Appendix 7.
Evidence-based programs (Best Practices) Information

A Weed and Seed site is expected to be a model or prototype for a community in how to reclaim high risk/crime neighborhood using new and existing resources to develop effective interventions. The success of a Weed and Seed site is largely dependent upon the quality of the specific crime control (weed) programs and prevention, intervention and treatment (seed) programs implemented within the site. For this reason, the Community Capacity Development Office encourages Weed and Seed applicants to strongly consider implementing evidence-based best practice crime control and prevention, intervention and treatment programs whenever possible.

Evidence-based programs are programs that have been shown to be effective by scientifically rigorous evaluations. Evidence-based best practice programs should not be confused with programs that simply purport to represent best practice though lack the independent evaluations that validate their assessment of effectiveness. The vast majority of prevention, intervention and treatment as well as supervisory programs related to drug abuse, juvenile delinquency and adult crime have not been rigorously evaluated. This is true for most programs regarded as “best practices”, however, there are a considerable number of programs that exemplify evidence-based best practice some of which are noted in this appendix. Evidence-based best practice programs are not only effective in the services they provide, but, also, represent a very good investment which they can demonstrate. As a result, public and private funding agencies are usually more inclined to fund evidence-based programs given the programs immediate return in effective service and as a model for future quality program development.

This appendix explains how to determine if a program has scientifically strong evidence of effectiveness. The section also explains how to determine if a program is ready to be successfully replicated since whether a program is prepared to support replications is just as important as if the program has strong evidence of effectiveness. Listed at the end of this appendix are a selection of Web sites that identify specific evidence-based programs relevant to Weed and Seed programming.

Evidence of Effectiveness and Readiness for Dissemination Classification System

In 2004, the Office of Justice Programs/USDOJ convened a working group of top officials from the Office of Justice Programs, the Departments of Education and the Department of Health and Human Services in order to develop comprehensive criteria for determining the strength of a program’s evidence and readiness for large scale replication (dissemination). The classification system can be used by Weed and Seed sites to assess the evidence supporting programs the site is considering implementing.

The classification system includes five levels of evidence of effectiveness: 1) Effective; 2) Effective with Reservation; 3) Promising; 4) Insufficient Evidence; and 5) Ineffective.

Criteria for the Effective Classification

- A Randomized Controlled Study. Well-designed and implemented randomized controlled studies offer the most scientifically rigorous evidence (Shadish, Cook and Campbell. 2002). Randomized controlled studies randomly assign participants to an experimental group and a control group that does not participate in the program. Random assignment increases the chances that differences between the outcomes of the experimental and control groups are due to the intervention rather than to preexisting differences between the groups.

- Statistically significant behavior effects. The programs must positively change behavior not attitudes)

- At least one external replication (a second randomized controlled study implemented at a different site by a different implementation team).

- Sustained effects for at least one year

- Large sample size, adequate outcome measurement, controls for attrition, intent to treat-analysis and other criteria regarding study design and implementation. For definitions of these terms, see the glossary near the end of the section.

Effective with Reservation Criteria

Programs in the effective with reservation classification must meet the same criteria as above except they have internal instead of external replications. Internal replications involve the same implementation team (program staff) as the original implementation site. External replications are preferred over internal replications because they provide stronger evidence that the program will work in different settings.

Promising

- One strong randomized controlled or quasi-experimental study. (Quasi-experimental studies which do not randomly assign subjects but instead closely match experimental and control groups to eliminate differences provide meaningful results but are less reliable than randomized controlled studies)
- Statistically significant behavior outcome(s)
- Sustained effects lasting one year
- Other criteria regarding evaluation design and implementation

Insufficient Evidence

Programs with no evidence greater than unmatched controlled studies, uncontrolled studies such as pre-post tests, or randomized controlled studies and matched comparison studies with serious methodological problems such as small sample size, poor statistical methodology, or insufficient research designs.

Ineffective

- A randomized controlled study or a quasi-experimental study showing no statistically significant outcomes
- At least one replication with a randomized controlled or quasi-experimental design showing no significant outcomes.

Readiness for Dissemination

Before committing to replicating an existing program, Weed and Seed sites should determine whether the program is ready to be successfully replicated. Whether a program can be implemented as designed increases the chances that a replication of the program will have the same results as the original program. The classification system developed by the multi-agency working group consists of three dissemination readiness classifications: 1) Fully Prepared for Widespread Dissemination; 2) Fully Prepared for Limited Dissemination; and 3)Not Prepared for Widespread Dissemination.

