and implementation of corrective action when existing monitoring uncovers weaknesses in the provision of evidence-based practices. It should be noted also that a reduction in contract amounts paid for services, or a reduction in allocations to the Division of Juvenile Justice, would have an adverse effect on full implementation of Public Chapter 585.

In order to permit an orderly implementation of evidence-based programs, a four year graduated phase-in period is allowed. Beginning in fiscal year 2009-2010, the

Department shall ensure that twenty-five percent (25%) of the funds expended for delinquent juveniles are on evidence-based programs. For each fiscal year thereafter, a like percentage of programs and funds shall be certified as evidence-based through FY 2011-2013 when 100% of all delinquency programs shall meet the statutory requirements for being evidence-based.

Finally, DCS, in conjunction with the Tennessee Commission on Children and Youth, the Tennessee Alliance for Children and Families, the Administrative Office of the Courts, and experts appointed by the commissioner shall determine which of its current programs are evidence-based, research-based and theory-based and shall submit a report to the Governor and General Assembly by January 1, 2009.

Baseline Status of Implementation

During 2008, DCS has undertaken measures, outlined in the body of this report, which seek to identify the current functioning of public and private service provision to Juvenile Justice Youth and the systems-level changes which will be required in order to meet the goals and timeframes of Public Chapter 585.

Findings Related to Existing Services

Based on a hands-on survey by DCS staff of approximately 30 providers covering 80 locations and including the five Youth Development Centers operated by DCS, Dr. Lipsey and Dr. Chapman compared the services offered, public and private, with available research on their effectiveness for reducing recidivism. Approximately 94% of those services were found to employ components in their service array associated with a decrease in criminal recidivism for youth. One example of this would be group therapy led by a therapist which is associated with positive effects. Further analysis will be needed at the service level to determine if the quantity and quality of services provided also match the needs of Juvenile Justice Youth. The following general findings represent that Tennessee is beginning with a responsible baseline in working toward 100% compliance with the law and spirit of Public Chapter 585:

Findings:

- No one presently contracted for services and no one within public Juvenile Justice Facilities is using a practice shown by research to produce negative outcomes
- The approximately 1700 Juvenile Justice Youth are receiving over 630 distinct services throughout the state, and these services overwhelmingly use established methods associated with positive outcomes
- Specialized in-house programming such as alcohol and drug treatment (18 locations) and sex offender treatment (8 locations) are available to target needs with specific risks for the youth and for the communities from which they come
- More specific information will be needed from providers and from DCS operated programs to ensure that the services offered that are associated with positive outcomes are manualized (meaning they follow an established written protocol.)

The findings point toward short term and long term recommendations in order for DCS and other state agencies to comply fully with Public Chapter 585. The following recommendations may be modified by the steering panel as new evidence emerges and as DCS and providers learn more about existing practices and the growing literature on effective practices.

Recommendations:

- DCS must add language to existing contracts regarding the requirements for evidence-based practice for those agencies and contractors serving Juvenile Justice Youth. This should be accomplished by May 1, 2009 before the release of contracts to providers, with a review by the steering panel named in Public Chapter 585.
- DCS should share on an individual basis feedback to participating agencies how their services match up to existing programs, with specific recommendations for full compliance with Public Chapter 585. This should be accomplished prior to contract finalization in May, 2009.
- DCS should, with the collaboration of the Tennessee Alliance for Children and Families, communicate generally to the provider community the findings of this report and the implications for their future work. This should be accomplished during the current fiscal year ending June 30, 2009 in order to prepare for the best practice implementation schedule. Additionally, DCS should work with the Alliance in order to devise methodology for pilot programming and outcomes measurement for services falling outside of established evidence-based practice.
- DCS will utilize its existing relationship with Chapin Hall, the outcomes quality monitoring research agency affiliated with the University of Chicago, to assist with tracking and reporting of Juvenile Justice recidivism by service provider.
- DCS should identify a method for ongoing collection and evaluation of the quantity and quality of services provided to each youth, as much as possible incorporated into existing monitoring activities. DCS should maintain vigilance regarding any possible impact on services secondary to the current budgetary crisis.
- DCS will cooperate with other departments of state government, such as the Department of Mental Health, the Department of Education, the Division of Mental Retardation Services, and the Department of Labor and Workforce Development in order to assure consistent approaches to evidence-based programming across state governmental programs for Juvenile Justice Youth.
- DCS should continue work with the Steering Panel, at least semiannually, in order to monitor progress and make changes when necessary to reach full implementation of an evidence-based approach.

Current Status of Evidence-Based Practice Implementation

Goal Summary

Public Chapter 585 contains short term and long term objectives, outlined in greater detail in the following section. The immediate goal is an assessment of existing best practices in the programming currently applied to the juvenile justice population. This means a survey of the programs currently in use across the state with some measurement of the stated adherence to an evidence-based practice, the program design and components, the manner in which the stated program is actually administered (including the preparation level and qualifications of those implementing the service) and the degree of “model fidelity” or adherence to the design of the claimed program. An assessment of where Tennessee currently stands is a necessary start in planning the change process over the next four years.

A set of long range goals includes a discussion of how the Department will measure progress, how providers and the Department will work together to develop and measure the success of pilot programs, and what degree of technical assistance is available to providers who recognize the need for program change to conform to successfully proven program components. Additionally, ongoing work will involve the reconciliation of the outcome measures tied to the Department’s existing outcomes-oriented Performance Based Contracting (PBC) methodology and the process-oriented Evidence-based Practice initiative under Public Chapter 585. PBC rewards provider performance for improvement in outcomes such as decreased time to permanency, reduced criminal recidivism or repeat maltreatment, and increase in the percentage of exits from custody to a family setting (as opposed to lateral transfers to another institution or a negative outcome such as death, runaway, or aging out of care without family permanence). Public Chapter 585, being concerned that the process of obtaining outcomes follows a proven method or series of methods, should not in any way conflict with the PBC incentive structure. However, conversations with providers and the Public Chapter 585 Steering Committee will help assure consistency of goals and messages from the Department to the provider community.

Further Discussion and Summary of “Evidence-Based”

The term “evidence-based” has recently become a popular catch-phrase often used to convey a sense of credibility to a particular program or practice; however, there is limited consensus about what “evidence-based” actually means. Generally speaking, the term evidence-based means that a particular practice, program, protocol or methodology has a base of scientific research to support both its theory and practice for achieving the results it claims. To meet scientific standards, the research must include the use of a proper control group so that clients receiving the service are compared with similar clients who do not receive the service. Simply put, evidence-based program means that

there is scientifically accepted research supporting that a program in fact does what it claims to do.

Public Chapter 585 has a very specific and straightforward definition of evidence-based:

1. The program must follow a written protocol that specifies what the program does, how the services in the program are delivered to the recipients, how frequently and for what length of time; and,
2. Scientific research that conforms to high standards of acceptability has been used to evaluate the program outcomes. Two or more client samples must have demonstrated that improvements occurred with the clients that reflect the central purpose of the program.

For purposes of this report, it may be helpful to explain in more detail what evidence-based means in terms of programs that are used in the treatment and prevention of juvenile delinquency. Over the last thirty years, hundreds of research projects have been done on the causes, treatment and reduction of juvenile delinquency. Since the mid 1980's, researcher Dr. Mark Lipsey has used a process called meta-analysis to track the published studies of treatment approaches that provide acceptable scientific evidence about their effectiveness. The effectiveness of a particular program or approach is measured by the extent to which that approach reduces criminal reoffending (recidivism). Dr. Lipsey has compiled a database that is now approaching 600 research studies on delinquency treatment programs. He has used the evidence from those studies to determine what programs and practices can be effective at reducing juvenile recidivism. His research revealed some significant conclusions:

- Therapeutic programs that focus on restorative practices, positive skill-building, counseling and multiple individualized services yield the most positive results, but some therapeutic programs are more effective than others.
- Programs must deliver services in adequate amounts and quality in order to be effective.
- For optimum effectiveness, services must closely adhere to the program model, i.e. maintain "program fidelity".
- Some programs have been shown to be ineffective at reducing recidivism, e.g. those with a punitive, fear based approach such as paramilitary style boot camps and "Scared Straight" prison visitation programs.

