

Description of Evidence Based Programming

FUNCTIONAL FAMILY THERAPY

Program Background

Many therapies are named to reflect a theoretical perspective (e.g., behavioral, object relations) or a primary focus (e.g., multiple systems, cognitive). Functional Family Therapy (FFT) is named to reflect a set of core theoretical principles which represents the primary focus (family), and an overriding allegiance to positive outcome in a model that understands both positive and negative behavior as representations of family relational systems (functional). Thus, Functional Family Therapy has adopted an integrative stance that stresses functionality of the family, the therapy, and the clinical model.

The developers and replicators of Functional Family Therapy have recognized that solutions require an integration of high quality science, tested theoretical principles, and extensive clinical experience in pursuit of specific functional goals of:

1. Effectively changing the maladaptive behaviors of youth and families, especially those who at the outset may not be motivated or may not believe they can change;
2. Reducing the personal, societal, and economic devastation that results from the continuation or exacerbation of the various disruptive behavior disorders of youth; and
3. Doing so with less cost, in terms of time and money, than so many of the more expensive (but not necessarily effective) treatments currently available.

Unlike other therapies, FFT was not developed on college students, neurotic individuals, or inpatient adults. Instead, FFT grew out of a need to serve a population of at-risk adolescents and families that were under served, had few resources, were difficult to treat, and were often perceived by helping professions to be treatment resistant. In many cases these families entered the "system" angry, resistant, and unmotivated to change. Essentially the "helping professions" did not know how to treat this population. FFT developed out of the awareness that to be successful in treatment of this population we needed to be culturally competent, and understand why this group was so treatment resistant. Thus, FFT attempted to develop ways to engage these families in order to help them achieve obtainable change and become more adaptable and productive. Over the last 30 years, FFT has learned that it is important to do more than simply stopping bad behaviors. We know that it is important to motivate families to change in a positive way by uncovering and developing the unique strengths of the family in ways that enhance the families' self-respect while providing specific ways to improve.

Since its inception in 1969, FFT has accomplished its primary goals by integrating the most promising theoretical perspectives, the empirical data available, and hours and hours of direct clinical experience with the troubled youth we wanted to help. FFT is designed to increase efficiency, decrease costs, and enhance our ability to provide service to more youth by:

1. Targeting risk and protective factors that we can, in fact, change and then programmatically changing them;
2. Engaging and motivating the families and youth so they participate more in the change process;
3. Entering each session and phase of intervention with a clear plan and by using proven techniques for implementation;
4. Constantly monitoring process and outcome so we don't fool ourselves or make excuses for failure; and
5. Believing in the families we see and then believing in ourselves.

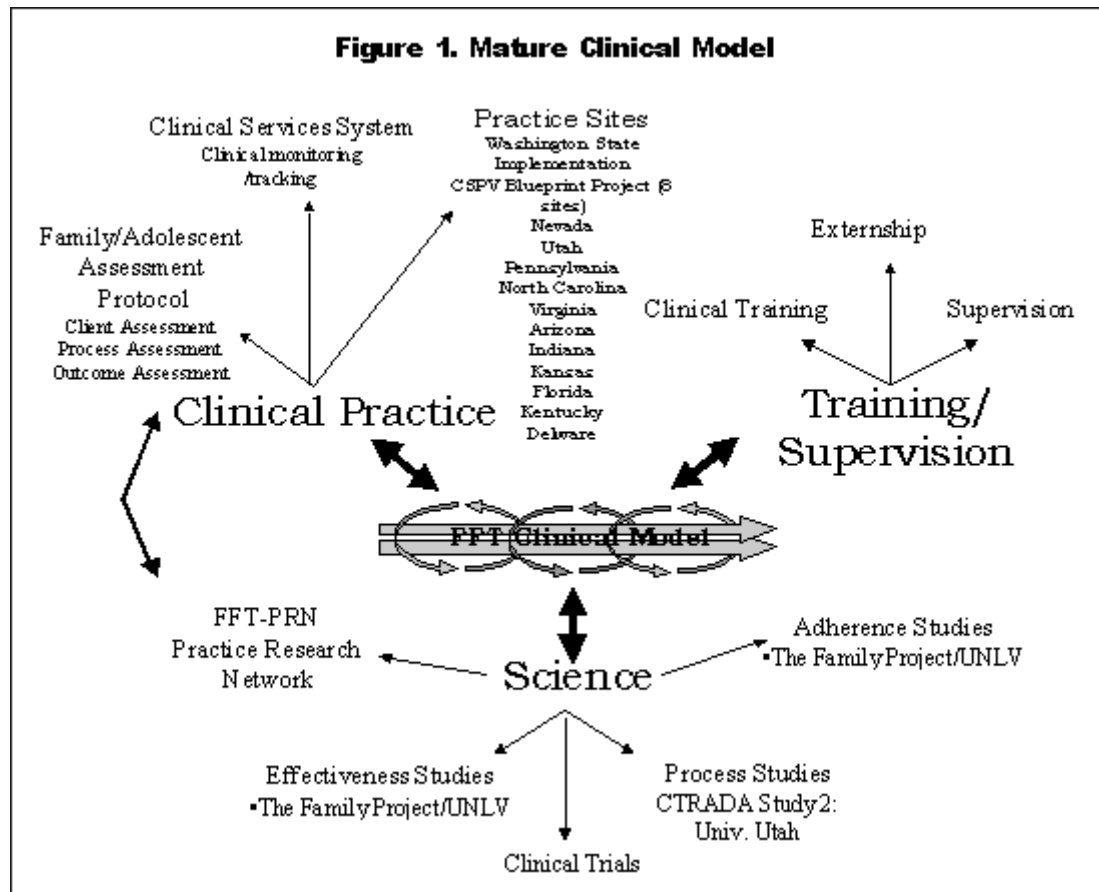
At the time of the inception of Functional Family Therapy, the major theoretical perspectives and services available for treating troubled youth in a family context were rudimentary, though promising. Early on, FFT represented an integration of systems perspectives and behavioral techniques. The systemic background of FFT emphasized dynamic and reciprocal processes which needed to be identified in referred families. This led to early observational research on the interactions of delinquent and nondelinquent families using a systemic framework. The behavioral background of FFT provided not only specific, manualizeable interventions such as contracting, but it also featured an urgent awareness of the need for rigorous treatment development—a scientific imperative to systematically examine the effects of intervention and develop strategies for identifying positive change processes. These origins led to a continuing series of studies involving controlled outcome evaluations and additional replications. During the mid-1970's, FFT also began addressing issues of therapist characteristics and in-session processes from an integrated clinical/research perspective, both reflecting and contributing to the training of therapists for subsequent interventions. In the late 1990's FFT further articulated the clinical change model adding a comprehensive system of client, process, and outcome assessment implemented through a computer-based client tracking and monitoring system (FFT-CSS).