Criteria for Fully Prepared for Widespread Dissemination Classification

- Training and related support materials (i.e., a detailed curriculum; prepared trainers and technical experts; supportive informational materials; operations manuals; implementation guides; case studies; evidence of change in risk/protective factors; cost information and cost-benefit estimates; and effectiveness indicators and/or other support materials employing a variety of educational mediums, such as videotapes, audiotapes, or interactive Web-based programs, all of which have been developed and tested in field settings for feasibility).

- Technical assistance support (i.e., following the provision of training experts are available on-site or online to provide specific guidance related to the implementation of the intervention techniques, problem solving, and modifications as necessary and appropriate).

- Informational materials (i.e., supplemental guidance provided over time through newsletters, Web sites, and other mediums to inform regarding innovations made in other sites, methods to enhance implementation, operations management and assessment procedures and practices).

- Quality Controls To Ensure Implementation Fidelity (i.e., procedures for ensuring that the intervention is implemented with fidelity to the original design. These may include clinical supervision, review of tape recordings of intervention sessions, or other methods).

A program that meets the criteria above though is restricted in its dissemination because of the program's unique design, or demographic or geographic focusqualifies for the **Prepared for Limited Dissemination classification**. Programs that do not adequately meet the criteria for readiness for dissemination delineated above fall into the **Not Ready for Widespread Dissemination** classification.

The classification system developed by the Office of Justice Programs/USDOJ working group gives cumulative ratings according to a program's evidence of effectiveness and

readiness for dissemination. For example, programs given top evidence of effectiveness and readiness for dissemination ratings receive a cumulative rating of 1A. Those programs classified lower than "Promising" do not receive a dissemination rating or cumulative rating. The following chart shows the cumulative ratings.

Levels of Effectiveness	Fully Prepared for Widespread Dissemination	Fully Prepared for Limited Dissemination	Not Ready for Dissemination
Effective	1A	1B	1C
Effective with Reservation	2A	2B	2C
Promising	3A	3B	3C
Inconclusive Evidence	N/A	N/A	N/A
Insufficient Evidence	N/A	N/A	N/A
Ineffective	N/A	N/A	N/A

Evidence-Based Programs Websites

Several online reviews identify evidence-based programs relevant to Weed and Seed sites. Each review uses different criteria to determine which programs have evidence of effectiveness. Weed and Seed sites should study the selection criteria for each review so as to be aware of what level of evidence a program needs to be ranked a certain way be a review.

Blueprints for Violence Prevention
http://www.colorado.edu/cspv/blueprints/

Blueprints for Violence Prevention uses a more demanding criteria to identify evidence-backed programs than the other review systems listed here. The criteria used by Blueprints is very similar to the evidence of effectiveness classification of the system developed by the multi-agency working group convened by OJP/USDOJ.

Child Trends What Works
http://www.childtrends.org/

The youth advocacy organization Child Trends has reviewed research on a wide range of youth development and prevention programs and practices. The Child Trends reviews discuss the evidence supporting programs (i.e. Big Brother/ Big Sisters) and specific practices (i.e. promoting self-esteem, involving parents, etc).

National Registry of Evidence-Based Programs and Practices
http://modelprograms.samhsa.gov/

The Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (NREPP) classifies substance abuse prevention and treatment programs into three categories: model, effective and

promising. NREPP Model NREPP programs for the most part have been found effective by strong randomized controlled studies, though they do not necessarily have replications or sustained effects and therefore do not have the same level of evidence as top Blueprints programs.

In the fall of 2006, SAMHSA plans to implement a revised National Registry of Evidence-Based Programs and Practices. The new NREPP system will not assign programs final ratings such as "model" or "effective". Instead, NREPP will assign programs strength of evidence and dissemination readiness scores based on criteria similar to the criteria used to determine the current NREPP ratings. SAMHSA decided to forgo final ratings or labels in order to enable communities to make final decisions about what programs are best for them. The new NREPP Web site will be located at www.nationalregistry.samhsa.gov.

OJJDP Model Programs Guide
http://www.dsgonline.com/mpg2.5/mpg_index.htm

The Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Model Programs Guide reviews evaluations of delinquency and substance abuse prevention programs as well as correctional and reentry programs for juvenile offenders. The guide classifies programs into three categories according to the strength of their evidence: Exemplary, Effective, and Promising. In general, Exemplary programs in the guide must have well-conducted randomized controlled studies, however, they do not need to have sustained effects or replications.

