Toward the Reduction of Recidivism Throughout the Continuum of the Florida Department of Juvenile Justice Services:

The Implementation of Evidence-Based Programming and Interventions

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Introduction

Historically, juvenile justice systems have operated along a continuum between two divergent perspectives: rehabilitation and incarceration. We, as juvenile justice professionals, believe to know what structure and services constitute a good program. We therefore, design programs that meet these views, but we often do not have empirical evidence to support their effectiveness. Many programs accomplish valiant goals without addressing the Department’s mission to reduce juvenile crime and delinquency.

Employing the scientific method in evaluating juvenile justice programs provides evidence to support the value of programs in meeting the Department’s mission as measured by reducing recidivism rates. Programs that are supported by scientific study are referred to as “What Works” or “Evidence-Based” programs.

The official definition of Evidence-Based Practices as defined by the Florida Department of Juvenile Justice is “treatments and practices, which have been independently evaluated and found to reduce the likelihood of recidivism or at least two criminogenic needs, with a juvenile offending population. The evaluation must have used sound methodology, including, but not limited to, random assignment, use of control groups, valid and reliable measures, low attrition, and appropriate analysis. Such studies shall provide evidence of statistically significant positive effects of adequate size and duration. In addition, there must be evidence that replication by different implementation teams at different sites is possible with similar positive outcomes.”

Random assignment is the gold standard of research as legislatures and juvenile justice and criminal justice systems begin to question the effectiveness of the programs they fund. The importance of rigorous evaluation designs has become increasingly necessary. Throughout the U.S., funding agencies have begun to demand that any program they fund have a random assignment of participants to treatment or control groups (Potter, 2007).

Recent research states, “As funders and program sponsors become more committed to implementing evidence-based programs, program developers are increasingly likely to promote their programs as evidence-based” (Small, Cooney, Eastman, & O’Connor, 2007:4). Simply because a developer markets their curriculum as evidence-based does not guarantee it meets the standards discussed above. As Small and colleagues illustrate, “A program might be ‘research-based’, but not ‘evidence-based’…A research-based program has been developed based on research about the outcomes or processes it addresses”, however, it has most likely not been evaluated utilizing the rigorous standards needed to designate a program as evidence-based (Small, et al., 2007:4).

Evidence-Based Steering Committee

As the Department transitioned to the new administration under Secretary Walter A. McNeil, the Evidence-Based Steering Committee was developed to promote the Department’s newly revised vision, mission and guiding principles. One of the priorities for the new administration is to develop a plan for coordinated strategies to implement evidence-based practices throughout the entire Department. The Evidence-Based Steering Committee is tasked with the development of a detailed implementation plan for evidence-based initiatives including:

- A definition of evidence-based practices;
- The establishment of a Program Review Committee to determine which interventions are evidence-based;
- Documentation of facilitator and master trainer qualifications (i.e., number of training hours to be certified, practicum requirements), as most programs recognized as evidence-based are copyrighted and require individuals to be certified in order to hold themselves out to the public as facilitators of the
• The creation of a sourcebook of evidence-based and promising practices;
• The development of a plan to build capacity and sustainability throughout the Department;
• The coordination of each program area’s efforts and potential projects with respect to evidence-based programming and implementation;
• The development of the Department’s plan to ensure fidelity monitoring of evidence-based practices throughout the continuum of services;
• Inventory current capacity of evidence-based practices (i.e., number of curricula or programs that meet the Department’s definition of evidence-based practices, number of Department and provider staff trained to facilitate evidence-based practices, number of Department and provider staff who are master trainers of evidence-based practices, percentage of programs and facilities in each of the four program areas utilizing evidence-based practices);
• The potential for data fields within the Juvenile Justice Information System (JJIS) database for name of evidence-based practice, frequency of intervention, duration in days of intervention, average number of minutes per group; and
• The identification of costs associated with implementation of evidence-based programs and practices.