Throughout its development FFT has insisted on step by step descriptions of the clinical change process as well as rigorous evaluation of both the process and outcomes of this work. FFT has also insisted on integrating high quality science (in regard to evaluation and research) with sound clinical judgment and experience and comprehensive theoretical principles. Thus, over the last 30 years FFT has been a dynamic and evolving clinical system that retains its core principles while adding clinical features that further enhance successful outcomes. In its most recent iteration, FFT has developed a functional family assessment system to aid FFT therapists in targeting and implementing therapeutic change goals in a way that leads to accountability through process and outcome evaluation. Thus, FFT has matured into a clinical intervention model with systematic training, supervision, and process and outcome assessment components all directed at enhancing the delivery of FFT in local communities.

Brief Description of Intervention

Functional Family Therapy (FFT) is a well documented family prevention and intervention program which has been applied successfully to a wide range of problem youth and their families in various contexts. While commonly employed as an intervention program, FFT has demonstrated its effectiveness as a method for the prevention of many of the problems of at-risk adolescents and their families. Functional Family Therapy (FFT) is an empirically grounded intervention program that targets youth between the ages of 11 and 18, although younger siblings of referred adolescents

are also treated. FFT is a short-term intervention with, on average, 8 to 12 one-hour sessions for mild cases and up to 26 to 30 hours of direct service for more difficult situations. In most programs sessions are spread over a three-month period of time. Target populations range from at-risk preadolescents to youth with very serious problems such as conduct disorder. The data from numerous outcome studies suggests that when applied as intended, FFT can reduce recidivism between 25% and 60%. Additional studies suggest that FFT is a cost-effective intervention that can, when appropriately implemented, reduce treatment costs well below that of traditional services and other family-based interventions.



As it developed, FFT has been readily adopted in many contexts due to its clear identification of specific phases, each of which includes descriptions of goals, requisite therapist characteristics, and techniques. The phases of intervention, and their component activities, have developed in the context of many clinical hours with many families of various characteristics, coupled with intensive supervision and clinical case discussion. As a result, each phase involves clinically rich and successful interventions that are organized in a coherent manner and allow clinicians to maintain focus in the context of considerable family and individual disruption. The phases consist of:

1. Phase 1: Engagement and Motivation. During these initial phases, FFT applies reattribution (e.g., reframing) and related techniques to impact maladaptive perceptions, beliefs, and emotions. This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reducing the oppressive negativity within family and between family and community, and increasing respect for individual differences and values.

2. Phase 2: Behavior Change. This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.
3. Phase 3: Generalization. In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist.

Each of these phases involves both assessment and intervention components. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multisystemic context in which the family operates. The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior. Intervention is directed at accomplishing the goals of the relevant treatment phase. For example, in the engagement and motivation phase, assessment is focused on determining the degree to which the family or its members are negative and blaming. The corresponding intervention would target the reduction of negativity and blaming. In behavior change, assessment would focus on targeting the skills necessary for more adaptive family functioning. Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns. In generalization, the assessment focuses on the degree to which the family can apply the new behavior in broader contexts. Interventions would focus on helping generalize the family behavior change into such contexts.

As a clinical model, FFT has been conducted in varied clinical settings and as a home-based model. The fidelity of the FFT model is achieved by a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability (FFT-CSS). The FFT Practice Research Network (FFT-PRN) allows clinical sites to participate in the development and dissemination of FFT model information.

