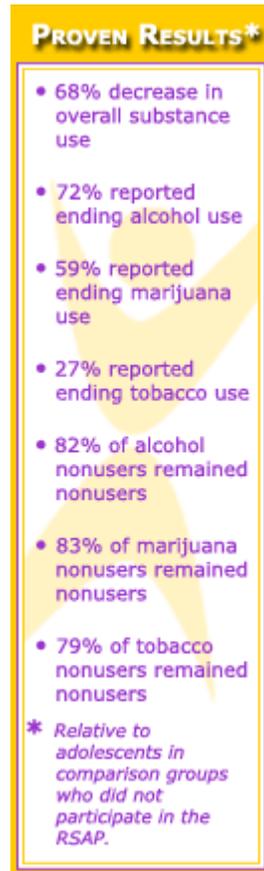


Brief Program Description

The Residential Student Assistance Program (RSAP) is a substance abuse prevention program developed for high-risk adolescents (14 to 17 years old) living in residential facilities. The program is based on the Westchester Student Assistance Model and works by placing highly trained professionals in residential facilities to provide residents with a full range of substance abuse prevention and early intervention services. The program uses proven prevention strategies that include:

- Information dissemination
- Normative and preventive education
- Problem identification and referral
- Community-based interventions
- Environmental approaches

RSAP counselors work with adolescents individually and in small groups. Intervention services are fully integrated into the adolescent's overall experience at the residential facility and have an impact on both their school and residential environments.



Recognition

Model Program: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Intended Population

RSAP was tested with 14- to 17-year-old adolescents, primarily African-American and Hispanic, living in various residential facilities. Whether voluntarily or involuntarily placed in such facilities, these youth typically present with multiple risk factors and problems, including early substance use; parents who abuse substances; participation in violent or **delinquent** acts; histories of physical, sexual, or psychological abuse; chronic failure in school; and mental health problems, including attempted suicide.

Implementation Essentials

RSAP requires the formation of a partnership between a prevention agency that will administer the program and a residential facility where it will operate. Specific staff involved in the partnership include:

- **Residential Facility Senior Executive.** This person establishes the initial implementation agreement, oversees the program, and appoints an RSAP liaison who will supervise the SAC and day-to-day program operations.
- **Executive Director/Project Director.** This person initiates and manages the program, sets up procedures, hires staff, and is responsible for direct program oversight.
- **Student Assistance Counselor (SAC).** This person implements the program at the facility and provides all prevention and early intervention services to residents.
- **Project Supervisor.** This individual supervises the SAC.

These staff members must complete the following administrative steps to ensure successful program implementation:

- Define program goals and objectives
- Define target population
- Provide training and consultation for school staff
- Establish a school staff substance abuse task force
- Establish a school substance abuse task force
- Obtain technical assistance and training

A 75-page implementation manual, which includes resource material for professionals and worksheets for students, and a video are available. Onsite and offsite training of varying lengths, up to 5 days, is also available.

Brief Program Description

Multidimensional Family Therapy (MDFT) is a comprehensive and flexible family-based program designed to treat substance abusing and **delinquent** youth. MDFT is a multicomponent and multilevel intervention system that assesses and intervenes with the--

- Adolescent and parent(s) individually
- Family as an interacting system
- Individuals in the family, relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent's development.

MDFT interventions are solution-focused and strive to obtain immediate and practical outcomes in the most important individual and transactional domains of the adolescent's everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including a hospital-based day treatment program. Treatment length is 4 to 6 months.

MDFT studies have been conducted at numerous wide-ranging geographic locales with African-American, Hispanic/Latino and White youth between the ages of 11 and 18 in urban, suburban and rural settings. Outcomes show that marijuana use decreases more rapidly, depression, anxiety and **delinquent** acts are more greatly reduced during MDFT compared to other treatments.

Program Development Support

MDFT has been supported with continuous Federal funding since 1985. The majority of this support has come from National Institute on Drug Abuse research grants and grants from the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health services Administration (SAMHSA), U.S. Department of Health and Human Services.