Strategic Framework
DJJ has turned to research for solutions to incorporate within the four substantive areas of operation: Prevention and Victim Services, Detention Services, Probation and Community Intervention, and Residential Services. The principles of effective intervention guide the development and operation of the Department in this endeavor. The five principles form a coordinated strategy for the reduction of juvenile crime based on the risk of re-offending and service needs related to re-offending behavior. The Department has implemented a statewide system of continual program improvement based on the following five principles:

Risk Principle: Interventions should target offenders who are most at risk. The intensity of services provided should mimic the risk to re-offend level of the youth, with the most intense services tailored to the highest risk to re-offend youth (Andrews & Bonta, 2003; Harland, 1996, McGuire, 2002; Sherman et al., 1998). Criminological literature shows high intensity services delivered to low risk to re-offend youth are iatrogenic, having the negative consequence of actually increasing recidivism.

Need Principle: Services provided should address criminogenic needs (dynamic, changeable needs associated with re-offending behavior). The strongest correlates of crime are peer relationships, family factors, substance abuse, and antisocial attitudes toward authority, education, and employment (Gendreau, Andrews, Cogin & Chanteloupe, 1992). Programs successful in reducing these criminogenic needs can expect corresponding reductions in recidivism (Andrews & Bonta, 2003; Gendreau et al., 1994; Elliot, 2001; Harland, 1996).

Treatment Principle: Employ evidence-based treatment approaches. These services should incorporate cognitive behavioral theoretical foundations (i.e., reinforcement of pro-social behaviors) and be structured, and focused on developing skills (Gendreau & Goggin, 1997; Palmer, 1995; Steadman & Morris, 1995).

Responsivity Principle: Services provided should be tailored with respect to matching the teaching style to the learning style of the youth, varying treatment according to the relevant characteristics of youth such as gender, culture, developmental stages, IQ, motivation, mental disorders, and psychopathy (Gordon, 1970; Miller & Rollnick, 2002).

Fidelity Principle: Monitor the implementation quality and treatment fidelity to ensure programs are delivered the way in which they were designed and intended to maximize program success and recidivism reduction.
These principles are derived from the results of a statistical technique, meta-analysis, which allows the results of many individual studies to be integrated to gain a clear indication of the empirical evidence on an issue. Meta-analyses have been used both to identify individual risk factors associated with recidivism, as well as to determine the characteristics of the most effective delinquency treatment programs (Andrews & Bonta, 2003; Andrews et al., 1990; Lipsey, 1989, 1992). Research on offender rehabilitation and behavioral change has evolved to the point of providing guiding principles to enable corrections to make meaningful decisions with regard to what works to reduce juvenile recidivism and improve public safety (Bogue, et al., 2004; Burrell, 2000; Carey, 2002; Corbett et al., 1999; Currie, 1998; Elliot et al., 2001; Latessa et al., 2002; McGuire, 2002; Sherman et al., 1998; Taxman & Byrne, 2001). Following these principles will ensure decision-makers that they are purchasing and providing what is needed to reduce juvenile crime and rehabilitate the juvenile offender population.

An integrated and strategic model for evidence-based practice is necessary to adequately bridge the gap between current practice and research-supported practice (Bogue, 2004). Research indicates that evidence-based practice in corrections should at the very least:

- Develop staff knowledge, skills, and attitudes congruent with research-supported practice;
- Implement programming consistent with research recommendations;
- Monitor implementation of programming to identify fidelity issues; and
- Routinely measure recidivism outcomes (Brogue et al., 2004).

**Implementation of Evidence-Based Practices**

“Diffusion of innovations” is the movement of an idea or practice from one setting to a variety of settings in order to achieve widespread adoption (Rogers, 2003). Potter states, “This is an era with strong competition for scarce public resources for corrections related programs. Knowing what it takes to move an idea, no matter how well intended, to a promising practice to a model program, is a good starting framework for innovative ideas…It takes evidence, not good intentions. Replication, sustained impact across multiple sites and repeated evaluations are the new requirements (2007:75).”