Evidence of Program Effectiveness

To date, thirteen studies in referenced journals (plus one in preparation) demonstrate dramatic and significant positive treatment effects, including follow-up periods of up to five years. Rates of offending and foster care or institutional placement have been reduced at least 25 percent and as much as 60 percent in comparison to the randomly assigned or matched alternative treatments, or base rates. One study also demonstrated a positive three year follow-up effect on siblings. Additional formal program reports (e.g., county and federal funded projects) from completed and ongoing replications reflect similar positive outcomes, and five currently funded trials (National Institute of Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, Government of Sweden) promise additional data regarding generalization of effects for FFT across more contexts and populations. Studies have also identified specific FFT based interventions and direct changes in family functioning which relate to the outcome findings.

One major factor in the successful evolution of FFT has been the continuous (29 year) involvement of its progenitors and many of its co-contributors in various university settings. This context has not only maintained a standard of scientific scrutiny, but has also contributed to the conceptual integrity of the major constructs and techniques. The prime example of this impact is the extensive work on reframing in FFT, informed by other well-developed theoretical perspectives such as information

processing theory, social cognition, and the psychology of emotion. Laboratory based research has identified specific components of this critical technique, which in turn has led to applied research on cognitive set and attributional processes in referred adolescent families. Further, investigations have identified in-session therapist characteristics and family interaction processes relevant to the phases of FFT which are predictive of positive change. Most notable process changes appear to be in family communication patterns, and especially negative/blaming communications and "withholding" types of silence. With respect to therapist characteristics, process and outcome data demonstrate that FFT therapists must be first relationally sensitive and focused, then capable of clear structuring and teaching, in order to produce significantly fewer dropouts during treatment and lower recidivism.

More recently, FFT has been widely adopted because it has evolved an increasingly multicultural perspective, and has added effective home-based intervention. In the home-based Clark County, Nevada, Youth and Family Services program, for example, referred adolescents are roughly 30 percent African American, 20 percent Hispanic/Latino (mostly Mexican American), and just under 50 percent European American with a few American Indian and Asian American youth. Preliminary data on the first year of FFT involvement indicate no difference in reoffense rate among the different ethnic/racial groups, supporting the generalizability of FFT effects across cultural/racial groups. The Fayetteville North Carolina, program has involved primarily White and African American families and therapists, including a significant number of mixed race relationships and offspring. The two clinical trials being conducted in New Mexico involve Hispanic/Latino and White youth, and the home-based program in urban Willow Run, Michigan, involves a large proportion of African American and mixed families. (See replication information in later sections for more details.) As the model has been increasingly adopted in multicultural contexts, focus is being placed on issues of culture and ethnicity, with much of this recent work undertaken in the context of the multi-site National Institute of Drug Abuse (NIDA) funded Center for Research on Adolescent Drug Abuse (CRADA, Howard Liddle, P.I.).

Taken together, 28 years of data and clinical experience with FFT involving hundreds of therapists and thousands of families have provided strong empirical support for this family-based intervention with adolescents. In addition, the research has demonstrated that intervention must include a major focus on changing emotional and attributional, especially blaming, components of family interaction, then provide a program of specific behavior change techniques that are culturally appropriate, family appropriate, and consistent with the capabilities of each family member.

The information for this section was excerpted from:

Alexander, J., Barton, C., Gordon, D., Grotmeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Parsons, B., Pugh, C., Schulman, S., Waldron, H., & Sexton, T. (1998). Blueprints for Violence Prevention, Book Three: Functional Family Therapy. Boulder, CO: Center for the Study and Prevention of Violence.

Program Summary

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes.

Program Targets:

Youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder. Often these youth present with additional comorbid challenges such as depression.

Program

FFT requires as few as 8-15 sessions of direct service time for commonly referred youth and their families, and generally no more than 26 total sessions of direct service for the most severe problem situations.

Content:**Delivery**

Flexible delivery of service by one and (rarely) two person teams to clients in-home, clinic, school, juvenile court, community based programs, and at time of re-entry from institutional placement. FFT Therapists carry a case load of 12-15 families.

modes:**Implementation:**

Wide range of interventionists, including trained probation officers, mental health technicians, degreed mental health professionals (e.g., M.S.W., Ph.D., M.D., R.N., M.F.T., L.C.P.).

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 phasic program with steps which build upon each other. These phases consist of:

- *Engagement*, designed to emphasize within youth and family factors that protect youth and families from early program dropout;
- *Motivation*, designed to change maladaptive emotional reactions and beliefs, and increase alliance, trust, hope, and motivation for lasting change;
- *Assessment*, designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they related to change techniques;
- *Behavior Change*, which consists of communication training, specific tasks and technical aids, basic parenting skills, problem solving and conflict management skills, contracting and response-cost techniques; and
- *Generalization*, during which family case management is guided by individualized family functional needs, their interface with community based environmental constraints and resources, and the alliance with the FFT therapist/Family Case Manager.

Program

Clinical trials have demonstrated that FFT is cable of:

Outcomes:

- 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;

- Interrupting the matriculation of these adolescents into more restrictive, higher cost services;
- Reducing the access and penetration of other social services by these adolescents;
- Generating positive outcomes with the entire spectrum of intervention personnel;
- Preventing further incidence of the presenting problem;
- Preventing younger children in the family from penetrating the system of care;
- Preventing adolescents from penetrating the adult criminal system; and
- Effectively transferring treatment effects across treatment systems.