Mendota Juvenile Treatment Center

Ages 15-18

Rating: Level 2

Intervention

The Wisconsin Department of Health and Family Services Mendota Juvenile Treatment Center (MJTC) is a unique residential facility that specializes in providing mental health treatment to extremely "hard cases" within the juvenile justice system. The program was established by the Wisconsin State Legislature in 1995 specifically to meet the needs of youths who were too disturbed, unruly, or "treatment refractory" to be housed in the State's traditional correctional centers. The Center seeks to control and rehabilitate such youths by combining the security consciousness of a traditional correctional institution with the strong mental health focus of a private psychiatric facility.

The overarching goal of the program is to replace the antagonistic responses and feelings created by traditional correctional institutions with more conventional bonds and roles, which can encourage positive social development. The treatment is based on the notion that defiant behavior can become cyclic when the defiant response to a sanction is itself sanctioned, resulting in more defiance and increasing sanctions. With each reiteration the young offender is further disenfranchised from conventional goals and values, and is increasingly "compressed" into a defiant behavior pattern. The MJTC uses a decompression model that attempts to erode the antagonistic bond with conventional roles and expectations and with authority figures and other potential sanctioning agents.

The Center's emphasis on mental health treatment is evident in its setting. Unlike most secure, State-funded correctional facilities, MJTC is housed on the grounds of a State mental health center. The staff is composed of experienced mental health professionals (including a fulltime psychologist, fulltime psychiatric social worker, and a fulltime psychiatric nurse manager) rather than security guards or corrections officers. In addition, residents in the program are housed in single bedrooms within small inpatient units (with about 15 youths per unit). Within this private, clinical setting, youths undergo

intensive individualized therapy designed to treat their underlying emotional problems and to “break the cycle of defiance” triggered by normal institutional settings. Whenever youths in treatment act out or become unruly, they receive additional therapy as well as enhanced security.

Evaluation

Caldwell and Van Rybroek employed a quasi-experimental design to assess the effectiveness of MJTC’s treatment program. Their study compared the recidivism rates of two groups of serious and violent offenders confined to Wisconsin correctional facilities. The treatment group consisted of 101 youths who received treatment at MJTC after being referred by one of the State’s conventional correctional institutions; the comparison group consisted of 147 youths with equally serious offenses who were referred to MJTC for assessment purposes but received no treatment. The entire sample was 52 percent African-American, 38 percent white, 9 percent Hispanic, and 2 percent Asian- (or Middle Eastern) American male juveniles. The average age at release was 17 years 1 month. The only significant demographic difference identified between the groups was the proportion of African-American subjects in the samples. The evaluators then used court and corrections department records to track each participant’s pattern of reoffending. All participants were tracked for at least 2 years after treatment, with the average follow-up time being 4½ years. A propensity score analysis was used to reduce the effects of nonrandom assignment.

Outcome

Youths in the treatment group were significantly less likely to recidivate within 2 years of release than youths in the comparison group. (The treatment group’s overall 2-year recidivism rate was 52 percent versus 73 percent for the comparison group.) While misdemeanor rates do not appear to have been significantly affected by the treatment, MJTC youths were only about half as likely to commit new violent and serious offenses. They also spent less time incarcerated and had a longer average “survival time” before reoffending. The authors attribute these results to the fact that the MJTC program “significantly increased the level of participation in rehabilitation services for the vast majority of youth transferred there.” Overall, the authors conclude, their findings “provide a challenge to the notion that this population is untreatable” or beyond rehabilitation.

Risk Factors

Individual

- Anti-social behavior and alienation/Delinquent beliefs/General delinquency involvement/Drug dealing
- Cognitive and neurological deficits/Low intelligence quotient/Hyperactivity
- Early onset of aggression and/or violence
- Lack of guilt and empathy
- Life stressors
- Mental disorder/Mental health problem/Conduct disorder

Protective Factors

Individual

- Healthy / Conventional beliefs and clear standards
- Perception of social support from adults and peers
- Positive / Resilient temperament
- Positive expectations / Optimism for the future
- Social competencies and problem-solving skills

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Contact

Greg Van Rybroek, Ph.D.

Mendota Mental Health Institute

301 Troy Drive

Madison, WI 53704

Phone: (608) 301-1042

Fax: (608) 301-1207

E-mail: vanrygj@dhfs.state.wi.us

Web site: <http://www.wi-doc.com/MJTC.htm>

Aggression Replacement Training® (ART®)

Ages 12-17

Rating: Level 2

Intervention

Aggression Replacement Training® (ART®) is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. *Skill-streaming* uses modeling, role-playing, performance feedback, and transfer training to teach prosocial skills. In *anger-control training*, participating youths must bring to each session one or more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. *Training in moral reasoning* is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations.