Several steps should be taken before a program/facility attempts to implement a curriculum or model proven to reduce the risk of recidivism (i.e. evidence-based). The program initially must decide which evidence-based practice is best for them. This issue is decided based on the needs of the youth in the program and the desired goal of the practice. The program should decide which criminogenic needs it wishes to target and then choose a practice designed to address those needs. Specific evidence-based practices each address specific criminogenic needs and have been evaluated with respect to decreasing specific risk factors. A practice evaluated and proven effective to reduce the likelihood of substance abuse and negative family relationships would not be appropriate for youth presenting with aggression/anger management issues (as evidenced by a validated risk/needs assessment such as the PACT, the YASI, or Back on Track!).

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Once the curriculum is chosen, the program must receive training on the facilitation of that specific curriculum or model. Simply being trained on one evidence-based curriculum, for example Aggression Replacement Training (ART), does not make an individual certified to facilitate other evidence-based curricula, for example LifeSkills Training (LST). It is necessary to receive formal training, and maintain documentation of that training, for each evidence-based curricula or model an individual delivers to youth.

There is a logical progression of steps that should occur prior to a program/facility simply sending staff to training on an evidence-based practice. The program should first:

1. **Identify appropriate staff to attend the training.** These staff should be available for every day of the training (missing one day, or even part of one day, will lead to the staff not being certified and waste the staff member’s, program’s, and trainer’s time). Appropriate staff are individuals who are capable of facilitating groups, both in terms of availability of time in the workweek and possession of the skills and personality to facilitate a group with youthful offenders. Many evidence-based practices have been proven effective when delivered by direct care/line staff and are psycho-educational, delinquency treatment groups. Many, in fact, began as prevention initiatives and have been delivered by teachers in a classroom setting for years (such as LifeSkills Training). These groups were later empirically validated to be effective with an offender population. Other evidence-based practices, such as Multisystemic Therapy (MST) and Functional Family Therapy (FFT) may require either mental health licensure or supervision of non-licensed staff by an individual who is licensed in order to be implemented in Florida. These are important considerations to be aware of prior to identifying which staff members are to attend an evidence-based practices training.

2. **Identify the number of times per week and time of day the curriculum or model will be delivered.** The program/facility should, prior to receiving training, identify the exact days of the week and times of day the curriculum will be delivered to youth once staff are trained and return. This will require the program/facility to examine their daily youth schedule and block out the days and times the curriculum or model will be delivered. As fidelity (delivering the curricula completely and exactly as intended) is a major principle of evidence-based practices, the program/facility must ensure that the scheduled time of day is sufficient for the returning trained staff member to complete each lesson of the curriculum. Specific evidence-based practices may have varying optimal number of days per week recommended for delivery, and this should also be taken into account. The extant empirical literature on the subject, deduced from meta-analysis of over 400 studies, finds the optimal number of days per week for delivery of delinquency treatment interventions to be at least two days per week (Lipsey, 1992). Programs/facilities should ensure the returning trained staff are able to deliver the curriculum on a consistent basis, optimally at least two days per week, with one day between deliveries so as to allow youth sufficient time to practice the newly learned skills.

3. **Identify the start date for curriculum delivery.** The program/facility should identify the start date for implementation of the evidence-based practice. This step follows from the previous step of identifying the days per week and the time of day to deliver the curriculum. The program/facility knows the dates of the training in advance and is able to plan when staff return from training. Having identified the days of the week, and time of day the curriculum will be delivered, the program is able to choose a start date fitting those criteria. It is imperative that staff returning from training begin to facilitate groups as soon as possible. The longer the lag time between receiving training and beginning to facilitate, the greater the probability of distorting the lesson plans and decreasing adherence to the fidelity of the model.