Dr. Lipsey and his staff at Vanderbilt Institute for Public Policy Studies serve as the consultants for the Department in measuring and implementing an evidence-based approach to juvenile delinquency. DCS has formed an evaluation team consisting of the senior leadership in the Division of Juvenile Justice and other members of DCS core leadership to test the current use of evidence-based practices in our existing providers. This team works closely with Dr. Lipsey and his associate, Dr. Gabrielle Chapman, thus having the benefit of their extensive research database. This has been an invaluable tool to arrive at an accurate and fair evaluation of the programs and services used in Tennessee to treat delinquency and reduce recidivism. Drs. Lipsey and Chapman have included a more complete set of definitions of service categories in the attached Appendix A: "Therapeutic Program Approaches and Types of Programs within Each

Approach Identified in the Current Classification Scheme for Research on the Effectiveness of Programs for Juvenile Offenders.”

Process of Engagement in Implementing PC 585

Public Chapter 585 outlines a steering committee comprised of representatives of the providers of services to DCS children (The Tennessee Alliance for Children and Families, or TACF), The Administrative Office of the Courts, and the Tennessee Commission on Children and Youth, to act in a consulting and advisory capacity. This group has met in person and by teleconference in order to frame the design of the approach in establishing the baseline of existing services and to design system improvement over the next four years.

DCS has also engaged the provider community through two sets of meetings held in each grand division of the state in the fall of 2007 and in June of 2008. The initial meetings reviewed the elements of Public Chapter 585 and an overview on evidence-based practice. The second set of meetings included Dr. Lipsey's overview of how compliance is measured in other states. At these meetings, DCS also provided discs to providers with templates for a self assessment of the implementation of best practice models. For providers that serve juvenile justice clients who were not at the meetings, DCS mailed session handouts and discs, and followed up by phone with all agencies that did not respond with information. DCS conducted in-person visits to all providers serving at least 5 juvenile justice youth as of July 31, 2008, with one visit outstanding to be conducted January 5, 2009. Both the structuring of these visits and the results were shared with the steering committee for comment and interpretation.

The Department currently contracts for a variety of non-custodial prevention services with providers that includes juvenile courts, community resource agencies and other entities. Services include intensive probation, day treatment, after school tutoring, counseling, and other activities. The scope of services in each contract specifies the type of services to be provided. Providers submit regular reports that are closely monitored by the Department for compliance and were not included in site visits. While these programs are based on proven acceptable juvenile justice practices that reduce delinquency, they will require program enhancement in order to comply with PC 585.

Systematic Review of Existing Service Delivery

Phase I: Design for Capturing Components of Existing Practice

The Institute of Medicine and SAMSHA, the Substance Abuse and Mental Health Administration, have each documented lag of up to 17 years in the times between research in a given field of the behavioral sciences and the eventual incorporation of that research into routine clinical practice. (Broderick, 2006). The process of implementing an evidence-based practice approach begins with an assessment of the current level of best practice implementation in DCS operated and privately contracted services for

Juvenile Justice adjudicated youth. This meant a review of DCS Group Homes, Youth Development Centers, and case management services as well as a review of the different programs serving delinquent youth.

Once the preliminary information was returned, DCS scheduled onsite visits with all Youth Development Centers and Group Homes (operated by DCS) and over thirty Juvenile Justice Serving private providers. The visits lasted from a couple of hours up to a couple of days based on the size and scope of service to Juvenile Justice Youth. Each review included a structured agency interview and, as appropriate, interviews with staff and youth. Visits took place between August and December, 2008 and primarily included Program Manager Amanda Lewis, Assistant Commissioner Randal Lea, Program Director Terry Bracey, and Deputy Commissioner Steve Hornsby. Additional staff participated in some of the youth interviews. These onsite surveys held educational value for DCS as well as for partner agencies, which generally stated a commitment to helping the state implement a comprehensive, evidence-based network of services. As the term evidence-based practice has gained political interest and funding momentum nationally, the terminology has come to mean different things to different people. Not all materials marketed as having an evidence basis meet the criteria cited in Public Chapter 585. For those providers who have adopted an actual evidence-based program targeted toward the types of juvenile justice clients served, it was determined important to allow providers to demonstrate they have hiring and supervisory practices and the ongoing training and supervision that assures model fidelity. These reviews were targeted to determine whether a proven practice had been selected, whether practitioners were qualified to deliver that service, and if service recipients experienced enough group, family, or individual counseling contact hours for that service to be effective.

Phase II: Integrating Information

DCS has undertaken the task with Dr. Mark Lipsey and Dr. Gabrielle Chapman of matching the services and programs offered by our network to those which appear in research studies on programs for juvenile offenders. Many of the programs offer special services to youth, such as alcohol and drug counseling, counseling for youth who have offended sexually, or youth who are developmentally delayed. Many of these services are offered to youth who may or may not have another mental health diagnosis, or to youth whose sole mental health condition may be a form of conduct disorder or oppositional defiant disorder. The array of services for youth must not only meet the need for mental health improvement, but must also show a decrease in criminal recidivism. For instance, a substance abuse program may use the model "Living in Balance" which is not evidence-based in terms of criminal recidivism, but which contains elements such as cognitive-behavioral individual counseling, group counseling exercise on a cognitive behavioral model, and client education about the relapse process in substance use. The component parts of "Living in Balance" may in fact be evidence based even though the full program model has not been studied for recidivism effects.

The DCS visits were able to capture information about specialty programming and for the offering of "Milieu" services for adjudicated youth. It is important also to describe "Milieu" services, which are also often based on a model that may or may not have an evidence basis with this population. "Milieu" has been a term of art in child serving agencies for over 60 years, and implies that for a program to be effective with

adolescents, the principles of the service offered should be consistent across shifts of workers and should be enforced evenings, weekends, and during group outings. “Milieu” programs such as “Re-Ed,” a program developed in Tennessee and still widely used here, and such as “Circle of Courage,” developed by and for a South Dakota Native American tribal association, may be effective integration tools for establishing a daily regimen for youth. Unfortunately, there is not a body of research evidence as to the effectiveness of these programs for delinquent youth. Therefore, when such programs exist, we have evaluated them in terms of the counseling components or services that may be contained within the milieu, such as individual counseling, group counseling, family counseling, token economy, behavior modification, and so forth. The evaluation of these programs rests in the effectiveness of the components and neither sanctions nor disallows the use of these particular branded models.

Phase III – More Detailed Provider Engagement

The goal of evidence-based practice implementation in the U. S. has been “an effort to change the behavior of clinicians through the dissemination of research findings.” (Tanenbaum, 2003, p. 298). Part of the visitation of providers by DCS in this process has been an educational attempt to clarify what empirically-supported treatments for juvenile justice involved youth really means – a discussion of what is proven to have worked as opposed to what people think “ought to work” with these youth.

The process of reviewing materials with providers and against proven practice is not simple. Providers do not necessarily track information in the way DCS has gathered it, and DCS has not always captured information in the ways various bodies that certify evidence-based programming define a service. This has at times been a tedious crosswalk; and at times has yielded some vital information as to exactly where Tennessee DCS and providers will benefit from targeted technical assistance. For example, an agency may have evolved into the use of a very generic form of cognitive behavioral therapy which has proven effective for its population. Yet staff training records and interviews may not support with proof that the staff are providing a model that adheres exactly to the most highly proven methods. DCS is in a position to give targeted feedback to this provider about how better training can bring the provider into compliance with the spirit and letter of Public Chapter 585.

Phase IV – Monitoring, Refinement, and Long term tracking

Over the course of the next six months, DCS will engage different data-gathering or monitoring arms to sort through the most efficient means of collecting and evaluating data over time. There may be data captured in the Quality Service Review process (QSR, successor to C-PORT), which can feed the data collection process. Data may also arise during departmental utilization review, particularly for special populations such as adolescents who offend sexually or youth with substance abuse treatment needs. Additionally, DCS frequently has staff in such programs through the monitoring arms of DCS licensure or Program Accountability Review (PAR) who may be able to feed salient points into a central repository. That central repository will likely need to be managed by the Division of Juvenile Justice which is responsible for carrying out the mandates of Public Chapter 585.