The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the "core" curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking. The ART® training manual presents program procedures and the curriculum in detail and is available in both English and Spanish editions. ART® has been implemented in school, delinquency, and mental health settings.

Evaluation

The ART® program has been evaluated in numerous studies. In general, the studies were comprehensive and used acceptable evaluation designs, psychometrics, and data analysis techniques. But many of the studies did not provide a demonstrated effect on violent behavior or on other conduct problems 1 year or longer beyond baseline.

One evaluation used a quasi-experimental design with nonequivalent comparison groups. The sample was collected from a New York State Division for Youth facility and included 60 youths, most of whom had been incarcerated for crimes such as burglary, robbery, and various drug offenses. Twenty-four of these youths received the 10-week ART® program. Another 24 youths were assigned to a no-ART®, brief-instructions control group. This condition controlled for the possibility that any apparent ART®-derived gains in skill performance were not due to ART® per se. Finally, 12 youths were placed in the no-treatment control group.

A second study was designed to both replicate the procedures and findings of the aforementioned study as well as extend them to youths incarcerated for substantially more serious felonies. The study sample included 51 youths who were incarcerated for murder, manslaughter, rape, sodomy, attempted murder, assault, and robbery. In all of its procedural and experimental details, the second study replicated the effort of the first. The second study employed the same preparatory activities, materials, ART® curriculum, testing, staff training, resident training, supervision, and data analysis procedures.

A third evaluation was designed to examine the efficacy of ART® as a community-based, postrelease intervention. This study also employed a quasi-experimental design with a three-way comparison of ART®. Condition 1 provided the ART® program to youths and to youths' parents or other family members. Condition 2 provided the ART® program to youths only. Condition 3 provided neither parents nor youths with ART®. For the most part, youths were assigned to project conditions on a random basis, with departures from randomization becoming necessary on occasion as a function of the five-city, multisite, time-extended nature of the project.

A fourth study conducted by Washington State Institute for Public Policy used a pseudo-random assignment waitlist procedure to assign 1,229 adjudicated youths to either a control (n=525) or treatment group (n=704). Youths who met the selection criteria and had sufficient time on supervision to complete the program were assigned by court staff to the appropriate program. When the program reached capacity (all therapists had full caseloads or sessions were full), the remaining eligible youths were assigned by court staff to the control group and never participated in the program; instead, they received the usual juvenile court services. The sample was roughly 80 percent 15-year-old males. The analyses use multivariate statistical techniques to control for systemic differences between the program and control groups on key characteristics (gender, age, and domain risk and protective factor scores). Recidivism was measured by using conviction rates for subsequent juvenile or adult offenses. The follow-up "at risk" period for each youth is 18 months.

Outcome

The findings from the first two studies reveal ART® to be an effective intervention for incarcerated juvenile delinquents. It enhanced prosocial skill competency and overt prosocial behavior, reduced the level of rated impulsiveness, and—in one of the two samples studied—decreased (where possible) the frequency and intensity of acting-out behaviors and enhanced the participants' levels of moral reasoning.

The first study revealed that, compared with both control groups, youths who participated in the ART® program significantly acquired and transferred 4 of the 10 skill-streaming skills: expressing a complaint, preparing for a stressful conversation, responding to anger, and dealing with group pressure. Similarly significant ART®-versus-control-group comparisons emerged for the number and intensity of in-facility acting out and for staff-rated impulsiveness. During the 1-year follow-up, 54 youths were released from the facility. Of those released, 17 had received ART® and 37 had not. In four of the six areas rated—namely, *home and family*, *peer*, *legal*, and *overall*, but not *school* and *work-ART®*—youths were rated significantly superior at in-community functioning than were youths who had not received ART®. Similar findings were reported in the second study.

In the third evaluation (the postrelease community-based study), results indicated that, though they did not differ significantly from one another, the two ART® groups each increased significantly in their overall interpersonal skill competence compared with the control youths. Perhaps more important, however, rearrest rates were tracked during the 3 months in which youths in the two intervention groups received the ART® program and during the 3 subsequent no-ART® months. Meaningful differences in favor of the two intervention groups were found. Youths in both of the ART® groups were rearrested less often than youths not receiving ART®. And the ART® youths-plus-family-members group did better than the ART® youths-only group.