4. **Understand how youth will be identified to participate in the evidence-based practice.** One of the
major tenets of the principles of effective intervention is the treatment principle holding that individuals should only receive treatment for individualized criminogenic needs. This means that youth should not receive extensive services for needs and risk factors they do not present, as based on the findings from a validated risk/needs assessment. For example, a youth without a history of aggressive behavior or aggression issues should not be placed in an Aggression Replacement Training (ART) group. The best way to reliably identify which youth should be placed in an evidence-based group would be a validated risk/needs assessment. All youth referred to the Department receive a PACT assessment, which would meet this standard. Youth entering residential placement should, at a minimum, have a PACT overview report contained in the commitment packet. Furthermore, all providers should have JJIS access, where a PACT assessment for each youth can be found. The overview report contains information related to the extent of risk and strength the youth possesses on each of the PACT-identified criminogenic needs. The greater the extent of the risk on a criminogenic need, the greater the need for treatment related to that need. Youth should be identified for possible inclusion in a group that addresses the risks and needs as presented by the PACT, or other validated risk/need assessments. Youth presenting a risk or need for a certain practice may still be inappropriate for that practice due to which stage they present based on the Motivational Interviewing Stages of Change. Youth in the pre-contemplation stage related to a particular risk factor should be guided, using the techniques of Motivational Interviewing, to attempt to ready those youth for inclusion into the evidence-based practice particular to that risk/need.

5. **Identify the size of the group.** Specific evidence-based practices have an optimal number of youth that should be included in each group, usually between eight (8) and twelve (12) youth. Others allow for more youth to be included, such as those originally designed as prevention initiatives to be delivered in a classroom setting and later validated with a juvenile offending population. Many times this is not an issue to belabor by programs/facilities, as staffing ratios may be predetermined and therefore dictate the group size.

6. **Identify whether the group will have one facilitator or be co-facilitated.** If the decision has been made for the groups to be co-facilitated additional staff must be sent to receive training. Some evidence-based practices are designed to be facilitated by one staff member; most lend themselves to co-facilitation. Co-facilitators must receive formal training in the evidence-based practice. This is paramount due to the reality of staff having to cover for others who are absent, or staff turnover issues requiring staff to be re-allocated to other shifts or duties. The high rate of staff turnover in many programs/facilities makes it essential to have more than one staff member trained in an evidence-based practice, so as to ensure the group continues and the treatment for the youth is uninterrupted by program/facility events.

7. **Address logistical issues related to scheduling groups.** Most evidence-based practices are researched, and intended by the developer(s) to be delivered to closed groups. This means that once youth are identified as appropriate and selected for inclusion in the group, and once the group begins, that group should progress throughout the curriculum uninterrupted. No additional youth should be permitted to join the group after the introductory lessons. This is logistically the most difficult aspect of implementing an evidence-based practice. Youth chosen to participate in a group must have enough time remaining in the program/facility to complete every lesson of the group (in the interest of fidelity and achieving the intended results as demonstrated in the research regarding each practice). Many programs/facilities find it difficult to not add youth to a group at some point along the way, either as youth leave or as youth are removed from the group for a multitude of reasons. These logistical issues should be discussed and potential solutions developed prior to the implementation of an evidence-based practice. This process ensures the program adheres to the fidelity principle and each youth participates
in each lesson of the curriculum, and in the appropriate order. This is essential as later lessons within many evidence-based practices build on previous lessons, so that attendance in the previous lessons is critical (if an individual were to enroll in an algebra class they would not be placed in the class during the time the other students were learning Chapter 12 as Chapter 12 requires skills taught in the previous 11 chapters).

8. **Identify materials and supplies needed and how to procure those materials.** Staff returning from training should not only have the number of days per week, time of day, start date, participating youth, and group size predetermined, they should also have the necessary materials and supplies on hand to facilitate the group beginning on the determined start date. Most evidence-based practices have scripted, “manualized” curriculum that must be followed, as well as youth workbooks for participating youth. It is required that both staff and youth have the necessary material when the group begins. The program/facility should ensure a sufficient supply of youth workbooks, facilitator guide(s), and office supplies, overhead projectors, chart paper, etc., depending on the chosen curriculum. Additionally, the program/facility should be aware of the procedure to procure additional workbooks and facilitator guides from the provider of the curriculum for the purposes of replacing lost/damaged materials, as well as for new youth as the groups cycle from one set of youth to another.