Contracts for the 2009-2010 fiscal year and subsequent years will change to reflect the treatment compliance needed on the part of contract agencies. So far, providers have been told that, rather than engaging in sanctions, the Department will simply shape future contracting around only those providers who can satisfy the graduated percentage of compliance with evidence-based practice over time.

The initial review of provider agencies has been a labor-intensive effort drawing upon DCS leadership and contract resources of Dr. Lipsey and his staff. Over time, the task will be to devise an institutionalized method of capturing the delivery of services which can be folded into an existing monitoring program, or to devise a selective method of specialized and targeted agency review. As of this writing, DCS anticipates that at least the first year of monitoring and data collection will require hands-on leadership involvement at each successive stage until such time as data collection is institutionalized at the level of service delivery (public and private) and at the level of monitoring (DCS). The Steering Panel for this legislation can assist this process through the engagement of other departments of state government that engage with juvenile justice youth and with guidance in interpreting the findings and forming the technical assistance or corrective actions needed to come into compliance with Public Chapter 585. Thereafter, it is likely a collection arm such as the evaluation and monitoring component of DCS can collect compliance data and engage agency leadership and the steering panel named in the legislation on a quarterly basis for agency-specific intervention or system-wide policy planning as needed.

One important caveat is that there may be a temptation to make the public approach simple by dictating a form (or forms) of treatment. The effectiveness of an evidence-based approach may be hampered if cast into a firm and inflexible policy, as the entire system will likely become sluggish against change and improvement. Research continues in this area and flexibility in implementing a proven practice as it gains stature in the evidence hierarchy should not require cumbersome DCS rule or policy changes. DCS engages providers who can be efficient in conducting research and implementing programs best suited for the clients they serve. At a minimum, choice within limits is preferable to a single decreed approach. However, the more flexibility providers have in researching and implementing evidence based approaches, the more complex the monitoring duties of DCS will become.

Determining Which DCS Funded Juvenile Justice Programs are Supported by Research

Definition of Evidence-Based Program

PC585 defines an evidence-based program or practice as one that meets the following two standards:

1. It is governed by a program manual or protocol that specifies the nature, quality, and amount of service that constitutes the program;
2. Scientific research using methods that meet high scientific standards for evaluating the effects of such programs must have demonstrated with two or more separate

Before judgments can be made about whether either of these standards is met, it is first necessary to define what is meant by a “program or practice” and, more specifically, to identify and enumerate the DCS-funded juvenile justice programs and practices that meet that definition. With those specified, it is then possible to examine each one to determine if it meets the PC585 standards.

In some perspectives on evidence-based practice, a program is a specific brand name intervention or service, usually one marketed by the developer who provides materials, training, and other support. Familiar examples in juvenile justice include Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Reasoning and Rehabilitation (a cognitive-behavioral program). These are the kinds of programs that show up on various lists of evidence-based model programs, e.g., the Blueprints for Violence Prevention list and the National Registry of Evidence-based Programs and Practices (NREPP). There are relatively few programs for juvenile offenders on these lists, however, and not all of those are supported by credible research on their effects. Moreover, their scope is not sufficient to cover all the program needs of juvenile justice systems. Though there is potential to make much better use of these distinct brand name programs, few are in widespread use in juvenile justice.

Another perspective on evidence-based practice defines a program more broadly as a service or package of services with a distinctive character that is defined by its treatment philosophy, the nature of the activities and client interactions involved, and its service delivery format. Family therapy is a program of this sort, as are individual counseling, cognitive-behavioral therapy, behavioral contracting, and academic tutoring. There are brand name versions of some of these programs, but also home grown versions that are substantially similar in their key characteristics. These are the kinds of programs that are identified in research reviews, especially systematic research synthesis or meta-analysis, that integrate the evidence of effectiveness from all the studies of any version of such a program.

The approach used to assess DCS-funded juvenile justice programs took this latter perspective on program definition. Doing so not only encompassed a wider range of the programs actually used in the Tennessee juvenile justice system, but allowed fuller use of the hundreds of available studies of the effectiveness of various juvenile justice programs that have been conducted over the years.

Over the last 20 years, Dr. Mark Lipsey and his colleagues at the Vanderbilt Institute for Public Policy Studies (VIPPS) have built a comprehensive database of studies of the effectiveness of intervention programs for juvenile offenders. That database currently contains detailed information on program characteristics, research methods, and effects on recidivism from 548 controlled studies that meet methodological standards that make their results credible as estimates of program effectiveness. The nature of this database and the findings about the effectiveness of juvenile justice programs that it supports are well documented in the peer-reviewed literature (e.g., Howell & Lipsey, 2004; Lipsey, 2009 in press; Lipsey, Wilson, & Cothorn, 2000; Lipsey, 1999a, 1999b; Lipsey & Wilson, 1998; Wilson, Lipsey, & Soydan, 2003).

This extensive database can be used to identify those juvenile justice programs for which there are existing research studies that investigate their effects on recidivism. The programs in that database represent two very broad approaches, seven different intervention philosophies, and various specific program or service types as listed below. More detailed descriptions and definitions of each type of program or service are provided in Appendix A.

Therapeutic Approaches

Restorative programs. Programs that aim to repair the harm done by the juvenile's delinquent behavior by requiring some compensation to victims, reparations via community service, or reconciliation between victims and offenders.

- Restitution (32 studies).
- Mediation (14 studies).

Counseling and its variants. Programs characterized by a personal relationship between the offender and a responsible adult who attempts to exercise influence on the juvenile's feelings, cognitions, and behavior; family members or peers may also be involved.

- Individual counseling (12 studies).
- Mentoring by a volunteer or paraprofessional (17 studies).
- Family counseling (29 studies).
- Short term family crisis counseling (13 studies).
- Group counseling led by a therapist (24 studies).
- Peer programs (22 studies).
- Mixed counseling (39 studies).
- Mixed counseling with supplementary referrals for other services (29 studies).

Skill building programs. Programs that provide instruction, practice, incentives, and other such activities and inducements aimed at developing skills that will help the juvenile control his/her behavior and/or enhance the ability to participate in normative prosocial functions.

- Behavioral programs-- behavior management, contingency contracting, and token economies (30 studies).
- Cognitive-behavioral therapy (14 studies).
- Social skills training (18 studies).
- Challenge programs (16 studies).
- Academic training (41 studies).
- Job related interventions—vocational counseling and training, job placement (70 studies).

Multiple coordinated services. Programs that provide a package of multiple services which may be similar for all the participating juveniles or individuated with different juveniles receiving different services.

- Case management (58 studies).
- Service broker—referrals are made for the service or services deemed appropriate for each juvenile (49 studies).
- Multimodal regimen—a multimodal curriculum or coordinated array of services provided to all participating juveniles, often in a residential setting (32 studies).

Services for special populations. Interventions defined largely in terms of the type offender and service need addressed by the treatment.

- Alcohol and drug treatment (>10 studies; still being collected).
- Sex offender programs (approximately 10 studies; still being collected).

The research studies on the above programs show that each has positive effects on recidivism with average reductions ranging from 3% to 26%.

Control Approaches

Surveillance (17 studies). Interventions based on the idea that closer monitoring of the juvenile will inhibit reoffending. The main program of this sort is intensive probation or parole oriented toward increasing the level of contact and supervision.

Deterrence (15 studies). Interventions that attempt to deter the youth from reoffending by dramatizing the negative consequences of that behavior. The prototypical program of this sort is prison visitation-- Scared Straight type programs in which juvenile offenders are exposed to prisoners who graphically describe the aversive nature of prison conditions.

Discipline (22 studies). Interventions based on the idea that youth must learn discipline to succeed in life and avoid reoffending and that, to do so, they need to experience a structured regimen that imposes such discipline on them. The main programs of this sort are paramilitary regimens in boot camps.

The research studies on the above programs show that, on average, each has minimal or negative effects on recidivism.