The Washington State study found that when ART is delivered competently, the program reduces felony recidivism and is cost effective. For the five courts rated as not competent, the adjusted 18-month felony recidivism rate is 27 percent compared with 25 percent for the control group. This difference is not statistically significant. However, for the 21 courts rated as either competent or highly competent, the 18-month felony recidivism rate is 19 percent. This is a 24 percent reduction in felony recidivism compared with the control group, which is statistically significant. Moreover, the cost-benefit analysis demonstrates that when ART is delivered by competent courts, it generates \$11.66 in benefits (avoided crime costs) for each \$1.00 spent on the program. When not

competently delivered, ART costs the taxpayer \$3.10. Averaging these results for all youths receiving ART, regardless of court competence, results in a net savings of \$6.71 per \$1.00 of costs.

Risk Factors

Individual

- Anti-social behavior and alienation/Delinquent beliefs/General delinquency involvement/Drug dealing
- Early onset of aggression and/or violence
- Lack of guilt and empathy
- Life stressors
- Mental disorder/Mental health problem/Conduct disorder
- Victimization and exposure to violence

Family

- Family history of the problem behavior/Parent criminality
- Family management problems/Poor parental supervision and/or monitoring
- Family violence
- Pattern of high family conflict

Peer

- Association with delinquent and/or aggressive peers

Protective Factors

Individual

- Perception of social support from adults and peers
- Positive / Resilient temperament
- Self-efficacy
- Social competencies and problem-solving skills

Family

- Effective parenting
- Opportunities for prosocial family involvement

School

- Presence and involvement of caring, supportive adults

Community

- Prosocial opportunities for participation / Availability of neighborhood resources
- Rewards for prosocial community involvement

Peer

- Good relationships with peers
- Involvement with positive peer group activities

Endorsements

- NIJ: What Works

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Contact

Barry Glick, Ph.D.

G&G Consultants, LLC

106 Acorn Drive

Scotia, NY 12302

Phone: (518) 399-7933

Fax: (518) 384-2070

E-mail: bglick01@nycap.rr.com

Web site: <http://www.g-gconsultants.org>

Trauma-Focused Cognitive Behavioral Therapy

Ages 3-18

Rating: Level 1

Intervention

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment intervention designed to help 3- to 18-year-olds and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse. TF-CBT was created for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (e.g., loss of a loved one, physical abuse, domestic or community violence, motor vehicle accidents, fires, tornadoes, hurricanes, industrial accidents, terrorist attacks). The program targets boys and girls from all socioeconomic backgrounds, in a variety of settings, and from diverse ethnic groups. It has been adapted for Hispanic/Latino children.

TF-CBT was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies to help children talk directly about their traumatic experiences in a supportive environment. The program operates through the use of a parental treatment component and several child-parent sessions. The parent component teaches parents effective parenting skills to provide optimal support for their children. The parent-child session encourages children to discuss the traumatic events directly with the parent, and both parent and child learn to communicate questions, concerns, and feelings more openly.

Evaluation

There have been several randomized controlled trials demonstrating the efficacy of TF-CBT in children ages 3-18. The largest evaluation to date is Cohen and Deblinger's 2004 study involving 229 sexually abused and traumatized children between ages 8-14. All children in the study were confirmed victims of contact sexual abuse who exhibited multiple symptoms of PTSD. They also all had at least one responsible, nonabusive parent or guardian willing to participate in the parental component of the study. Approximately half of the children and their parents were randomized to 12 weeks of treatment with TF-CBT; the remainder received comparable levels of conventional child-centered therapy. A variety of semistructured interviews, standardized questionnaires, and common psychometric tests (including the K-SADS-PL and the Children's Depression Inventory) were used to measure participants' psychiatric symptoms at baseline and after

treatment. A multivariate statistical analysis was then performed to determine which group showed greater improvement over the course of the study.

Outcome

In Cohen and Deblinger's study, children in the treatment group showed significantly more improvement in their PTSD symptoms (depression, shame, abuse-related attributions, and other behavior problems) than their counterparts in the control group. Their parents also showed greater improvement (than the control parents) in their own self-reported levels of depression, abuse-specific distress, support of the children, and effective parenting practice.