Program

Costs:

The 90-day costs range between \$1,600 and \$5,000 for an average of 12 home visits per family. Current costs vary and are highly dependent on cost of labor.

The information for this section was excerpted from:

Alexander, J., Barton, C., Gordon, D., Grotspeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Parsons, B., Pugh, C., Schulman, S., Waldron, H., & Sexton, T. (1998). *Functional Family Therapy: Blueprints for Violence Prevention, Book Three*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

MULTISYSTEMIC THERAPY

Program Background

Multisystemic Therapy (MST) was developed in the late 1970s. It addresses several limitations of existing mental health services for serious juvenile offenders which include minimal effectiveness, low accountability of service providers for outcomes, and high cost.

Treatment efforts, in general, have failed to address the complexity of youth needs, being individually-oriented, narrowly focused, and delivered in settings that bear little relation to the problems being addressed (e.g., residential treatment centers, outpatient clinics). Given overwhelming empirical evidence that serious antisocial behavior is determined by the interplay of individual, family, peer, school, and neighborhood factors, it is not surprising that treatments of serious antisocial behavior have been largely ineffective. Restrictive out-of-home placements, such as residential treatment, psychiatric hospitalization, and incarceration, fail to address the known determinants of serious antisocial behavior and fail to alter the natural ecology to which the youth will eventually return. Furthermore, mental health and juvenile justice authorities have had virtually no accountability for outcome, a situation that does not enhance performance. The ineffectiveness of out-of-home placement, coupled with extremely high costs, have led many youth advocates to search for viable alternatives. MST is one treatment model that has a well-documented capacity to address the aforementioned difficulties in providing effective services for juvenile offenders.


Theoretical Rationale/Conceptual Framework

Consistent with social-ecological models of behavior and findings from causal modeling studies of delinquency and drug use, MST posits that youth antisocial behavior is multidetermined and linked with characteristics of the individual youth and his or her family, peer group, school, and community contexts. As such, MST interventions aim to attenuate risk factors by building youth and family strengths (protective factors) on a highly individualized and comprehensive basis. The provision of home-based services circumvents barriers to service access that often characterize families of serious juvenile offenders. An emphasis on parental empowerment to modify the natural social network of their children facilitates the maintenance and generalization of treatment gains.

Brief Description of Intervention

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to:


- improve caregiver discipline practices;
- enhance family affective relations;
- decrease youth association with deviant peers;
- increase youth association with prosocial peers;
- improve youth school or vocational performance;
- engage youth in prosocial recreational outlets; and
- develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes.


The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources, that promotes health.

Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, and community). The treatment plan is designed in collaboration with family members and is, therefore, family driven rather than therapist driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources that promotes health. The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring each week, determined by family need.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident:


MST has demonstrated decreased criminal activity and incarceration in studies with violent and chronic juvenile offenders.

1. MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains.
2. MST programs have an extremely strong commitment to removing barriers to service access (e.g., the home-based model of service delivery).
3. MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes).
4. Most importantly, MST has well-documented long-term

outcomes with adolescents presenting serious antisocial behavior and the adolescents' families.

The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders. Importantly, results from these studies showed that MST outcomes were similar for youth across the adolescent age range (i.e., 12-17 years), for males and females, and for African American as well as White youth and families.

Evidence of Program Effectiveness

The first controlled study of MST with juvenile offenders was published in 1986, and three randomized clinical trials with violent and chronic juvenile offenders have been conducted since then. In these trials, MST has demonstrated long-term reductions in criminal activity, drug-related arrests, violent offenses, and incarceration. This success has led to several randomized trials and quasi-experimental studies aimed at extending the effectiveness of MST to other populations of youth presenting serious clinical problems and their families.

The information for this section was excerpted from:

Henggeler, S.W., Mihalic, S.F., Rone, L., Thomas, C., & Timmons-Mitchell, J. (1998). Blueprints for Violence Prevention, Book Six: Multisystemic Therapy. Boulder, CO: Center for the Study and Prevention of Violence.

Program Summary

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

Program

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.

Targets:

Program

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.

Content:

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. Intervention strategies are integrated into a social ecological context and include strategic

family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

MST is provided using a home-based model of services delivery. This model helps to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists have low caseloads), and enhances the maintenance of treatment gains. The usual duration of MST treatment is approximately 60 hours of contact over four months, but frequency and duration of sessions are determined by family need.

Program

Outcomes:

Evaluations of MST have demonstrated for serious juvenile offenders:

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

Program

Costs:

MST has achieved favorable outcomes at cost saving in comparison with usual mental health and juvenile justice services, such as incarceration and residential treatment. At a cost of \$4,500 per youth, a recent policy report concluded that MST was the most cost-effective of a wide range of intervention programs aimed at serious juvenile offenders.

The information for this fact sheet was excerpted from:

Henggeler, S.W., Mihalic, S.F., Rone, L., Thomas, C., & Timmons-Mitchell, J. (1998). *Multisystemic Therapy: Blueprints for Violence Prevention, Book Six*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

MULTIDIMENSIONAL TREATMENT FOSTER CARE

Program Background

Violent juvenile crime is a growing concern in most communities. Citizens are reaching for solutions. Getting youth who commit crimes off the streets has become a high priority. This is especially true for violent and sexual offenders. Increased capacity for incarceration is an option that many states have taken. However, long-term incarceration is costly and has other disadvantages. Alternatives to incarceration typically involve placement and treatment of youth in congregate care settings.