The Phase II assessment of which DCS funded programs or service packages for juvenile offenders are evidence-based relied upon the above typology of interventions (each defined more fully in Appendix A). Following the PC585 standards, DCS funded programs were examined to determine if they were (a) governed by a program manual or protocol and (b) could be clearly identified as an instance of one of the intervention types with research evidence showing it reduces recidivism; that is, an intervention listed above under “therapeutic approaches.” If both these criteria were met, the program and/or service(s) were judged to be supported by evidence of effectiveness and thus, at this stage of the project, to qualify as “evidence-based.”

For a program or service to be effective, however, it is not sufficient that it be a type of intervention for which evidence shows positive average effects. It must also be implemented well—an adequate amount and quality of the respective service must be provided to appropriate clients. The research shows that, while a particular type of program may have positive average effects, poorly implemented programs have effects well below that average that may be negligible. Well implemented programs, on the other hand, have effects above that average that may be quite substantial.

Phase III of the EBP project will, therefore, collect further data on the amount and quality of services delivered in each program and rate them against guidelines derived from the

database of research studies described above. Those guidelines are based on the program characteristics that the research studies show to be most strongly related to positive program outcomes. Programs of a given type that more closely match the guidelines are more in line with the evidence for the effectiveness of that program than those that match less well. Phase III will begin early in 2009 and is expected to produce these more detailed evidence-based program ratings for all the relevant DCS funded programs by the end of that calendar year.

Procedure for Identifying DCS Funded Programs of a Type that Research Shows to be Effective

A data collection and classification procedure was used to determine which DCS funded programs and services for juvenile justice youth were instances of the program types identified above as having positive supportive research evidence.

The first step was to gather substantial descriptive information about the programs and services of each provider. Some of this information came from a survey each provider filled out, but the majority of the information was obtained from site visits to each provider. Those site visits involved interviews with program directors, line staff, and juveniles. Program materials, schedules, and other such descriptive material were also gathered. Appendix C describes the collection and systematic coding of this information in more detail.

The information obtained through this process was then used to classify each provider's program(s) or service(s) according to the intervention types listed above (and more fully described in Appendix A). Existing programs or services that did not match the definition for any of the intervention types represented in the research database were identified as such in a separate category for programs or services without research evidence of effectiveness.

A challenging issue in this process was determination of the appropriate "units" to identify as programs and services. Some providers offer more than one program, with different programs for different groups of juveniles, and many provide more than one service to their juvenile clients as part of an organized package of services under an overarching programmatic concept or milieu. Indeed, the residential programs provide multiple diverse services as a matter of course. As a result, different levels of analysis were possible. The classification process proceeded by first identifying each distinct service and each distinct set of clients who received the services. When an individual service could be identified as one of the interventions in the research database, e.g., individual counseling, it was designated as one for which supportive research evidence was available. As a result of this process the analysis in this report focused on the most descriptive, exhaustive level of intervention, the service level.

Once services were identified for each provider by location and set of clients, an attempt was made to classify each separately identified service for each provider into the intervention categories presented earlier that were derived from the research database. All services that matched one of the intervention categories with a therapeutic approach were identified as services for which there was research evidence of effectiveness. Those that did not match any of those categories were identified as services for which

there was no research evidence of effectiveness. Appendix B also provides more detail about how this part of the process was accomplished.

Results of Program Classification Compared to Evidence in the Research Literature

Data Overview

For this report, the programs/services of 26 juvenile justice youth providers (including DCS and DCS youth development center subcontractors) were reviewed. These providers are currently responsible for interventions with youth in approximately 80 residential locations across Tennessee (see Appendix E for a detailed listing of providers/locations reviewed in this report). Based on our analysis, these locations are currently engaging youth in over 630 programs or intervention services (see definitions in Appendix B).

Once identified by provider and location all the services were reviewed, coded, and classified according to Dr. Lipsey's program or service types (see Appendix A). While service types and overall service arrays varied among the 26 providers, group and individual counseling were the most common services provided to the juvenile justice youth in the 80 residential locations reviewed in this report.

While the incidence of manualization (i.e, following an established treatment protocol) still requires a higher level of validation, these services were relatively well documented in terms of intervention content and it appears that a majority of the services offered to juvenile justice youth by DCS staff and their contracted providers are manualized and/or have protocols in place that specify the nature, quality, and amount of service that constitutes the intervention.

Evidence-based Programs and Services

Based on this phase of analysis, the program and service coding indicate that none of the providers are engaged in programs or services that match categories of treatment found to produce negative effects such as discipline or deterrence based interventions.

Out of all the current services identified, approximately 94% of the coded current juvenile justice residential services matched evidence-based services that result in positive average intervention effects (e.g., lower rate of repeat delinquency or recidivism) according to available research. For example, the most common services provided to the juvenile justice youth were group counseling sessions led by a therapist and these services have shown positive effects for this population.

Group and individual counseling made up almost 27% of all the services identified while the larger counseling service category that included family counseling, peer counseling, and mentoring accounted for just over 40% of all identified services.

Skill building was also a common service category, making up 43% of all services identified. Based on the information available it appears that social skills training, job related training, and academic training make up a majority of the service subtypes in the skill building category.

Service Type Associated with Positive Outcomes/Effects	Service Prevalance ¹	
	#	% ²
Restorative	5	0.8%
Mediation	5	
Counseling and its variants	238	40.1%
Individual	78	
Mentoring	10	
Family Counseling	58	
Group Counseling led by a therapist	81	
Peer Counseling	11	
Skill Building	255	43.0%
Behavioral	45	
CBT ³	15	
Social Skills training	70	
Challenge	9	
Academic	55	
Job Related	61	
Multiple Coordinated Services	20	3.4%
Case Management	3	
Service Broker	17	
Services for Special Populations	75	12.6%
Alcohol and Drug	59	
Sex Offender	16	
TOTAL	593	

¹ Number of times this service is presented based on the providers/services reviewed for this report, for a detailed list, see Appendix E

² Total refers to all services that matched evidence-based services shown to have positive effects.

³ Based on currently available service information; it is anticipated that skill building services will include more services qualified as CBT after more detailed information is obtained in Phase III.

Specialized programs such as alcohol/drug and sex offender treatment interventions made up almost 13% of all identified services. These services were not all concentrated in one or two providers, rather alcohol and drug treatment were offered in-house at 18

locations while sex offender treatment was available to juveniles in-house in approximately 8 of the locations reviewed in this report.

The restorative and multiple coordinated program or service categories accounted for the remaining 4% of service types identified.

The remaining 6% of services fell into a third category of interventions. For example, programs such as art therapy, bibliotherapy, and pet assisted therapy fell into this classification group. These programs and services could not be matched to evidence-based intervention practices. The effect of these programs is therefore unknown based on the current research.

Provider Analysis

Each provider was evaluated in terms of what percentage of their services (at all locations) matched evidence-based intervention types with proven positive effects. As was mentioned above, none of the providers reviewed in this analysis utilized an intervention type that has shown negative effects. For all providers reviewed in this analysis, the majority of services utilized at each location matched evidence-based services resulting in positive average intervention effects. About 50% of the providers utilized one to two services with unknown effects as part of their existing (evidence-based) service array.

While the results of this Phase II analysis are notable – 94% of current programs and services appear to be evidence-based - the next phase of analysis, Phase III of the project, will determine if these programs and services meet evidence-based best practice standards in terms of implementation and treatment quality for each program type. Additional validation and information will be gathered for this phase and a more elaborate analysis of services with additional variables will result.

Conclusions

The report would have suffered greatly without the cooperation of private agencies and local service providers. The process of collecting information, provider engagement, and work with the steering panel has been an informative process for DCS and for the provider network. Most providers expressed a willingness to work with the Department in implementing approaches that have been proven effective, and many providers have sought guidance from the Department about specific programming to match the populations they serve. Some reactions about the cost of implementation or questions about who will define the evidence arose at different points in this process, and all of those questions have increased the quality of discussions around what constitutes evidence and how that body of knowledge can take root in Tennessee. Regarding cost, full implementation of Public Chapter 585 is contingent on at least the current level of funding for Juvenile Justice Services, and provider contract reimbursements in general. Demanding greater evidence-based compliance with lower per diem reimbursements would not be a realistic expectation of the provider network.