9. **Identify the process of information dissemination related to the evidence-based practice.** The program/facility should proactively identify the process and procedures it will utilize to disseminate information within the program related to the evidence-based practice. Research shows that the more individuals on each level of a program organizational chart are knowledgeable about the practice, the more effective that practice will be at achieving the desired outcomes. It is important for the administration of a program/facility to be aware of the evidence-based practice so as to encourage buy-in from multiple levels of staff, and articulate the types of treatment youth are receiving. In addition, case management, therapists, and direct care/line staff must be knowledgeable about the practice. In many instances, direct line staff are the individuals facilitating the groups, or co-facilitating the groups. Furthermore, direct line staff should attempt to foster the efforts of staff delivering evidence-based groups and model the pro-social behaviors demonstrated in groups, as well as be aware of any terminology utilized in the groups. For example, Thinking for A Change (T4C) utilizes thinking reports which suggest youth place their fingers up to their head when verbalizing what they are thinking; direct line staff should be aware of this process and understand its relevance when watching youth interact or interacting with the youth themselves. One goal for direct line staff is to supplement and foster the activities, lessons, and skills youth receive in the evidence-based delinquency treatment interventions. In the event direct line staff are facilitating the groups, case managers and therapists should be knowledgeable in the evidence-based practice so as to be aware of the types of services youth are receiving and to look for progress of the youth on specific criminogenic needs and risk factors.

10. **Identify ways to combat staff turnover.** One of the largest obstacles to the implementation and consistent provision of evidence-based practices is the issue of staff turnover. Training of an appropriate number of staff is important, as only individuals formally trained in the specific evidence-based practice
should facilitate the groups. In the event only one staff member is trained in the practice, the services to the youth will be interrupted if that staff member is absent, leaves the program, or has to cover a different shift. Programs/facilities should attempt to train enough staff to combat these circumstances to ensure services to youth are uninterrupted.

11. **Identify the process by which the program/facility will monitor the fidelity to the evidence-based curriculum or model.** One of the five principles of effective intervention is the fidelity principle. A central tenet of this principle is the need to deliver evidence-based curriculum as intended. This means following the “manitized” curriculum, teaching the lessons in the order presented by the manual, ensuring each youth receives each lesson in order, and facilitating each lesson in its entirety. Empirical analyses show that practices delivered at a high degree of fidelity achieve recidivism and risk factor reductions significantly greater than those identical practices delivered with low fidelity. A practice becomes evidence-based when rigorous evaluations are capable of demonstrating significant positive effects (such as reduction in recidivism) for youth who received the practice over youth who received either no treatment, an alternative treatment, or “business as usual”, and that the effect can not be attributable to selection bias (such as youth volunteering for the program; youth who volunteer for treatments are often the very youth who have low probability of recidivating to begin with). The practice that becomes evidence-based does so only in the manner in which it was delivered throughout the research period. Replication of the practice exactly as delivered during the period prior to evaluation is essential in order to achieve similar positive results. This is the reason most evidence-based practices are scripted /“manitized”/ to ensure facilitators deliver the lessons in the same manner and cover identical material. Though group facilitation skills will vary from facilitator to facilitator, a youth participating in an evidence-based practice in one program/facility should receive the identical service if receiving that practice in an alternative facility. The central premise is adherence to the model and delivery of the curriculum as intended, in its entirety. Programs/facilities should identify the ways in which they will monitor the facilitation of an evidence-based practice they are using with youth to ensure adherence to the model. Many evidence-based practices have fidelity checklists that can be used by individuals observing a group to substantiate the facilitator is delivering with fidelity. It is the responsibility of the program to do periodic checks of fidelity. The individual doing the checks should have a high degree of familiarity with the practice and knowledge of the central concepts to determine whether the facilitator covers them. Fidelity monitoring should occur frequently in the beginning of implementation of an evidence-based practice to determine the facilitator absorbed the necessary information and skills from the training. Monitoring can be reduced as the facilitator becomes more comfortable with the material and the process, but should remain a regular practice for the program/facility. Fidelity monitoring is perhaps the most overlooked of all the principles of effective intervention. Many programs/facilities assume that sending staff to a training and placing appropriate youth in groups is all that is needed, neglecting the fact that even highly skilled, experienced counselors may deviate from the intended delivery of an evidence-based practice. Instead, facilitators may begin to “tweak” the lessons to conform to other previous trainings or experiences, therefore decreasing the fidelity of the curriculum and reducing the likelihood of achieving the positive results garnered from empirical research.
The following is a non-exhaustive list of unacceptable adaptations that will compromise the fidelity of an evidence-based practice (O’Connor, Small, & Cooney, 2007):