The Oregon Social Learning Center (OSLC) Multidimensional Treatment Foster Care (MTFC) Program was developed as an alternative to institutional, residential, and group care placement for teenagers with histories of chronic and severe criminal behavior. In most communities, such juveniles are placed in out-of-home care settings prior to being sent to closed custody incarceration. Typically, these settings include some type of group home or cottage on a larger institutional campus where youngsters reside with others who have similar problems and histories of offending. On a continuum of care, MTFC is a relatively non-restrictive community-based placement that can be used in lieu of residential or group care or that can be used for youth transitioning back to the community from such settings. MTFC is less expensive than placement in group, residential care, or institutional settings.

Theoretical Rationale/Conceptual Framework

Many adults, including some policy makers and treatment providers, accept the notion that adolescents are beyond adult influence. From the popular literature on adolescence and from personal experiences "we know" that the influence of peers takes on enormous proportions during the teenage years, especially in relation to the influence of parents. In the scholarly literature on the development and maintenance of delinquency, there has been consistent empirical support for the powerful role of negative (or deviant) peer relations. Therefore, it seems logical that treatment approaches must abandon or at least not rely on parental efforts to supervise and discipline youngsters in the face of the emerging power of the peer group.

Association with deviant peers has been shown to be a strong predictor of involvement in and escalation of aggressive and delinquent behavior. For example, peer support for aggressive behavior in the classroom increases aggression. Interaction with negative peers predicts substance use. Research in sociology and developmental psychology over the past 25 years has clearly shown that youngsters who have strong bonds with delinquent peers are at far greater risk for becoming delinquent in the first place and for escalating delinquency over time than those who associate with nondelinquent peers.

It is ironic then that most delinquency treatment programs put youngsters with criminal histories together in groups that can potentially facilitate further bonding and development of common social identities among group members. These treatments run the risk of actually contributing to the maintenance and enhancement of delinquent friendship cliques.

Most widely used treatments for delinquency, such as Positive Peer Culture, attempt to use the "group process" to gain a therapeutic effect. The assumption is that the peer group can best motivate and influence youth to change their behaviors and attitudes. However, it seems unreasonable to expect youngsters with histories of serious delinquent behaviors to function as a group and somehow become good influences on each other or establish prosocial norms or values. It may be that these approaches vastly underestimate the influence that adult-initiated norms and rules of conduct can have in the face of day-to-day involvement in a peer-dominated culture. A more sensible intervention would involve minimizing the influence of peers and immersing the youngster in a nondelinquent culture.

A number of studies have shown that parents play a key role in the support and socialization of their adolescents. Specifically, adolescent adjustment can be enhanced by the extent to which parents are able to effectively supervise their teenager, to follow through with consequences when necessary, and to promote positive involvement in school and other normative activities. Conversely, the development of adolescent antisocial behavior leads not only to escalating problems with delinquency and drug use, but the behavior itself wears down and neutralizes what normative socialization forces exist that could potentially guide the adolescent into more prosocial patterns of adjustment. As the conflict between parents and youth increases, parents' capacity to provide a supportive or corrective influence decreases, and the youngster becomes increasingly committed to and influenced by delinquent peers who, in turn, reinforce the teenager's alienation from adult influence. If delinquency escalates, the youngster's behavior finally begins to compromise community safety to the point where courts intervene and require that the youth be held accountable. At this point in the youth's development, where close parental supervision and guidance are absolutely critical, parents are typically distressed, demoralized, defeated, and cynical. The challenge is to come up with an intervention to provide corrective or therapeutic parenting for antisocial adolescents whose parents, for one reason or another, are unable to rise to the occasion.

Social Learning Theory underpins the MTFC model. Social Learning Theory describes the mechanisms by which individuals learn to behave in social contexts. In family settings, daily interactions between family members shape and influence both prosocial and antisocial patterns of behavior that children develop and carry with them into their interactions with others outside of the family (e.g., peers, teachers, coaches). A number of studies at the Oregon Social Learning Center and elsewhere have identified specific family processes or interaction patterns that predict the development of antisocial behavior patterns in children and adolescents. Parents in these families inadvertently reinforce their child for being negative or coercive as a means of getting their own way or avoiding tasks or minding. Typically these parents will make repeated requests and demands, the child will whine, yell, and otherwise noncomply, and the parent will respond by giving in. In this manner the child is actually reinforced for coercive behavior and has "learned" that negative coercive responses such as crying are an effective way to get parents to back off. Thousands of these interactions are embedded in family life and because they may "work" in the short term, both parents and children are gradually shaped to use more negative control strategies over time. Unfortunately, there are damaging long term effects. For example, observational studies in family homes have shown that not only do families with antisocial youngsters have more negative interactions, parents also do not notice when their child is behaving appropriately. The child is not only "taught" to be coercive, they do not develop the skills necessary to have positive behaviors that could be of use in making friends or in relating positively to teachers, coaches, or other adults.