Virtually all the programs involve multiple services and treatment interventions in different combinations. This allows flexible tailoring of the service mix to client needs. This assessment of the evidence-based status of programs, therefore, has focused on the evidence base for the component services and the proportion of those component services from each provider/program that are evidence-based.

When these component services are classified according to the general type of treatment they represent, a large majority (94%) appear to meet the Public Chapter 585 definition of evidence-based: They report having a written protocol and there are more than two studies of scientifically acceptable standards that show favorable effects on recidivism for services of that respective type. In addition, the majority of the services in the mix for each individual provider/program appear to meet this standard.

DCS recognizes, however, as does the language of Public Chapter 585, that the quality of the implementation of these services is critical to their effectiveness and aspires not just to evidence based practices, but evidence based *best* practices. For the next phase of this evidence-based process, therefore, DCS will integrate further information about the amount and quality of each service provided and assess that against standards for best practice derived from the research studies that provide the supporting evidence for each type of service provided. For FY 2009-10, the DCS goal is for 25% of the funding to go to programs that meet this higher standard of evidence based best practice. That goal appears to be well within reach.

As the full implementation of Public Chapter 585 takes root, Tennessee will have a solid base of effective treatments for Juvenile Justice Youth. Documentation already gathered by the Department suggests Tennessee is well positioned to be among the nation's leaders in the provision of services proven to reduce criminal recidivism. DCS looks forward to continued work on an interdepartmental and interdisciplinary level to ensure the continuance of this work.

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APPENDICES

Appendix A: Therapeutic Program Approaches and Types of Programs within Each Approach Identified in the Current Classification Scheme for Research on the Effectiveness of Programs for Juvenile Offenders

Definitions, Descriptions, and Examples from Research Studies

Restorative programs. Programs of this sort aim to repair the harm done by the juvenile's delinquent behavior by requiring some compensation to victims or reparations via community service. They may also involve some form of direct reconciliation between victims and offenders. Two different intervention types appear in the research, sometimes combined in the same program:

- **Restitution.** Offenders provide financial compensation to the victims and/or perform community service. Restitution focuses on making the offender accountable to the community through some form of service/payment, e.g., fines or payment/service to the victim; community service.

Example: The program provides the means for juveniles to become accountable for their crimes while compensating victims for their loss. Youthful offenders are held accountable for their conduct by performing a work service for the community in an effort to aid the rehabilitation of the delinquent youth and/or to compensate the victims for losses suffered.

Example: The program is comprised chiefly of community service activities as restitution. The program works with Habitat for Humanity, Special Olympics, food drives, the Humane Society, tutoring and convalescent homes.

Example: Youths were required to pay monetary restitution to the victims of their crimes or, if there was no outstanding monetary loss, they were required to complete a specified number of community service hours.

- **Mediation.** Offenders apologize to their victims in spoken or written form and may meet with them under supervision. These interventions typically also include a restitution component. Mediation: A counselor mediates/arbitrates between parties in conflict or between victim and offender.

Example: Program involved the mediation of victim-youth conflicts via an arbitration meeting.

Counseling and its variants. This diverse and popular program approach is characterized by a personal relationship between the offender and a responsible adult who attempts to exercise influence on the juvenile's feelings, cognitions, and behavior. Family members or peers may also be involved and the peer group itself may take the lead role in the relationship. The major variants on this intervention approach that appear in sufficient numbers in the research to warrant separate consideration are the following:

- **Individual counseling.** Individual Counseling, Therapy, Psychotherapy, Guidance – Any of a range of treatment techniques that focus on psychological or interpersonal problems or issues faced by an individual and that involves a one-on-one relationship with a therapist or counselor.

Example: Counseling sessions are provided to address client problems on a weekly basis or more if needed. Each student receives a minimum of one hour of individual counseling per week. Counseling sessions also offer the opportunity to discuss family problems and conflicts and will provide time to counsel with the clients on specific problems they experience during the day, such as self esteem

issues, peer relationships, disruptive classroom behavior, truancy, and academic problems.

Example: The student becomes a participant in ongoing individual counseling sessions held to address individual problems as well as family and community obligations. These sessions provide time to discuss the student's disruptive behavior in the classroom, community, and home.

- **Mentoring by a volunteer or paraprofessional.** An individual provides support, friendship, advice, and/or assistance to the delinquent individual. The mentor spends time with the juvenile on a regular basis involving activities such as sports, movies, helping with homework, etc. The mentor does not necessarily have to be an adult, but may be an older youth.

Example: The program consists of matching an appropriate adult volunteer to an at-risk youth. Volunteers provide positive role modeling behaviors and mentoring of appropriate behaviors, monitoring of school and community behaviors, constant discussion of life choices, access to knowledge, guidance to families, and exposure to new experiences and opportunities. Volunteers meet with youth for an average of 2 hours a week for one year.

Example: The presence of a consistent positive role model provides the youth an opportunity to bond with another person in their community who establishes clear rules and boundaries for both behavior and academic performance.

- **Family counseling.** Family Counseling, Family Systems Intervention, Functional Family Therapy – Any of a range of treatment techniques that focus on family dynamics as a factor impacting delinquent behavior. This type of treatment may encompass the entire family, but at a minimum involves the child and his or her parent(s).

Example: The program conducts intensive family counseling with both parents, juveniles, and other family members. Family treatment plans are developed to assist families in creating goals, which will help them change dysfunctional behavior patterns. Treatment issues addressed include family communication skills, anger control in the home, setting clear rules and boundaries for behavior, and parenting skills.

Example: Family therapy intervention includes family preservation services, face-to-face and telephone consultation with family members, home visits, referral and consultation with schools and other community agencies, family assessment and evaluation.

- **Short term family crisis counseling.** The availability of a trained individual to respond either over the phone or in person to a crisis involving the juvenile and/or his or her family.

Example: 7 day-a-week telephone crisis service.

- **Group counseling led by a therapist.** Any of a range of treatment techniques that focus on psychological or interpersonal problems or issues faced by an individual and that involves a group of youths interacting with each other and with a therapist or counselor.

Example: Treatment involved formal, insight-oriented discussions of the problem situations various members had been involved in during the week.

Example: Through guided discussions in a group counseling format and planned activities youth have the opportunity to be part of a group where positive interaction occurs, and encouragement of positive behavior is provided through modeling and social reinforcement.

- **Peer programs** in which the peer group plays much of the therapeutic role; for

Example: Program involved determination of treatment sessions by the youth. Group decisions were encouraged regarding all activities. Throughout these discussions, it was emphasized that as group cohesion developed, the leader should encourage greater freedom on the part of the group to determine their own activities.

- **Mixed counseling**—combinations of any of the above but especially individual, group, and/or family.
- **Mixed counseling with supplementary referrals** for other services, a common form for diversion programs.

Skill building programs. These programs provide instruction, practice, incentives, and other such activities and inducements aimed at developing skills that will help the juvenile control his/her behavior and/or enhance the ability to participate in normative prosocial functions. The main forms of these programs are the following:

- **Behavioral programs**—behavior management, contingency contracting, token economies and other such programs that reward selected behaviors. This treatment operates on the basic principle that individuals will adapt their behavior in response to positive (rewards) and negative (punishment) responses from their environment. Typically, a set of goals reflecting specific behaviors is agreed upon. If the goals are achieved the individual is rewarded, if not there is a cost or penalty either in terms of not receiving the reward or other sanctions.

Example: Each youth has an individual program plan that describes the goals and time line the youth must abide by to successfully complete the program. Positive behaviors are rewarded and privileges are withheld for non-achievement.

Example: The program rewards positive behavior at schools, homes, and within the program. Certain days are set aside for incentives. Clients may earn certain activities by performing well and demonstrating consistent and positive behaviors.

Example: Boys could earn mini-bike time for: bike safety, performing maintenance at scheduled times, and displaying appropriate social behaviors (including attending school regularly, abstaining from criminal activities and status offenses, being on time for group meetings, and cooperating with staff and peers).