- Reducing the number, length, or duration of group sessions;
- Decreasing the level of participation engagement;
- Eliminating key concepts or skills learned;
- Removing topics;
- Changing the theoretical approach;
- Using staff who are not adequately trained or qualified; and
- Using fewer staff members than recommended.

12. Identify the process to obtain feedback from youth served. An important aspect of providing evidence-based services is how the youth participating in those services are reacting to the practice. The program/facility should design a process to obtain feedback from the youth participating in the practice to gather information related to youth buy-in, staff competence, and any cultural change that may be occurring as a result of the implementation of the evidence-based practice. Feedback from youth served will help the program/facility examine the qualitative impact the evidence-based practice is having on the youth participating in that practice.

13. Plan for sustainability. There are two types of trainers for most evidence-based practices recognized by the Department. Staff that attend initial training on an evidence-based practice become a Facilitator Trainer. This means those staff are then capable of delivering the specific curriculum for which they were trained to youth. Most evidence-based practices allow experienced Facilitator Trainers to become Master Trainers. For most evidence-based practices this “experience” means that the Facilitator Trainer has delivered at minimum two full cycles of the curriculum in which they have been trained to youth. Completing a full cycle is defined as delivering each lesson of the curriculum in its entirety, and in its prescribed order, to youth. Upon completion of the two-cycle requirement, Facilitator Trainers become eligible to be “master trained” in the curriculum for which they were facilitator trained. To receive master training a Facilitator Trainer who has delivered two cycles of the curriculum must attend a master training that is a progressively more advanced than facilitator training. Master training certifies a Facilitator Trainer to train staff to facilitate the specific evidence-based practice. In the interest of cost savings and ensuring continuation of services, having a master trainer on-site is suggested. Due to staff turnover some Facilitator Trainers may need to be replaced. Having a master trainer on-site allows the program to train new staff internally to facilitate the evidence-based practice without incurring additional costs. Ideally, Master Trainers would be individuals with the highest degree of requisite skills and programmatic knowledge, who have the greatest likelihood of remaining at the program and/or with the provider agency/state.

Determination of Evidence-Based Practices
Several government agencies, research organizations, and other associations have developed rating criteria for programs. These criteria are used to rate programs along a continuum based upon how rigorously a program or practice has been evaluated. Programs and practices that are based on theory and have been experimentally tested using random assignment and reported in peer reviewed journals are viewed as most rigorous. Additional criteria include replication in various settings and implementation with the highest degree of fidelity (Metz, Espiritu, & Moore, 2007). Searching well-established evidence-based registries can facilitate the determination of whether a particular practice is evidence-based.
Agencies that have developed evidence-based rating criteria include the U.S. Department of Education, Office of Juvenile Justice Delinquency Prevention (OJJDP), Substance Abuse and Mental Health Services Administration (SAMHSA), Child Trends, Harvard Family Research Project, Promising Practices Network, Helping America’s Youth, National Clearinghouse on EBP in Child Welfare, and American Public Human Services Administration (Metz, et al., 2007). Other registries include Blueprints for Violence Prevention, Promising Practices Network, and National Registry of Evidence-Based Programs and Practices. The most rigorously evaluated programs and practices are commonly labeled:
- Model programs or practices;
- Demonstrated effective programs or practices; and
- Exemplary programs or practices.