These findings confirm the results of numerous earlier (and smaller) trials, which have repeatedly demonstrated TF-CBT's efficacy in reducing multiple PTSD symptoms in abused children and their parents. In general, randomized controlled trials have found that, compared with children who received supportive therapy, children who received TF-CBT

- Had significantly less acting-out behavior
- Had significantly reduced PTSD symptoms
- Had significantly greater improvement in depressive symptoms
- Had significantly greater improvement in social competence
- Maintained these differential improvements over the year after treatment ended

Risk Factors

Individual

- Anti-social behavior and alienation/Delinquent beliefs/General delinquency involvement/Drug dealing
- Early onset of aggression and/or violence
- Early sexual involvement
- Life stressors
- Mental disorder/Mental health problem/Conduct disorder
- Teen parenthood
- Victimization and exposure to violence

Family

- Child victimization and maltreatment
- Family history of the problem behavior/Parent criminality

- Family management problems/Poor parental supervision and/or monitoring
- Family transitions
- Family violence
- Maternal depression
- Parental use of physical punishment/Harsh and/or erratic discipline practices
- Pattern of high family conflict
- Poor family attachment/Bonding

School

- Low academic achievement

Community

- Low community attachment

Protective Factors

Individual

- Healthy / Conventional beliefs and clear standards
- Perception of social support from adults and peers
- Positive / Resilient temperament
- Self-efficacy
- Social competencies and problem-solving skills

Family

- Effective parenting
- Good relationships with parents / Bonding or attachment to family
- Opportunities for prosocial family involvement

Endorsements

- SAMHSA: Model Programs

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Contact

Judith A. Cohen, M.D.

Center for Traumatic Stress in Children and Adolescents

Allegheny General Hospital

Four Allegheny Center, Eighth Floor

Pittsburgh, PA 15212

Phone: (412) 330-4321

Fax: (412) 330-4377

E-mail: JCohen1@wpahs.org

Web site: <http://www.pittsburghchildtrauma.com>

Functional Family Therapy

Ages 11-18

Rating: Level 1

Intervention

Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 11 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. It integrates several elements (established clinical theory, empirically supported principles, and extensive clinical experience) into a clear and comprehensive clinical model. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive.

The model includes specific phases: engagement/motivation, behavior change, and generalization. Engagement and motivation are achieved through decreasing the intense negativity often characteristic of high-risk families. The behavior change phase aims to reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions (skill training in family communication, parenting, problem-solving, and conflict management). The goal of the generalization phase is to increase the family's capacity to adequately use multisystemic community resources and to engage in relapse prevention.

FFT ranges from an average of 8 to 12 one-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings as an outpatient therapy and as a home-based model.

Evaluation

Several evaluation studies using matched or randomly assigned control/comparison group designs were conducted between 1973 and 1997. The studies have included follow-up periods of 1, 2, 3, and 5 years. The model has been applied to populations in urban and rural settings and among many racial and ethnic groups.

For instance, in one of the first randomized trials of FFT, 86 families of delinquents were randomly assigned to one of four treatment conditions: 1) no treatment, 2) a client-centered family approach, 3) an eclectic–dynamic approach, or 4) FFT. The evaluation

was developed to measure three levels of outcomes: process changes in family interaction, recidivism rates of the youths, and the rate of sibling contact with the court 2½ to 3½ years following the intervention.

In a comparison study, 27 delinquents (male and female) who had either recently been placed out of the home or for whom placement was imminent were court-referred to FFT. A comparison group of 27 lower risk delinquents received only probation. Outcomes were measured by the number and severity of offenses during 2½ years following group assignment.

Outcome

In multiple evaluations of FFT, the findings show that when compared with standard juvenile probation services, residential treatment, and alternative therapeutic approaches, FFT is highly successful. The outcome findings of the research conducted during the past 30 years show that when compared with no treatment, other family therapy interventions, and traditional juvenile court services (e.g., probation), FFT can reduce adolescent re-arrests by up to 60 percent. Moreover, both randomized trials and comparison group studies show that FFT significantly reduces recidivism for a wide range of juvenile offense patterns. In addition, studies have found that FFT dramatically reduces the cost of treatment. A Washington State study, for example, shows savings of up to \$14,000 per family. FFT also significantly reduces potential new offending for siblings of treated adolescents.