By the time an antisocial child has reached school age, three processes are well underway. Parents are responding to him/her negatively; the child uses coercive tactics as his/her main strategy for getting what s/he wants and avoiding what s/he does not want (e.g., chores, homework); and s/he has deficits in prosocial behavior, having failed to learn the skills necessary to cooperate in the classroom, on teams, or in clubs. There is substantial evidence that aggressive children are likely to be rejected by their peers and that rejected children are more likely to associate with other aggressive, rejected children who tend to reward negative behavior in their interactions with each other. Antisocial aggressive children are also at risk for school failure. The "coercive training" that they received in their families reduces their behavioral and social competencies which sets them up for social and academic failure at school.

Over time, without effective intervention, these processes continue and become amplified. The youth's experience of early failure in school, parental negativity, rejection by peers, and exclusion from clubs and sports activities all set the stage for association with delinquent peers, school drop-out, drug use, and delinquency in adolescence.

Brief Description of Intervention

In Multidimensional Treatment Foster Care, adolescents are placed, usually singly or at most in twos, in a family setting for six to nine months. Community families are recruited, trained, and supported to provide well-supervised placements and treatment. MTFC parents are part of the treatment team along with program staff. They are paid a monthly salary and a small stipend to cover extra expenses. MTFC parents implement a structured, individualized program for each youth that is designed to simultaneously build on the youngster's strengths and to set clear rules, expectations, and limits. MTFC parents are contacted daily (Monday through Friday) by telephone, and data are collected on the youth's behavior during the past 24 hours. During this call, potential problems are discussed, and plans for the coming day are reviewed. MTFC parents are supported by a case manager who coordinates all aspects of the youngsters' treatment program. Additional components of the program include weekly supervision and support meetings for MTFC parents; skill-focused individual treatment for youth; weekly family therapy for biological parents (adoptive or other aftercare resource); frequent contact between participating youth and their biological/adoptive family members, including home visits; close monitoring of the youngsters' progress in school; coordination with probation/parole officers; and psychiatric consultation/medication management, as needed.

Weekly meetings with MTFC parents are run by the case manager and attended by other involved program staff. During these meetings, telephone data collected during the prior week are reviewed and discussed, and the youths' individualized programs are adjusted as needed. Each individualized program is structured to give the youth a clear picture of what is expected of him/her throughout the day and evening. During the placement period, individualized programs are readjusted to fit youths' changing needs, to reflect progress, and to target new problem behaviors that emerge. The individualized programs help guide MTFC parents to be specific in the way they reinforce progress and to consistently set limits and consequences. Individualized programs give youth a concrete way to measure their success. The individualized programs also are used by biological/adoptive parents or relatives during home visits and when youth return home after placement.

Because youth who participate in the program have committed several delinquent acts (i.e., an average of thirteen previous arrests in our most recent sample), the level of supervision required is

high. Youth are not permitted to have unsupervised free time in the community, and their peer relationships are closely monitored. Over the course of the placement, levels of supervision and discipline are adjusted, depending on the youth's level of progress or lack thereof. Close monitoring of youngsters at home and at school is a hallmark of the MTFC model. There is heavy emphasis placed on teaching interpersonal skills and on participation in positive social activities, including sports, hobbies, and other forms of recreation.

The MTFC model uses a specific and structured multi-modal treatment approach. Multi-modal treatment includes behavioral skills training across settings (e.g., home, school, with peers). The success of the program depends on the group of adults, including the MTFC parents and the MTFC program staff (i.e., case manager, family therapist, individual therapist), that work intensively with the youth and his/her parents (or other relatives) and that surround the youngsters with positive role models and mentors. The youth is taught how to do well in a family setting and at school and is intensively supervised, consistently disciplined, and isolated from other delinquent peers. Both the youth and his/her parents participate in a structured program where the rules and limits are clear, as are the consequences for failing to comply with the program rules. By the time youth return home, their parents have improved their ability to provide a successful home environment. They are practiced in keeping youth from associating with delinquent peers. They know how to set limits and follow through with discipline. They understand the importance of helping the youth succeed in school and on the job. The MTFC placement is an opportunity for youth and their families to experience a turning point towards positive and productive relationships and activities.

Throughout the MTFC placement, the youth's biological family (or adoptive family or other aftercare resource) participates in the treatment. Parents attend weekly treatment sessions and have on-call access to MTFC staff. During weekly sessions, effective methods for supervising, disciplining, and encouraging the youth are discussed. Biological parents and youth have a number of opportunities to practice these skills during home visits that are scheduled throughout the youth's placement. During home visits, parents run the youth's individualized program which is similar to the one used in the MTFC home. Home visits start out being short, one to two hours in length, and as the youth and his/her parents progress through the program, eventually overnight visits are scheduled. Following each home visit, the family therapist debriefs the biological parents and the youth regarding problems and progress.

Evidence of Program Effectiveness

Researchers and policy makers agree that development of effective interventions for youngsters with severe conduct problems should take advantage of the substantial body of basic research that addresses the life course development of aggression and antisocial behaviors. Further, to be most useful, expensive intervention trials need to provide experimental tests of their underlying theoretical model of change. Thus, an efficient intervention study should ideally serve two purposes: evaluate the effectiveness of the intervention and provide specific information that can guide the development of better interventions in the future. Therefore, the goals of our program of research have been:

- to systematically evaluate the immediate and longer-term outcomes of the interventions, and
- to evaluate the contribution of the intervention's key variables to changes in outcomes.