Helping America's Youth Program Tool
http://www.helpingamericasyouth.gov/programtool.cfm

Helping America's Youth is an initiative of the office of the First Lady's Office. The Helping America's Youth Program Tool uses the same criteria as the OJJDP Model Programs Guide and ranks many of the same programs.

Guide to Community Preventive Services
http://www.thecommunityguide.org/

The Centers for Disease Control and Prevention supports the Guide to Community Preventive Services. The guide assesses the effectiveness of a wide range of prevention programs, including violence and alcohol abuse programs. In contrast to Blueprints and the other reviews, the guide focuses on whether types of programs (i.e. school-based drug abuse programs) are effective instead of whether individual programs (Big Brothers Big Sisters) are effective.

Promising Practices Network
http://www.promisingpractices.net/

The Rand Corporation's Promising Practices Network identifies evidenced-based programs that prevent at-risk behavior and delinquency. Programs are placed into two classifications: Proven or Promising. Proven programs must have either a randomized controlled research design or a strong matched comparison design (quasi-experimental).

Social Programs that Work
http://www.evidencebasedprograms.org/

The Coalition for Evidence-Based Policy has compiled a short list of social programs supported by very strong evidence. The criteria used by the review are similar to the criteria for the Effective with Reservation classification of OJP/USDOJ Working Group classification system. The following chart compares the criteria for the top classification in the multi-agency working group classification system and in each of the reviews listed above. An "X" indicates that top programs must meet the criteria listed above the columns. A question mark indicates that a review may require the criteria atop the column but that the review does not clearly state that this is the case.

Review Name	Randomized Controlled Design	Sustained Effects	Replications	Large sample size, adequate measurement, controls for attrition, other criteria
Working Group Classification System	X	X	X	X
Blueprint (Model Programs)	X	X	X	X
NREPP Exemplary	X			X
OJJDP Model Programs Guide	X			?
HAY Program Tool	X			?
Promising Practices Network				?
Social Programs That Work	X		X	X

The following chart shows programs that attained a rating of "promising" or higher according to the multi-agency working group classification system. The chart also shows how Blueprints for Violence Prevention, the National Registry of Evidence-Based Programs and Practices, the OJJDP Model Programs Guide and the Hay Program Tool ranked the same programs.

Name of Program	WWR Rating	HAY, NREPP and Blueprints Ratings	Comments and contact information
Big Brothers Big Sisters	2	HAY – 1	External replication yielded no

http://www.bbbsa.org/		OJJDP Guide - 1 BP – 1	significant effects and involved a small sample
Bullying Prevention www.clemson.edu/olweus	3	BP – 1, SAMHSA – 1 HAY – 2,OJJDP -1	No random assignment studies.
Functional Family Therapy www.fftinc.com	1	BP – 1 HAY-1 OJJDP -1	Meets all criteria.
Life Skills Training www.lifeskillstraining.com	1	BP – 1, SAMHSA - 1 OJJDP -1, HAY -1	Meets all criteria.
Midwestern Prevention Project Information from: karenber@usc.edu	2	BP – 1 SAMHSA - 2 HAY – 2 OJJDP -2	This program does not have an external replication.
Multidimensional Treatment Foster Care www.oslc.org	2	BP – 1, SAMHSA - 3 HAY -1, OJJDP -1	This program does not have an external replication.
Multisystemic Therapy www.mstinstitute.org	1	BP – 1, HAY -1 SAMHSA - 1	Meets all criteria.
Nurse-Family Partnership www.nursefamilypartnership.org	2	BP – 1 SAMHSA - 1 HAY – 1, OJJDP -1	This program does not have an external replication.
Project Towards No Drug Abuse (Project TND) http://tnd.usc.edu/	2	HAY -1 SAMHSA - 1 BP -1	This program does not have an external replication.
Athletes Training and Learning to Avoid Steroids www.atlasprogram.com	2	SAMHSA – 1 HAY -1	This program does not have an external replication.
Brief Strategic Family Therapy www.cfs.med.miami.edu/Docs/ClinicalApproach.htm	2	HAY – 2 SAMHSA - 1 BP - 2	This program does not have an external replication.
CASASTART www.casacolumbia.org	3	BP - 2 HAY -2 SAMHSA-1	This program does not have any replication study.
Cognitive Behavioral Therapy for Child Sexual Abuse www.hope4families.com	2	SAMHSA – 1 HAY – 3	Internal replications, weak evidence of sustained effects 2 years post intervention, positive outcomes across 3 random trials.
Community Trials Intervention to Reduce High-Risk Drinking www.PREV.org	3	HAY – 2 SAMHSA -1	Promising because no replication studies