- **Behavioral Contracting/Contingency Management:** A behavior modification/reinforcement system in which a specific reward is paired with a specific behavior. A set of goals reflecting specific behaviors is agreed upon. If the goals are achieved the individual is rewarded, if not there is a cost or penalty either in terms of not receiving the reward or other sanctions.

Example: Then the panel meets privately to design a contract that addresses the interests of the youth. The contract is read aloud and the youth can accept or reject it. If the youth accepts, he or she is then assigned a monitor who is responsible for seeing that the youth fulfills the conditions of the contract and nothing more.

- **Token Economy:** A behavior modification/reinforcement system in which individuals are given tokens as rewards for appropriate behavior. Tokens can then be exchanged for valued privileges such as recreational opportunities, exemption from chores, etc. If an individual behaves inappropriately tokens can be taken away, thus discouraging the behavior.

Example: Subjects received tokens in the classroom contingent on academic and social performance. The tokens were exchangeable for a variety of

privileges and items, including free time, recreational activity, money, and snacks.

- **Cognitive-behavioral therapy.** The goal of cognitive behavioral therapy is to correct an individual's faulty cognitions or perceptions of themselves or the world around them. Additionally, this type of therapy provides skills individuals can use to monitor their thought patterns and correct their behavior as situations unfold around them. This type of treatment element may also focus specifically on relapse prevention by having juveniles evaluate situations that may lead to a relapse of delinquent behavior and plan for how to either avoid them or cope with them effectively.

Example: The program utilized a cognitive-behavioral, relapse approach- changing distorted thought patterns, reducing deviant interests, and developing healthy patterns of thought and behavior.

- **Social skills training.** Based on the premise that individuals who lack appropriate social skills may be perceived as threatening, disruptive, or otherwise deviant. Interpersonal skill building is a treatment technique focusing on developing the social skills required for an individual to interact in a positive way with others. The basic skills model begins with an individual's goals, progresses to how these goals should be translated into appropriate and effective social behaviors, and concludes with the impact of the behavior on the social environment. Typical training techniques are instruction, modeling of behavior, practice and rehearsal, feedback, reinforcement. May also include training in a set of techniques, such as conflict resolution or decision making, that focus on how to effectively deal with specific types of problems or issues that an individual may confront in interacting with others.

Example: Communication skills included group activities that encourage effective communication between the youths and their peers, family members, and communities. Assertiveness skills training involved group activities to increase youth skills in assertive communication methods as opposed to passive or aggressive communication styles.

Example: The program helps youth and their families learn appropriate positive communication skills. Subjects are given an opportunity to practice skills in listening, talking with respect, setting and maintaining appropriate house rules and negotiating conflicts.

Example: The program offers classes on conflict resolution and making appropriate decisions concerning behaviors and consequences.

- **Challenge programs**—interventions that provide opportunities for experiential learning by mastering difficult or stressful tasks. Juveniles participate in physically challenging activities such as hiking, ropes courses, or canoeing. The objective of these programs, based in the philosophy of experiential education, is two fold: First, to teach self-esteem and confidence through the mastery of a progressively more difficult set of physically challenging tasks; and second, to introduce participants to the prosocial interpersonal skills (i.e., problem solving, communication, trust, etc.) required to work successfully as a group.

Example: The survival program deliberately induced physical challenge including long marches, rappelling, forging streams, student expeditions, and a solo wilderness experience.

- **Academic training;** for example, tutoring, GED programs. Remedial Education— any education designed to address deficits in a juvenile's education and bring him or her up to the level expected of youth in his or her age group.

Example: The program was based on an academic treatment model which provided

individual instruction in functional areas of greatest learning deficiency, e.g., expressive and written language, reading or arithmetic. During treatment sessions, the learning disabilities specialist and participant worked to improve academic skills and attitudes toward school with materials, which had been carefully selected to be compatible with the adolescent's strongest learning modality (visual, auditory, or motor).

Tutoring— juvenile receives assistance with understanding and completing schoolwork.

Example: University students tutored subjects in reading, math and language.

Example: Each week the volunteers help the youth with any homework or reading assignments.

- **Job related interventions**—vocational counseling and training, job placement. The overall emphasis is on preparing the juvenile to enter the work force. Program may include employment, job placement, non-paid work service (non-restitution based), job training or career counseling.

Example: The program encourages youth to train for and enter the work force to improve their self-esteem, independence, employment skills and marketability.

The program focuses on increasing basic skills, as well as focusing on computer and other technology skills that will improve the opportunities of participants in a competitive job market.

Example: Juveniles conducted supervised work with various public service agencies throughout the community. Volunteers and the Program Manager monitor the juvenile for his/her progress.

Supervised Work Program— juvenile is employed either in a specialized program for delinquents or in a regular job but monitored because of his or her delinquent status.

Example: Wards were assigned to a half-day work crews and supervisors throughout their stay. Their tasks included assisting tradesmen with the maintenance of reception center grounds and buildings, with kitchen work, and other housekeeping operations. Tradesmen and supervising staff expected wards to adhere to simple rules and accept instructions regarding assignments.

Job Training— juveniles are taught skills specific to a particular trade or profession.

Example: The vocational training consisted of courses in the areas of machine shop, welding, power mechanics, automotive mechanics, automotive paint and body repair, and horticulture.

Employment/Job Placement of Individual Juveniles— juvenile is employed as a regular employee with no distinction based on delinquent status or history.

Example: Following release, the youth either begins the job identified prior to his release or continues to work with the offender specialist until suitable employment is found.

Career Counseling— individuals are provided with guidance in evaluating their vocational interests and information about specific jobs or careers.

Example: The job counselors assisted in the preparation of job applications, counseled youths regarding job interviews. Job openings, job hunting techniques, interviewing, and employer expectations were all discussed.

Multiple coordinated services. Programs in this category are not organized around a primary service type or a combination of a few such service types but, rather, are designed to provide a package of multiple services which may be basically similar for all the participating juveniles or may be individuated with different juveniles receiving different services. The primary intervention forms of this type are the following:

- **Case management**—a designated case manager or case team develops a service

plan for each juvenile, arranges for the respective services, and monitors progress. A technique typically used by probation or parole officers to manage and monitor a client's progress. This can take many forms such as providing needs assessment, coordinating services, monitoring an individual's progress, or acting as an advocate. Case managers do not implement treatment directly.

Example: The case management model provides frequent and consistent support and supervision of youth and their families. Case managers use a 'client-level strategy for promoting the coordination of human services, opportunities, or benefits.' Case managers link youth to community-based services and closely monitor their progress.

- **Service broker**—referrals are made for the service or services deemed appropriate for each juvenile with a relatively minimal role for the broker afterwards. Juveniles are assessed or evaluated for specific needs and then referred to appropriate service providers.

Example: Once the youth has been referred, the counselor will interview the youth, then the parents, then both together until the basic problem is identified. The youth may then be sent to any one of the several programs offering an appropriate type of treatment or may remain in the project to receive services.

- **Multimodal regimen**—a multimodal curriculum or coordinated array of services is provided to all participating juveniles, often occurring in a residential setting.

APPENDIX B: Procedure for Classifying Programs

Information about each DCS program was collected with provider surveys, on-site interviews, and treatment materials such as daily schedules, protocols, and other program or service related manuals. These were then used to determine what intervention services the juvenile justice youth are receiving at each provider location. The following data elements were recorded into an excel spreadsheet for each provider to be used in this report as well as Phase III of this evidence-based project:

- Provider Name
- Location Name
- Location Description
- Gender of Youth Served
- Type of Youth Served
- Residential (Yes, No, Mixed)
- Notes/Miscellaneous

- Program Name
- Program Description
- Brand Name Program (Yes, No)
- Manualized Program (Yes, No)

- Service Name (and/or short descriptor)
- Service Description
- Brand Name Service (Yes, No)
- Manualized Service (Yes, No)
- Duration of Service
- Service Recipients

- Evidence-based main category [for each program]
- Evidence-based subcategory [for each program]
- Evidence-based main category [for each service]
- Evidence-based subcategory [for each service]

All 21 items above were coded for each provider (including the DCS YDCs and Group Homes). Because many of the providers have multiple locations and multiple intervention services, the data was set up hierarchically so that all intervention information could be easily attributed to each provider and/or residential location (see Appendix C below for a graphic representation of the coding/classification process).