The MTFC model has been tested in two studies where the feasibility of using this model in lieu of incarceration for adolescents referred for delinquency was explored. The first study of 32 youth used a matched control group. Results from this study showed that MTFC was not only feasible but, compared to alternative residential treatment models, it was cost effective and the outcomes for children and families were better. For example, during a two-year follow-up period, the number of days delinquent youngsters were incarcerated in the state training school were lower for participants in MTFC than for a comparison group of youngsters placed in group care programs. The savings in incarceration costs alone were \$122,000 (see Study 2, in Evaluation chapter, for more information). The boys and girls in this study had all been committed to the state training school and due to overcrowding were being diverted to placement in community-based programs. All youngsters came into the program from juvenile detention. Three-quarters of the youth in both the MTFC and the matched groups had previously spent some time during the last year in the state training school (an average of 23 days for MTFC youth and 15 days for youth in the comparison group).

These initial findings encouraged us to apply for federal funding to conduct a full-scale clinical trial on the efficacy of MTFC for adolescents with serious and chronic delinquency. When designing the study, in addition to looking at the relative effectiveness of the treatment models, we were interested in the broader issue of understanding the factors or key treatment components which led to success or failure for individual participants.

In 1991, a study to compare the effectiveness of two treatment models for male adolescents who had histories of chronic delinquency was initiated (see Study 1, in Evaluation chapter). The two models used very different approaches to exposure to delinquent peers one attempted to use peer group interactions therapeutically, and the other attempted to maximize the influence of mentoring adults and prosocial peers and to isolate boys from their delinquent peers. Seventy-nine boys, who were mandated into out-of-home care by the juvenile court, were randomly assigned to placement in Group Care (GC) or Multidimensional Treatment Foster Care (MTFC). In GC, boys lived with six to fifteen others who had similar histories of delinquency. In MTFC, a boy was placed in a home with a family who had been recruited from the community. MTFC parents were trained in the use of behavior management skills and were closely supervised throughout the boy's placement. In both conditions, treatment lasted for an average of seven months.

Boys who participated were from 12 to 17 years old (average age, 14.3), had an average of thirteen previous arrests and 4.6 prior felonies, and half had committed at least one crime against a person. All participants had extensive previous contacts with the juvenile justice system, had been supervised by parole or probation officers, and were labeled by the Department of Youth Services as chronic offenders. On average, study boys had spent 76 days during the previous year in juvenile detention. Their offenses included both misdemeanors and felonies; parole violations and status offenses were not included in the boy's offense counts. All boys were on parole or probation, depending on whether they had previously been committed to the state training school (in which case they were on parole), and were supervised by a parole/probation officer throughout the course of their placement and in aftercare. The period of time that parole/probation supervision lasted after treatment varied depending on the length of the jurisdiction, the boy's age, and whether he had completed restitution. There was no difference in parole/probation supervision for the two groups.

Data was collected on official arrests, including each boy's arrest history prior to entering the study. In addition, confidential self-reports of criminal activity were collected from each boy. The number

of days each boy was incarcerated and/or "on the run" was tracked, as was information on school attendance and academic advancement. Mental health outcomes were also assessed. To measure outcomes, boys were assessed at baseline, three months after placement, and then every six months throughout a two-year follow-up period. To assess the contribution of key treatment components, variables were identified that were thought likely to influence a boy's success or failure in treatment. This was done by reviewing the research literature on the development of aggression and delinquency. Problems with adult supervision and discipline practices, as well as adult attachment and involvement with the child, were indicated as powerful predictors of child conduct problems. As discussed, the influence of negative peers appeared to play a key role, especially in escalation of delinquency, and especially if problems already existed. To examine the relative contribution of these variables to individual outcomes, the boy and his caretaker (i.e., line staff in GC, MTFC parent in MTFC) were assessed in the placement setting after he had been there for three months. The relationship between scores on these in-program variables and case outcomes were then examined.