Project Northland www.epi.umn.edu/projectnorthlad	3	HAY = 1 SAMHSA - 1 BP – 2	No replication study.
Strengthening Families Program (10-14) www.extension.iastate.edu/sfp/	3	HAY - 1 BP – 2	Needs replication – trying to get article on replication w/African Americans.

Programs with Strong Evidence:

The following programs are examples of programs with strong evidence and readiness for dissemination:

Nurse-Family Partnership

The Nurse-Family Partnership program provides nurse home visits to low-income, pregnant women, most of whom are (unmarried, teenagers, and without previous children. The nurses visit the women approximately once per month during their pregnancy and the first two years of their children's lives. The nurses teach positive health related behaviors, competent care of children, and maternal personal development (family planning, educational achievement, and participation in workforce (From Social Programs That Work).

Evidence: Three randomized controlled trials of the program show a major impact on life outcomes of the mothers and their children.

Costs: The program's cost is approximately $9,140 per woman over the three years of visits (in 2002 dollars).

Contact Information:

Nurse-Family Partnership National Office
1900 Grant Street, Suite 400
Denver, CO 80203-4307
Toll-Free: (866) 864-5226
Phone: (303) 327-4240
Fax: (303) 327-4260
Email: info@nursefamilypartnership.org
Website: www.nursefamilypartnership.org

References:

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Olds, David L., JoAnn Robinson, Ruth O'brien, Dennis W. Luckey, Lisa M. Pettitt, Charles R. Henderson Jr, Rossanna K Ng, Karen L Sheff, Jon Korfmacher, Susan Hiatt, and Ayelet Talmi. "Home Visiting By Paraprofessionals and By Nurses: A Randomized, Controlled Trial." *Pediatrics*, vol. 110, no. 3, September 2002, pp. 486-496. Click here for a link to this study.

Olds, David L., JoAnn Robinson, Lisa Pettitt, Dennis W. Luckey, John Holmberg, Rossanna K. Ng, Kathy Isacks, Karen Sheff and Charles R. Henderson Jr. "Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-Up Results of a Randomized Trial." *Pediatrics,* vol. 114, no. 6, December 2004, pp 1560-1568.

Multisystemic Therapy (MST)

Multi-systemic Therapy (MST) is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multi-systemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. MST targets chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of-home placement, and the offenders' families.

MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which youth are embedded. MST strives to promote behavior change in the youth's natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate change.

The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior (From Blueprints for Violence Prevention).

Evidence: Evaluations of MST have found;

- reductions of 25-70% in long-term rates of re-arrest.
- reductions of 47-64% in out-of-home placements,
- extensive improvements in family functioning, and
- decreased mental health problems for serious juvenile offenders.

Costs: Multi-systemic Therapy estimates the cost per family served at $6,000 to $8,500 depending on local salaries for MST and associated administrative staff. The minimum size of a team is two therapists, maximum of four. Each therapist can serve up to 15 families per year. Larger programs enjoy some economy of scale that reduces the per-family cost.

Contact information:

Marshall E. Swenson, MSW, MBA
Manager of Program Development, MST Services
710 J. Dodds Blvd.
Mt. Pleasant, SC 29464
Email: marshall.swenson@mstservices.com
Phone: 843.856-8226
http://www.mstservices.com/

References:

Borduin C.M. & Henggeler S.W. (1990). Multisystemic approach to the treatment of serious delinquent behavior. In R.J. McMahon & R. DeV. Peters (Eds.), *Behavior disorders of adolescence*. New York: Plenum Press.

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Family Functional Therapy

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth aged 11-18 who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. FFT requires as few as 8-12 hours of direct service time for commonly referred youth and their families, and generally no more than 26 hours of direct service time for the most severe problem situations. The therapy can be administered by a wide range of interventionists, including para-professionals under supervision, trained probation officers, mental health technicians, degreed mental health professionals. Each FFT site consists of 3-8 therapists. Most FFT therapists are master's level mental health professionals, but the criteria for hire can vary from site to site. Each therapist handles a caseload of at least 5 cases at any given time (10-15 hours per week), and up to 12-15 cases at any given time (40 hours/week). (Blueprinits for Violence Prevention and FFT).