Programs and practices that meet less rigorous criteria are termed:
- Emerging programs or practices;
- Promising programs or practices; and
- Theory-based programs or practices.

Evaluation studies should be examined for practices not listed on evidence-based registries to seek out empirical evidence of effectiveness. Research states, “at a minimum, you should review any evaluation studies that have been conducted by the program developer and external evaluators…Ideally, these evaluations use an experimental or quasi-experimental design” (Small, et al., 2007:5). Preferably, the results of these studies will have been published in peer-reviewed scientific journals.

The Florida Department of Juvenile Justice is in the process of compiling an evolving list of Department-approved evidence-based and promising practices in delinquency treatment. The Evidence-Based Steering Committee seeks to establish a Program Review Committee, consisting primarily of researchers and treatment professionals, to review program models for demonstrated positive effects on risk to re-offend and criminogenic needs. The Program Review Committee will assess evaluation studies to examine the adequacy of sample sizes, research assumptions, and methodology submitted in support of the program’s claim as evidence-based.

Those programs for which the research is deemed adequate will be compiled into an Evidence-Based Sourcebook. The Sourcebook will include information such as:
- Practice Name;
- Practice Developer;
- Target Population;
- Criminogenic Need/Risk Factors Addressed;
- Number of Sessions/Program Duration;
- Setting (i.e., community-based, residential);
- Program Area (i.e., Prevention, Probation, Detention, Residential);
- Facilitator and Master Trainer qualifications and training requirements;
- Cost Information; and
- Contact Information.

Costs of Evidence-Based Practices
There are various costs associated with the implementation of evidence-based practices. Potential costs include:
- Initial facilitator training of staff;
- Costs as a result of time in training (i.e., travel expenses, staff to cover shifts);
- Facility space;
- Transportation;
- Cost of facilitator guide, youth handbooks (recurring), materials/office supplies (recurring);
- Certificates for participants;
Subsequent facilitator training due to turnover of trained staff; 
Master training of Facilitator Trainers; and
Fidelity Monitoring and verification of facilitator competence.

Efforts to develop a shared training schedule and lists of certified facilitators and master trainers might result in reduced training costs and maximization of training slots.

**Recommendations**
Recent research on the implementation of evidence-based practices includes the following recommendations (Fagan, 2007):

1. Continued evaluation of practices utilizing the most rigorous standards, such as random assignment and quasi-experimental matched comparison groups.
2. Prioritize the implementation of evidence-based practices over non-evaluated practices.
3. Hold programs (provider and state-run) accountable to high standards of fidelity monitoring.

**Conclusions**
The purpose of this white paper is to disseminate information regarding the objectives of the Evidence-based Steering Committee and the implementation of evidence-based practices. The Florida Department of Juvenile Justice has developed, with guidance from national experts, a comprehensive definition of evidence-based practices. This paper serves to inform relevant stakeholders throughout the state and the continuum of services of the move by the Department toward expanding evidence-based practices, as well as the preferred method for that expansion. The definition provided should serve as a guideline for the Department’s standard of empirical research documenting positive results necessary for a practice to be considered evidence-based. The newly created Evidence-based Steering Committee will serve as both the provider of initial information dissemination, as well as the catalyst for ensuring programs and facilities have the necessary support and guidance as the Department transitions to practices proven to reduce recidivism throughout the state. The role of the Steering Committee, in conjunction with the formal evidence-based practices definition and the steps to implement those practices, will assist the continuum of services in adherence to the Department’s goals of increasing public safety by reducing juvenile crime through effective treatment services.
References