The first item coded, Provider Name, was based on the name of agency or group that provides the residential treatment services (e.g., Holston United Methodist Home for Children, Inc.) and Location Name was coded as the site of at which the youth in juvenile justice custody engage in intervention activities (e.g., Wiley Center). In addition to Location, a general description of each provider site was recorded (e.g., 40-bed residential treatment center with five 8-bed residences). The gender of the youth served at this location was coded (male, female, both) as well as the Type of Youth Served. The latter category utilized the DCS contract categories (e.g., level 2 continuum, level 3 special, etc.). All the provider locations reviewed were residential but the Residential code was still included to distinguish locations that served both residential and nonresidential juveniles (Yes, No, Mixed). An additional item, Notes/Miscellaneous was

reserved for any comments, clarifications, and questions requiring follow up during the coding process.

Based on a review of the provider information gathered, it was inductively determined that the provider's intervention activities should be classified at two levels to ensure all therapeutic interactions with the juvenile justice youth were accounted for and appropriately matched with evidence-based intervention categories. The full coding process is outlined in the flow chart in Appendix C. As shown in the flow chart, each provider's intervention activities were coded at two levels: program and service. For the purposes of this analysis, Provider Programs were defined as the location's primary milieu or overall orientation (e.g., Circle of Courage) while Provider Services were defined as the specific intervention (guided group therapy, group counseling, anger management) used at the location being examined. This was done in an effort to be as exhaustive as possible and give credit to each provider for all of their treatment based interaction with the juvenile justice youth in their care. The program and services codes are not mutually exclusive as a program can also be a service. However, for the vast majority of the DCS providers, each program, or overall intervention milieu, included a number of different direct client services that qualify in-and-of-themselves as evidence-based practices with substantial research indicating their effectiveness in reducing repeated delinquency or recidivism. In some cases, the research was not sufficient for a program to be termed evidence-based however, a majority of the services delivered as part of the overall intervention milieu qualified as evidence-based practice.

It should also be noted that a location or program is coded or classified only for services that it directly provides. For example, if referrals are made in a service brokerage format (i.e., youth from one location participate in an alcohol and drug treatment program at another location) and a secondary location provides a program or service, the secondary location should receive credit for the intervention activity. This is not meant to diminish the importance of referrals; rather it is intended to direct the credit for the program or service to the appropriate location and provider.

Another set of items indicated if each program and service were Brand Name (Yes, No) and Manualized (Yes, No). Brand name was defined as a program or service that exists and is commercially available as an intervention package (e.g., Cognitive Behavioral Therapy) and manualized reflects the extent to which a program or service has a written, standardized format (e.g., an intervention handbook, training materials, treatment protocol, etc.) that specifies the nature, quality, and amount of service that constituted the intervention. At the time of this writing, these variables require validation. When this variable is finalized, it will be included in the Phase III analysis.

At the service level, the Duration of the intervention activity was also recorded (e.g., 1 session per week, 1 hour per session). For this phase of the analysis, duration information was based on daily schedules and/or provider interviews. For the next phase of the analysis (Phase III), this item will be validated and additional detail will also be gathered.

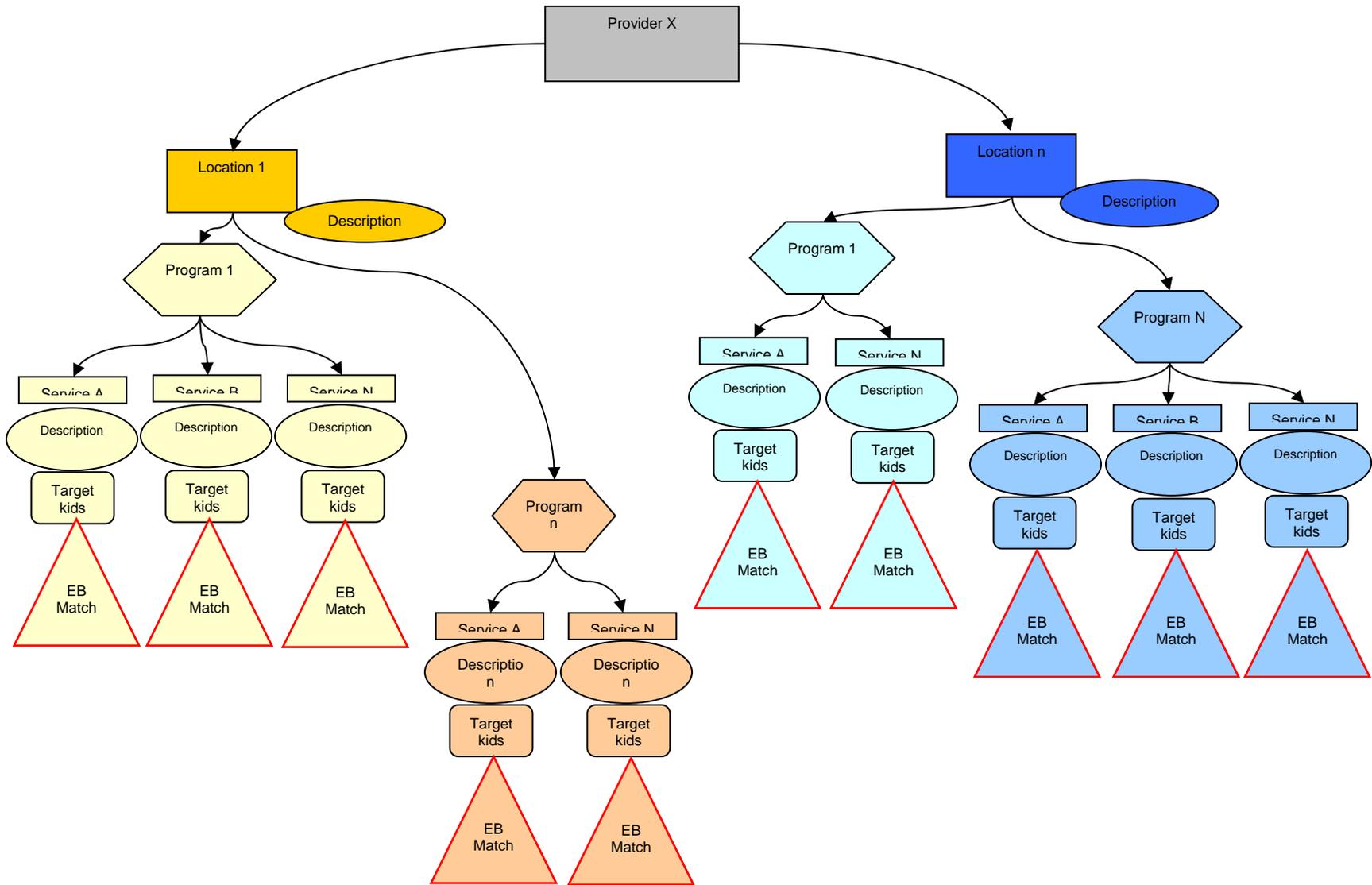
The youth receiving the specific service, Service Recipients, were also identified during the coding process. This item ranged from "all residents" for service components available to all juveniles at the program location to "per treatment plan" for more specialized services available to juveniles who qualify for the service based on their assessment (e.g., trauma counseling).

Evidence-based Classification Process

All existing provider programs and services were classified or coded into juvenile intervention categories based on evidence-based practice research. Essentially, the services being provided to juvenile justice youth in residential care were matched with research on evidence-based programs and services (see Appendix A for a complete list of evidence-based categories and sub categories). Because there is no standardized method for characterizing juvenile interventions, the categories were inductively derived from the program and service descriptions in juvenile intervention research and program evaluations. There are seven broad intervention philosophies: Surveillance, Deterrence, Discipline, Restorative Programs, Counseling and its variants, Skill-building Programs, and Multiple Coordinated Services. As can be seen in Appendix A, each of these broad treatment philosophies includes one or more specific interventions. The broad philosophies and the specific interventions are not considered to be mutually exclusive categorizations. For example, an overarching treatment milieu may include an array of services that include counseling, restorative, and skill building types of intervention services.