Evidence: Randomized and quasi-experimental trials have demonstrated that FFT is cable of effectively treating adolescents with conduct disorder, oppositional defiant disorder, disruptive behavior disorder, alcohol and other drug abuse disorders, and who are delinquent and/or violent (From HAY Program Tool).

FFT effectiveness derives from emphasizing factors which enhance protective factors and reduce risk, including the risk of treatment termination. In order to accomplish these changes in the most effective manner, FFT is a program with steps which build upon each other.

Costs: The program costs $1,350 to $3,750 for an average of 12 home visits per family, over the course of 90 days. Training and technical assistance costs per site are an additional $60,000.

Contact Information:

James F. Alexander
Department of Psychology
380 South 1350 East, #502
University of Utah
Salt Lake City, UT 84112
Phone: (801) 581-6538
Fax: (801) 581-5841
E-mail: jfafft@psych.utah.edu
Web site: http://www.fftinc.com

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Sexton, Thomas L., and James F. Alexander. 2002. *Functional Family Therapy: Principles of Clinical Intervention, Assessment, and Implementation.* Seattle, Wash.: FFT LLC.

Allen County Reentry Court Project

The judge-centered Allen County Indiana ReEntry Court Project is based on the drug court model. The Indiana Parole Commission has given authority to the reentry court judge to supervise released adult offenders. Offenders are granted early release (averaging 90 days early) in exchange for participating in the Reentry Court. A transition team, composed of treatment providers, corrections staff, law enforcement, employment trainers, and family counselors, is assigned to the offender to help develop, monitor, and enforce the reentry plan that is implemented on the offender’s release from the institution. The reentry plan is based on assessments (i.e., risk, educational, vocational, mental health, and substance abuse) and is developed with input from the offender and his or her support system. The offender’s reentry into the community is guided by this plan. Many offenders have been connected with a network of mentors who help guide their transition back to the community.

When the reentry plan is completed and the offender has been released from commitment, he or she appears before the reentry court judge for formalization or ordering (depending on the offender) of the reentry plan, the support system, and the government agencies representing the community. Typically, an offender will be required

to remain drug free, make restitution to his victim and reparation to the community, participate in programs that began in commitment (work, education, emotions management, parenting classes, etc.), refrain from committing crime, and comply with any other terms and conditions of the reentry plan. The offender is also required to appear before the reentry court judge on a regular basis to determine if the plan remains appropriate and effective and if the offender is in compliance.

Evidence: An evaluation of a two-year pilot project from 2001 to 2003 compared the outcomes of participants in the Reentry Court with five comparison groups: 1) community transition with parole; 2) community transition with probation; 3) offenders who refused to participate who went under supervision upon completion of their sentence; 4) offenders ineligible to participate placed under supervision; and 5) offenders ineligible to participate not placed under supervision

The evaluation found that Reentry Court Program participants had significantly lower recidivism rates than all the comparison groups except for the group in community transition with probation. The arrest rate for reentry court participants during the two years was 24%. The arrest rate for the comparison group in community transition with parole was 38%. The rate for the comparison group under supervision and the group under no supervision was 36% and 46% respectively. The community transition with probation comparison group had a re-arrest rate of 29%, which was not significantly different than the reentry group rate.

Costs: Services and supervision for the 209 released offenders in the pilot project cost $635,000 per year, $3,038 per person. The evaluation of the pilot project estimated that the Reentry Court resulted in an annual savings of $1,952,907 in corrections and victims of crime costs.

Contact Information:

Stan Pflueger
Director, Allen County Reentry
Allen County Community Corrections
260-449-4578

References:

Lombard D.N, C. Krouse, K. Krouse, S Pfluger, and Sheila Hudson (2004). Allen County Reentry Study 2 Year Pilot Study. Center for Applied Behavioral Studies. http://www.allencountycorrections.com/2YRReport.pdf

Law Enforcement Weeding Strategies

Directed Patrols

Description (from Sherman et al. 1998): Police directed focus on the times and places with the highest risks of serious crime. The hypothesis behind the strategy is that the more patrol presence is concentrated at the "hot spots" and "hot times" of criminal activity, the less crime there will be in those places and times. The epidemiological underpinning for this claim is National Institute of Justice funded research showing that

the risk of crime is extremely localized, even within high crime neighborhoods (Pierce, Spaar and Briggs, 1988; Sherman, Gartin and Buerger, 1989).