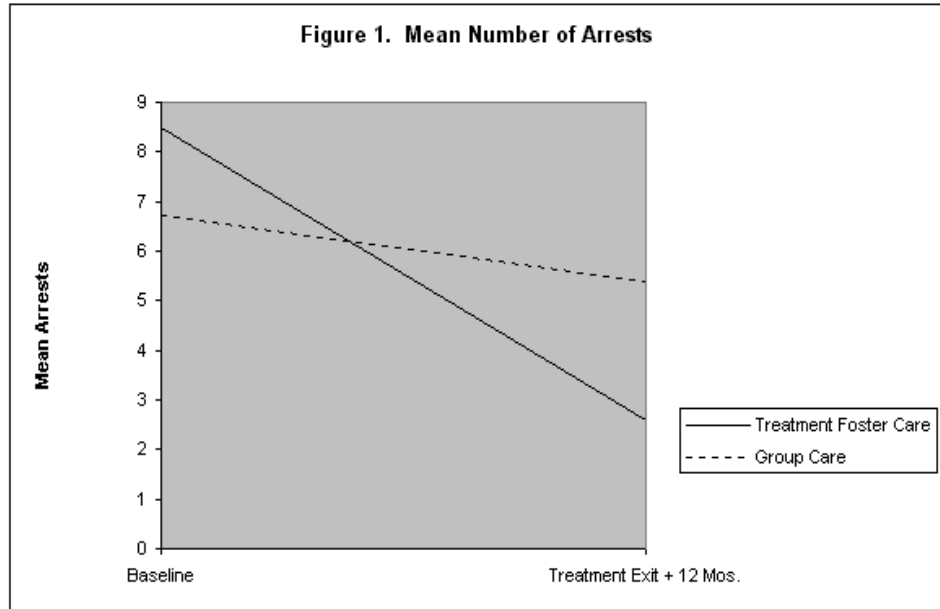
Summary of Results

At one-year after treatment exit, boys in MTFC had less than half the number of arrests as boys in GC (i.e., an average of 2.6 offenses for MTFC boys and 5.4 offenses for GC boys; see Figure 1). Boys in MTFC had an 83 percent higher rate of desistance from arrest than did boys in GC. Nearly three times as many boys ran away or were expelled from their programs in GC than in MTFC (5 out of 36 MTFC boys, and 15 out of 38 GC boys). Boys in MTFC spent about twice as many days living with parents or relatives in follow-up than did boys in GC.

A series of analyses were conducted to control for factors that commonly effect rates of delinquency. These included boy's age, age of first offense, and number of previous arrests. In a multiple regression analysis we found that where the boys were placed (in MTFC or GC) was the only factor that reliably predicted further arrests even given consideration of the control variables (i.e., age, age at first offense, number of previous offenses); placement in MTFC predicted significantly fewer arrests than placement in GC.

In addition to looking at official arrest rates, rates of boy's self-reported delinquency was examined. Boys were asked in a confidential self-report interview to tell how many criminal acts they had committed during the past six months. Boys in MTFC reported committing significantly fewer criminal acts than GC boys at 6, 12 and 18 months post-enrollment in the study.

Next, we looked at whether the variables that we thought would mediate the effectiveness of treatment related to arrest rates during the time that boys were in the program and in follow-up. It was found that regardless of placement setting (i.e., MTFC or GC), the mediating variables examined (i.e., supervision, discipline, deviant peers) predicted arrests one year



after boys had completed treatment. In other words, boys in either MTFC or GC who got good supervision; consistent, predictable discipline; and had less association with delinquent peers had fewer arrests in follow-up than those who did not.

However, the structure of the GC programs (i.e., boys lived with other delinquent youth) promoted association with delinquent peers. Because of this, for GC boys, scores on the association with delinquent peers measure were higher (more negative), but the scores for effective supervision and discipline were lower than the scores for boys in MTFC. The evidence supports the theoretical rationale to the extent that the risk factors are impacted, the behavioral outcome (i.e., arrests) will be impacted. This set of findings has implications for all programs which aim to reduce rates of criminal offending in juveniles.

The information for this section was excerpted from:

Chamberlain, P., & Mihalic, S.F. (1998). Blueprints for Violence Prevention, Book Eight: Multidimensional Treatment Foster Care. Boulder, CO: Center for the Study and Prevention of Violence.

Program Summary

Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. Community families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers.

Program Targets:

MTFC targets Teenagers with histories of chronic and severe criminal behavior at risk of incarceration and those with severe mental health problems at risk for psychiatric hospitalization.

Program**Content:**

MTFC Training for Community Foster Families emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a pre-service training and placement of the youth, MTFC parents attend a weekly group meeting run by a program supervisor where ongoing support and supervision are provided. Foster parents are contacted daily during telephone calls to check on youth progress and problems. MTFC staff are available for consultation and crisis intervention 24/7.

Services to the Youth's Family occur throughout the placement . Family therapy is provided for the biological (or adoptive) family, with the goal of returning the youth back to the home. The parents are supported and taught to use behavior management methods that are used in the MTFC foster home. Closely supervised home visits are conducted throughout the youth's placement in MTFC. Parents are encouraged to have frequent contact with the MTFC program supervisor to get information about their child's progress in the program.

Coordination and Community Liaison. Frequent contact is maintained between the MTFC program supervisor and the youth's case workers, parole/probation officer, teachers, work supervisors, and other involved adults.

Program Outcomes:

Evaluations of MTFC have demonstrated that program youth compared to control group youth:

- Spent 60% fewer days incarcerated at 12 month follow-up;
- Had significantly fewer subsequent arrests;
- Ran away from their programs, on average, three time less often;
- Had significantly less hard drug use in the follow-up period;
- Had quicker community placement from more restrictive settings (e.g., hospital, detention); and
- Had better school attendance and homework completion at 24 months follow-up.

Program**Costs:**

The cost per youth is from one-half to one-third less in MTFC than in residential, group or hospital placements and averages approximately \$3,900 per month. The average length of stay is seven months.

The information for this section was excerpted from:

Chamberlain, P., & Mihalic, S.F. (1998). *Multidimensional Treatment Foster Care: Blueprints for Violence Prevention, Book Eight*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

Chamberlain, P., Leve, L., & DeGarmo, D. (2007). Multidimensional Treatment Foster Care for Girls in the Juvenile Justice System: Two Year Follow-up of a Randomized Clinical Trial. *Journal of Consulting and Clinical Psychology, 75*(1), 187-193.