Risk Factors

Individual

- Anti-social behavior and alienation/Delinquent beliefs/General delinquency involvement/Drug dealing

Family

- Family management problems/Poor parental supervision and/or monitoring
- Pattern of high family conflict

Protective Factors

Family

- Effective parenting

Endorsements

- OJJDP: Blueprints
- OJJDP/CSAP: Strengthen Families
- HHS: Surgeon General

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Contact

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>

Multisystemic Therapy

Ages 12-17

Rating: Level 1

Intervention

Multisystemic Therapy (MST) typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including behavioral, cognitive-behavioral, and the pragmatic family therapies. This family-therapist collaboration allows the family to take the lead in setting treatment goals as the therapist helps them to accomplish their goals.

Evaluation

The first controlled study of Multisystemic Therapy with juvenile offenders (Henggeler et al., 1986) evaluated the effectiveness of MST compared with usual community treatment for innercity juvenile offenders and their families. The study's success led to several randomized trials and quasi-experimental studies aimed at extending the effectiveness of MST to other populations of youths who presented serious clinical problems and their families.

The National Institute of Mental Health–funded Simpsonville, S.C., study (Henggeler et al., 1992; Henggeler et al., 1993) examined MST as an alternative to the incarceration of violent and chronic juvenile offenders. The primary goals of the project were to decrease criminal activity, out-of-home placements, and cost of services. The project included 84 violent and chronic juvenile offenders, of whom 54 percent had been arrested for violent crimes. Their mean number of arrests was 3.5, and they averaged 9½ weeks of prior placement in correctional facilities. The average age of the youths was 15.2 years, and 77 percent were male. The average Hollingshead social class score was 25. Twenty-six percent lived with neither biological parent. Fifty-six percent were African-American, with the remainder white. Youths were assigned randomly to receive MST, using the family preservation model of service delivery (MST; n=43) or usual services provided by the South Carolina Department of Juvenile Justice (n=41). The average duration of treatment was 13 weeks. Assessment batteries, consisting of standardized measurement instruments, were administered pretreatment and posttreatment.

In the most comprehensive and extensive completed evaluation of MST to date (Borduin et al., 1995), the effectiveness of MST was compared with individual therapy (IT). Participants (n=200) were 12- to 17-year-old juvenile offenders and their families, referred from the local Department of Juvenile Justice office and randomly assigned to receive either MST (n=92) or IT (n=84). Twenty-four families refused services. The juvenile offenders were involved in extensive criminal activity as evidenced by their average of 4.2 previous arrests and the fact that 63 percent had been incarcerated previously. The average age of the youths was 14.8 years, with 67 percent male. Seventy percent were white, 30 percent African-American. Sixty-five percent were from families characterized by low socioeconomic class, and 53 percent lived with two parental figures. Standardized assessment batteries were conducted at pretreatment and posttreatment.

Outcome

The results of the Simpsonville study showed that MST was effective at reducing rates of criminal activity and institutionalization. At the 59-week postreferral follow-up, youths receiving MST had significantly fewer rearrests and weeks incarcerated than did youths receiving usual services. At posttreatment, youths receiving MST reported a significantly greater reduction in criminal activity than did youths receiving usual services. Families receiving MST reported more cohesion, whereas reported family cohesion decreased in the usual services condition. Further, families receiving MST reported decreased adolescent aggression with peers, while such aggression remained the same for youths receiving usual services. Significantly, the relative effectiveness of MST was not moderated by demographic characteristics (e.g., race, age, social class, gender, and arrest and incarceration history). Similarly, preexisting problems in family relations, peer relations, social competence, behavior problems, and parental symptomatology were not differentially predictive of outcomes. Moreover, a 2.4-year follow-up (Henggeler et al., 1993) showed that MST doubled the percentage of youths who did not recidivate, in comparison with usual services.