Evidence: All eight known evaluations have found that the approach reduces crime in the targeted location. Two of the evaluations (Sherman and Weisburd 1995 and Koper 1995) used stronger research designs than the other studies. According to Sherman (1997), "Koper's (1995) analysis of the Minneapolis Hot Spots Patrol data found a very strong relationship between the length of each police patrol presence (which averaged 14 minutes) and the amount of time the hot spot was free of crime after the police left the scene. The longer the police stayed before they left, the longer the time until the first crime (or disorderly act) after they left.…The experimental analysis found that there was an average of twice as much patrol presence and up to half as much crime in the extra-patrol hot spots as in the no-extra-patrol group."

References:

Sherman et al. (1998) Preventing Crime: What Works, What Doesn't, What's Promising. National Institute of Justice. http://www.ncjrs.gov/works/

Proactive Arrests of Serious Repeat Offenders

Description: (From Sherman et al.1998)**:** Like directed patrol, proactive (police-initiated) arrests concentrate police resources on a narrow set of high-risk targets. The hypothesis is that a high certainty of arrest for a narrowly defined set of offenses or offenders will accomplish more than low arrest certainty for a broad range of targets. In recent years the theory has been tested with investigations of four primary high risk targets: chronic serious offenders, potential robbery suspects, drug market places and areas, and high-risk places and times for drunk driving. All but the first can be tested by examining the crime rate. The hypothesis about chronic serious offenders is tested by examining the rate at which such offenders are incapacitated by imprisonment from further offending.

Evidence: The evidence on proactively arresting high-risk people comes from two strong controlled evaluations of police units aimed at repeat offenders (Martin and Sherman 1986, Abrahamse et al. 1991). Martin and Sherman evaluated a Washington, D.C. unit that employed pre-arrest investigations, designed to catch offenders in the act of crime to enhance the strength of evidence. Abrahamse et al studied a Phoenix police unit that employed post-arrest investigations, designed to enhance the evidence in the offender's latest case based upon the length and nature of the offender's prior record. Both projects aimed at increasing the incarceration rate of the targeted offenders, and both succeeded in increasing arrests and incarcerations.

Sherman et al. found the evidence that proactive arrests can reduce neighborhood drug traffic to be inconclusive. "The evidence on drug crackdowns shows no consistent reductions in violent crime during or after the crackdown is in effect. The strongest evidence is the randomized experiment in raids of crack houses (Sherman and Rogan, 1995), in which crime on the block dropped sharply after a raid. The rapid decay of the deterrent effect in only seven days, however, greatly reduces the cost-effectiveness of the labor-intensive raid strategy. Only the high yield of guns seized per officer-hour invested (Shaw, 1994) and its possible connection to community gun violence over a longer time period (Sherman, Shaw and Rogan, 1995) showed great cost-effectiveness.

Other drug enforcement strategies in open-air markets have even less encouraging results, with the exception of the Jersey City experiment in which the principal outcome measure was disorder, not violence."

Sherman et al. concluded that: "The evidence on drunk driving, in contrast, is one of the great success stories of world policing. The sheer numbers of consistent results from quasi-experimental evaluations of proactive drunk driving arrest crackdowns suggest a clear cause and effect."

Moral Recognition Therapy

Moral Recognition Therapy (MRT) is a comprehensive program for substance abusing offenders. MRT is an objective, systematic treatment system designed to enhance ego, social, moral, and positive behavioral growth in a progressive, step by step fashion. MRT® has 12 to 16 steps, depending on the treatment population. MRT® attempts to change how drug abusers and alcoholics make decisions and judgments by raising moral reasoning from Kohlberg's perspective. MRT is one of the most widely implemented cognitive behavior program, implemented in 40 states and several countries.

MRT seeks to move clients from hedonistic (pleasure vs. pain) reasoning levels to levels where concern for social rules and others becomes important. Research on MRT has shown that as clients pass steps, moral reasoning increases in adult drug and alcohol offenders and juvenile offenders.

Evidence: Controlled evaluations of MRT indicate that program participants have lower recidivism rates than controls (Hanson, 2000; Little, Robinson, Burnette and Swan, 1999, Miller 1997; Godwin, Stone, and Hambrock, 1995; MacKenzie, Brame, Waggoner, and Robinson, 1995).