It should be noted that this phase of coding is directed toward assessing the current services provided to juvenile justice youth in residential facilities to determine if these intervention activities match up to research supported evidence-based services. In Phase III of this project we will gather additional, more detailed implementation information to determine if the evidence practices meet the best practice standard or if they require additional work or reformatting in order to maximize the treatment effects.

APPENDIX C: Coding Process Flow Chart



APPENDIX D: Itemized List of Programs Visited Onsite

Date	AGENCY	CITY
8/14/08	Holston UMCH	Greeneville
8/14/08	Family Ministries	Greeneville
8/15/08	Frontier Health	Kingsport
8/15/08	Smoky Mtn Children's Home	Sevierville
9/10/08	Florence Crittenton Agency	Knoxville
9/11/08	Steppenstone [CCS]	Limestone
9/11/08	Mountain View YDC **	Dandridge
9/16/08	Omni & Subcontractors	Nashville
9/17/08	Youthtown	Pinson
9/17/08	Porter-Leath	Memphis
9/18/08	Memphis Recovery Center	Memphis
9/18/08	Wilder YDC **	Somerville
9/19/08	New Jerusalem/Hope House	Selmer
9/29/08	Woodland Hills YDC **	Nashville
9/29/08	Monroe Harding	Nashville
10/1-3	Youth Villages	Memphis
10/14/08	Taft YDC **	Pikeville
10/15/08	American Family Institute	Chattanooga
10/15/08	Parkridge Valley	Chattanooga
10/16/08	Partnership FCA	Chattanooga
10/16/08	Children's Home/ Chambliss	Chattanooga
10/17/08	Cumberland Hall of Chatt	Chattanooga
10/20/08	Highland Ret., NT and TGH	Hohenwald
10/21/08	UCHRA~ Chance and IM	Cookeville
10/22/08	VBH ~ ADAPT Program	Cookeville
10/22/08	Child and Family of TN	Knoxville
10/23/08	HRM ~ YES	Morristown
10/24/08	Comp. Community Svcs	Kingsport
10/29/08	NV YDC **	Nashville
11/12/08	Centerstone CMHC	Nashville
11/19/20	Phoenix/ Subcontractors	Nashville
11/25/08	CRC ~ New Life Lodge	Burns
12/2/08	Tennessee Children's Home	Spring Hill
12/3/08	Camelot Care Centers	Nashville
	** State operated facility	

APPENDIX E: List of Providers and Locations

PROVIDER	LOCATION
Camelot Care Centers, Inc.	Camelot - East (Oak Ridge)
	Camelot - Middle (Nashville)
	Camelot - NE (Kingsport)
	Camelot - SE (Cleveland)
	Camelot - West (Memphis)
Centerstone	Hart Lane Boys Group Home
	Hayesboro Girls Group Home
	Lodge Group Home
Child and Family of Tennessee, Inc.	Blount County Boys Group Home
	Cooper House
	Johnson Group Home
Comprehensive Community Services (CCS)	CCS
Counseling and Consultation Services (CCS)	Steppenstone
CRC Health Tennessee Inc.	New Life Lodge
DCS	Bradley County Group Home
	Brighter Paths
	Elizabethton Group Home
	Henderson House
	Inman Group Home
	Johnson City Boys Group Home
	Johnson City Observation and Assessment Center
	Madisonville Group Home
	Mt. View Youth Development Center
	Nashville Transition Center
	New Visions Youth Development Center
	Peabody Residential Treatment Center
	Taft Youth Development Center - A&D
	Wilder Youth Development Center - gen pop
Woodland Hills	
Florence Crittenton	Florence Crittenton Female Step Down
	Florence Crittenton 60-day Enhanced
Frontier Mental Health	Crossing Point
	Link House
Freewill Baptist Ministries	French Cottage
	Jane Brown Cottage
	Niswonger Cottage
	Woolsey Cottage
DCS/Helen Ross McNabb	Mt. View Youth Development Center
Highland Youth Center/Natchez Trace Group Home	Highland Youth Center/Natchez Trace Group Home

PROVIDER	LOCATION
Holston United Methodist Home for Children Inc.	Bewley Developmental Center
	Brumit Center
	Greenville Family Services Center
	Hull Residence
	Intensive - In Home Trt
	Knoxville Family Services Center
	Tri-Cities Family Services Center
	Wiley Center
New Jerusalem	Hope House
Omni Visions	DLC
	Group Effort - Gallatin
	Group Effort - Mt. Juliet
	Group Effort - Murfreesboro
	Madison Oaks Academy
	Task
Phoenix Homes, Inc	Youth Dimensions
Psychiatric Solutions Incorporated	Cumberland Hall
Smokey Mtn Childrens Home	Smokey Mtn Children's Home
Tennessee Children's Home	Tennessee Childrens Home - Spring Hill
	Tennessee Childrens Home - West TN
Trace Group Home	Trace Group Home
Upper Cumberland Human Resource Agency	Chance Residential Center
	Indian Mound
Valley Hospital	Parkridge Valley Hospital
DCS/Vanderbilt	New Visions Youth Development Center
	Woodland Hills
Volunteer Behavioral Health Care System	Adolescent Diagnostic Assessment and Primary Treatment Center (ADAPT)
Youth Villages	Bartlett
	Binkley Group Home
	Brunswick Group Home
	Center for Intensive Residential Treatment
	Coteswood Group Home
	Deer Valley
	Dogwood Village
	Intensive - In Home Trt
	Paidia's Place Group Home
	Poplar Group Home
	Tallwood Group Home
Wallace Group Home	
Youthtown	Riverquest

APPENDIX G: Site visit instrument

DATE OF REVIEW _____

REVIEWER(S)

Agency Representative:

[IN ADVANCE OF VISIT]

AGENCY NAME: _____

PROGRAM LOCATION _____

STRUCTURE (CONTRACT OR SETTING) _____

PROGRAM TYPE(S) _____

EBPs CLAIMED _____

Materials for onsite review:

- Client roster for date of visit (supplied by agency or from recent TN-Kids pull)
- Roster of Staff (supplied by agency or as listed in EBP responses)
- Credential check for licensed staff
- Program Manual, Resident Handbook, Philosophy of Treatment, or Behavior Management Plan
- Daily or weekly schedule of events
- Client files, treatment team logs or treatment review notes
- Staff training manuals

FY 2009 Contract Totals: ***** OFFICE USE ONLY *****

Percentage JJ as of September 30, 2008

Percentage EBP target for JJ Children

Dollar Amount for EBP JJ Programming \$ _____ .00

Dollar Amount for Non-EBP JJ Programming: \$ _____ .00

Frequency and hours per week of group counseling _____ Sessions _____ Hours

Frequency and hours per month of family counseling _____ Sessions _____ Hours

Frequency and hours per week of skill building _____ Sessions _____ Hours

Frequency and hours per week _____ Sessions _____ Hours

[other, enter e.g restorative justice]

FY Target date for compliance improvement: 2010 2011 2012 2013

Background, Philosophy and Research

What is the agency understanding of what evidence based practice means, where does the agency leadership see the agency being in providing services through an evidence based approach?

How has the agency engaged experts or published materials about EBP and incorporated that by staff training, supervision, and program evaluation?

How was your model researched, developed, and implemented?

Describe the Frequency, duration, and intensity of each service you provide:

What is the level of supervision for staff providing the services listed? How is on-going supervision provided and are staff re-assessed after certain periods for adherence to your model of treatment?

Walk us through the way in which the agency conducts its own assessment of risk and need for the populations served.

What types of youth have needs that must be met outside the agency, what community resources are accessed to meet those needs? What agencies are utilized in the community?

How are the services at your agency:

A. Responsive to the following general risk areas in serving juvenile justice clients

Runaway/Absconder Risk _____

Criminal Recidivism _____

Skill Building _____

Academic vocational needs and deficits _____

Interpersonal skills and needs _____

Other (list) _____

B. How is your program responsive to the personal and individual needs of each client through

Assessment

Family involvement

Release or Discharge planning

Engagement of community professionals or paraprofessionals, including mental health, substance abuse, mentoring, vocational or educational linkage?
