



# Achieving successful evidence-based practice implementation in juvenile justice: The importance of diagnostic and evaluative capacity



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## ABSTRACT

Evidence-based programs (EBPs) are an increasingly visible aspect of the treatment landscape in juvenile justice. Research demonstrates that such programs yield positive returns on investment and are replacing more expensive, less effective options. However, programs are unlikely to produce expected benefits when they are not well-matched to community needs, not sustained and do not reach sufficient reach and scale. We argue that achieving these benchmarks for successful implementation will require states and county governments to invest in data-driven decision infrastructure in order to respond in a rigorous and flexible way to shifting political and funding climates. We conceptualize this infrastructure as diagnostic capacity and evaluative capacity: Diagnostic capacity is defined as the process of selecting appropriate programing and evaluative capacity is defined as the ability to monitor and evaluate progress. Policy analyses of Washington State, Pennsylvania and Louisiana's program implementation successes are used to illustrate the benefits of diagnostic and evaluate capacity as a critical element of EBP implementation.

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## 1. Introduction

The focus on evidence-based programing within juvenile treatment and corrections is growing (Greenwood & Welsh, 2012). Supported by foundation funding, federal policy and state mandates (Chambers, 2005), specific manualized interventions with demonstrated evidence of effectiveness are becoming a more visible element of the services landscape. These evidence-based programs are supported and promoted because they are good investments, yielding significant cost-benefit to taxpayers (Barnoski, 2004). Further, the most well studied and disseminated programs are supported by quality assurance mechanisms that encourage standardization of practice (Chamberlain et al., 2012; Schoenwald, Henggeler, Brondino, & Rowland, 2000). Despite some gains in implementation, however, the overall penetration of evidence-based services within juvenile justice programing remains quite low (Lipsey, Wilson, & Cothorn, 2000). This is a

research-to-practice failure mirrored by similar challenges across other child-serving systems (e.g., prevention, mental health and child welfare; Landsverk, Garland, Rolls Reutz, & Davis, 2011; Weisz et al., 2012). Increasingly, the research and policy literature indicates that an emphasis on evidence-based practice dissemination alone is unlikely to lead to successful implementation or outcomes when programs are not well matched to community needs, not sustained, or do not extend sufficient reach and scale (Backer, Liberman, & Kuehnel, 1986; Emshoff, 2008; Hoagwood, Atkins, & Ialongo, 2013; Rhoades, Bumbarger, & Moore, 2012; Wandersman et al., 2008).

The justice system is particularly vulnerable to funding instability due to high profile cases (e.g., egregious juvenile crimes) which impact whether funds are allocated to long-term corrections or community services. While the number of youth in juvenile corrections nationally has dropped 58% in the last decade (Sickmund, Sladky, Kang, & Puzanchara, 2013), this trend is not observed across all states (<http://www.pewtrusts.org>) and may increase if jurisdictions are not concurrently investing in effective community-based alternatives (Grisso, 2007). As noted above, this will require more than identifying which programs work; state and local governments must invest in increasing their capacity to support dissemination and implementation efforts. In this paper,

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we argue that effective programing will require improved diagnostic and evaluative capacity to respond dynamically to shifts in client needs, local conditions and innovations in treatment development. This will involve supporting data systems and analytic strategies for program selection and continuous quality improvement. We present a policy analysis of three different states, Washington, Louisiana and Pennsylvania, to illustrate the application of such diagnostic and evaluative capacity and its subsequent impact on improving outcomes in juvenile recidivism and delinquency prevention.

### 1.1. Implementation capacity

The difficulty of implementing new programs in human service environments is well-documented (Glisson & Schoenwald, 2005; Michie, Fixsen, Grimshaw, & Eccles, 2009; Schoenwald & Hoagwood, 2001) and has resulted in a number of different frameworks designed to capture the essential elements that play a role in successful implementation (Elliot & Mihalic, 2004; Tabak, Khoong, Brownson, & Chambers, 2012). Taken together, these elements describe an agency's (or system's) overall capacity. Capacity describes a broad range of characteristics related to organizational structure and leadership, staff competencies and community collaborations that affect the agency's likelihood of adopting and sustaining new practices (Damschroder et al., 2009; Durlak & DuPre, 2008; Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008; Greenhalgh, Robert, Bate, Macfarlane, & Kyriakidou, 2004).