Contact:

Correctional Counseling, Inc.
3155 Hickory Hill Rd
Suite 104
Memphis , TN 38115
Phone Number: (901) 360-1564
Fax Number: (901) 365-6146

Program Website: www.moral-reconation-therapy.com/

References:

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Miller, M (1997) Evaluation of the life skills program. Division of Correctional Education, Delaware Department of Correction.

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Todd A. Armstrong (2003). Effect of Moral Reconation Therapy on the Recidivism of Youthful Offenders: A Randomized Experiment. Journal: Criminal Justice and Behavior Volume: 30 Issue:6 December 2003. Pages 668 to 687

Research Evaluation Terms

Adequate Measurement: Consistent and systematic measurement of outcomes so that the study accurately records differences between the experimental and control groups

Attrition: Loss of participants that occurs after assignment to experimental and control groups (Shadish, Cook, and Campbell, 2002). Levels of attrition should not be significantly different between the intervention and control groups, since differential attrition can lead to inaccurate estimates of the intervention's effect.

Effect Size: The size of the effect of an intervention compared to no treatment or a standard treatment. An effect size greater than .20 is generally considered indicative of a small effect (Cohen, 1988). An effect greater than .50 is generally considered a medium effect, while an effect greater than .80 is widely recognized as a large effect (ibid.).

Randomized Controlled Studies/ Experimental Studies: A study that compares the outcomes of randomly assigned experimental and a control groups. Randomized controlled studies are the preferred means of scientifically assessing the effectiveness of community-based interventions (Shadish, Cook, Campbell, 2002).

Intention-to-treat analysis: An analysis of the outcomes of all subjects who were assigned to the experimental and control groups, including those who were assigned to the experimental group but did not actually participate (Shadish, Cook and Campbell, 2002).

Meta-Analysis: A statistical method that combines the results of several studies to produce estimates of the effectiveness of a general type of treatment or intervention (Surgeons General's Report, 2001). Meta-analysis is most often used to determine the effectiveness of a general type of program (mentoring, prison vocational programs, etc). Meta-analysis can be used to produce estimates of the effectiveness of specific

programs though few specific programs have been evaluated enough times to allow for a meta-analysis of multiple studies. A major concern with all types of meta-analysis is whether the studies incorporated in the analysis vary in quality. If studies in the meta-analysis have weak research designs, small sample sizes, or other problems, the results of the synthesis may not be valid.

Pre-Post Studies: Studies that do not have control groups but analyze test scores or other measures before and after the program starts. Pre-post test research designs do not have a control group and as a result cannot demonstrate whether a participant's success or failure is due to the intervention or other factors. Consequently, pre-post tests often result in erroneous conclusions regarding the effectiveness of the intervention (Institute of Education Sciences, 2003).

Quasi-experimental Research Designs: A controlled study where the experimental and control groups are not randomly assigned but matched to have similar characteristics.
Compared to randomized controlled trials, quasi-experimental studies have a greater chance of producing erroneous conclusions.

Replication: Repeating an intervention or prevention program at multiple sites to determine if the results will be the same (Surgeons General's Report, 2001). Successful replication confirms a program's effectiveness.

Sample Size: The total number of participants in the experimental and control groups. The larger the sample size, the greater the statistical power and confidence that differences between the intervention and control groups are due to the intervention rather than to chance.

Statistical Significance: The level of confidence with which one can conclude that a difference between two or more groups (generally a treatment and control group) is the result of the treatment delivered rather than the selection process or chance.

Sustained Effects: Sustained effects are positive outcomes that last after subjects stop participating in a specific program.

More Information on Evidence-Based Programs:

Coalition for Evidenced-Based Policy and the Institute of Education Sciences. (December 2003). Identifying and Implementing Educational Practices Supported by Rigorous Evidence: A User Friendly Guide
http://coexgov.securesites.net/admin/FormManager/filesuploading/User-Friendly_Guide_12.2.03.pdf

Coalition for Evidenced-Based Policy. (December 2003). Bringing Evidence-Driven Progress to Crime and Substance Abuse Policy: A Recommended Federal Strategy
http://coexgov.securesites.net/admin/FormManager/filesuploading/Final_report_-_Evidence-based_crime_subs_abuse_policy2.pdf

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Society for Prevention Research. (April 2004). Standards of Evidence for Efficacy, Effectiveness and Dissemination Trials.
http://www.preventionresearch.org/StandardsofEvidencebook.pdf