Evaluation capacity is one such element that is only occasionally included in implementation frameworks. Given the potential benefits of evaluation capacity, this area is arguably underrepresented in the general implementation literature. In a systematic review of experimental studies that tested the effectiveness of program implementation strategies, only four of the eleven studies reviewed examined evaluation activities as an integral strategy (Powell, Proctor, & Glass, 2014). Similarly, only four of the studies in this review used client data to inform the selection of the target program. This is in contrast to a quickly growing call to action from the evaluation field to develop evaluation capacity-building (ECB) models and tools to promote research-integrated practice (Clinton, 2014; Preskill, 2014). This interest in evaluation capacity building is largely a response to the recognition that the need for evaluation is outpacing the availability of outside research consultants in addition to the demonstrated benefits of internal evaluation capacity for program quality and sustainability (Clinton, 2014).

Evaluation capacity is useful because it can multiply the gains of a specific program or strategy by increasing (1) the ability to take on campaigns to address other areas of concern; (2) objective criteria to prioritize competing initiatives; and (3) a unifying set of priorities to promote coordination and collaboration (Hawe, Noort, King, & Jordens, 1997; Rhew, Brown, Hawkins, & Briney, 2013; Wandersman et al., 2008). Evaluation capacity also allows for agency flexibility as technologies (i.e., programs) become outdated and need to be updated and replaced over time (Sanders & Kirby, 2014).

We are using the term evaluation capacity as the most commonly used term in the literature to describe data-driven processes; however, in the implementation literature, evaluation often connotes an activity occurring only at the end of program implementation (Damschroder & Hagedorn, 2011; Greenhalgh et al., 2004). As we will argue below, the use of data to inform implementation processes is beneficial at every phase of implementation. Consequently, we use the term *Diagnostic and Evaluative Capacity* to describe the integration of data throughout the needs assessment, program selection, and active implementation phases of innovation. Diagnostic and Evaluative capacity reflects the very specific ability to (1) gather and analyze data to more clearly define the problem to be addressed and (2) to provide

ongoing feedback about the quality and impact of interventions. Essentially, *Diagnostic* asks "what should we do?" and *Evaluative* asks "how are we doing?" It describes the ability of a community, agency, or system to assess ongoing client and administrative needs, monitor ongoing progress of programs for clients, providers and community and inform, through data, efforts to adopt and adapt strategies to improve practice. In this paper, we particularly focus on diagnostic and evaluative capacity at a community or agency (organizational) level rather than a clinical level, although both are likely important to support effective practice. Consequently, we focus on tools and strategies state and local agencies can use to support the implementation and monitoring of programs for effectiveness.

### 1.2. Diagnostic capacity

Activities falling within the purview of diagnostic capacity have shown significant promise in assisting program implementation at community and agency levels. Community-level models of decision-making that begin with needs and gaps analyses, such as Communities that Care (Oesterle, Hawkins, Fagan, Abbott, & Catalano, 2014), Partnerships for Success (Julian, 2006), and Getting to Outcomes (Chinman et al., 2008), improve program sustainability (Moore, Bumbarger, & Cooper, 2013) and community health goals (Feinberg, Bontempo, & Greenberg, 2008; Oesterle et al., 2014; Wiseman et al., 2007). These models often involve a trained facilitator who guides the community through a series of data activities to identify the areas of most urgent need and where services gaps exist. The facilitator then presents a number of evidence-based programs to fill this need and the community selects an option from the list, based on considerations of evidence, fit, and feasibility.

At the agency-level, diagnostic planning can occur on a smaller scale with the same set of tools. The National Implementation Research Network (NIRN) suggests using the Hexagon Tool for Assessing Readiness as a strategy for identifying local needs and existing services to guide program implementation (<http://nirn.fgp.unc.edu>). Further, the Availability, Responsiveness and Continuity (ARC) framework, a participatory decision-making model, has demonstrated strong success in improving outcomes when used to implement services (Glisson & Schoenwald, 2005). ARC is based on evidence that organizational and social contexts govern expectations about how things are done and create shared beliefs about the cause, prevention and treatment of mental/behavioral health problems. It is a 10-component program which focuses on relationship and team building, information and data management, conflict resolution and self-regulation (Glisson & Schoenwald, 2005; Glisson, Schoenwald, Hemmelgarn, Green, & Dukes, 2010). Among other activities, an ARC facilitator works with an agency to define sources of data/information to guide decision-making and helps to develop processes that integrate the use of this data for ongoing program improvement. The focus of ARC is on supporting organizational infrastructure (personal as well as technological) that encourages ongoing program implementation and ongoing quality improvement. A two-way randomized trial found that adding ARC to EBP program implementation reduced out of home placement more effectively than implementing EBPs alone (Glisson & Schoenwald, 2005).

### 1.3. Evaluative capacity

In models that integrate data-driven decision-making throughout the implementation process, evaluative activities begin immediately after diagnosing the needs of the community and selecting a program (Wiseman et al., 2007). Sometimes programs struggle with sustaining programs, not because there is a concern

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