In the second study, families receiving MST reported and evidenced more positive changes in their dyadic family interactions than did IT families at posttreatment. For example, MST families reported increased cohesion and adaptability and showed increased supportiveness and decreased conflict–hostility during family discussions, in comparison with IT families. Most important, results from a 4-year follow-up of recidivism showed that youths who received MST were significantly less likely to be rearrested than youths who received individual therapy. MST completers (n=77) had lower recidivism rates (22.1 percent) than MST dropouts (46.6 percent; n=15), IT completers (71.4 percent; n=63), IT dropouts (71.4 percent; n=21), and treatment refusers (87.5 percent; n=24). Moreover, MST dropouts were at lower risk of rearrest than IT completers, IT dropouts, and refusers. In addition, MST youths were less likely to be arrested for violent crimes (e.g., rape, attempted rape, sexual assault, aggravated assault, assault/battery) following treatment than were IT youths. Neither adolescent age, race, social class, gender, nor pretreatment arrest history moderated the effectiveness of MST.

Risk Factors

Individual

- Anti-social behavior and alienation/Delinquent beliefs/General delinquency involvement/Drug dealing
- Early onset of aggression and/or violence
- Favorable attitudes toward drug use/Early onset of AOD use/Alcohol and/or drug use
- Mental disorder/Mental health problem/Conduct disorder

Family

- Family history of the problem behavior/Parent criminality
- Family management problems/Poor parental supervision and/or monitoring
- Poor family attachment/Bonding

School

- Low academic achievement

Peer

- Association with delinquent and/or aggressive peers

Protective Factors

Individual

- Perception of social support from adults and peers

Family

- Effective parenting
- Good relationships with parents / Bonding or attachment to family

School

- Student bonding (attachment to teachers, belief, commitment)

Peer

- Good relationships with peers
- Involvement with positive peer group activities

Endorsements

- OJJDP: Blueprints
- SAMHSA: Model Programs
- OJJDP/CSAP: Strengthen Families
- HHS: Surgeon General

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Contact

Marshall E. Swenson

MST Services

710 J. Dodds Boulevard

Mount Pleasant, SC 29464

Phone: (843) 856-8226

Fax: (843) 856-8227

E-mail: marshall.swenson@mstservices.com

Web site: <http://www.mstservices.com>

(This is the program Darren Carver uses in Utah, and recommends.)

MRT® - What is it? Why use it?

What is MRT®?

Moral Reconciliation Therapy (MRT®) was one of the first comprehensive, systematic attempts to treat substance abusing offenders from a purely cognitive behavioral perspective. In 1985 formal MRT® was developed by Dr. Greg Little and Dr. Ken Robinson by combining Smothermon's concepts with theories of moral development (Kohlberg), ego and identity development (Erikson), behavioral conditioning, Maslow's needs hierarchy, and Carl Jung's concepts.

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.

Briefly, 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.

MRT® focuses systematically on seven basic treatment issues: confrontation of beliefs, attitudes and behaviors, assessment of current relationships, reinforcement of positive behavior and habits, positive identity formation: enhancement of self-concept, decrease in hedonism and development of frustration tolerance, and development of higher stages of moral reasoning.

Training

- Moral Reconciliation Therapy - 32 hours

Family Integrated Transitions (FIT)

Intervention:

The Family Integrated Transitions (FIT) program provides integrated individual and family services to juvenile offenders who have mental health and chemical dependency disorders during their transition from incarceration back into the community. The goals of the FIT program include lowering the risk of recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health of the youth, and increasing prosocial behavior.

FIT is based on components of three programs: multisystemic therapy (MST), dialectical behavior therapy (DBT), and motivational enhancement therapy (MET). The overarching framework of FIT is derived from MST, a preservation model for community-based treatment. This treatment component uses therapists to coach caregivers in establishing productive partnerships with schools, community supports, parole, and other systems and help caregivers develop skills to be effective advocates for those in their care. While the MST component concentrates on the extent to which environments around the youth support prosocial behavior, FIT incorporates elements of DBT to address individual-level characteristics by replacing maladaptive emotional and behavioral responses with more effective and skillful responses. Finally, FIT uses aspects of MET to engage youths in treatment, with the objective of increasing their commitment to change. FIT therapists use MET techniques to develop the initial engagement of all parties and to maintain the commitment throughout the treatment.

The FIT program begins in a youth's final 2 months in a Juvenile Rehabilitation Administration (JRA) facility and continues for 4 to 6 months during parole supervision. The FIT team consists of contracted therapists, including children's mental health specialists and chemical dependency professionals. The FIT team serves four to six families at any given time. Services are available 24 hours a day, 7 days a week. JRA is responsible for identifying eligible youths and works closely with the therapists and FIT families. To be eligible for the youth program a youth must be under 17½, be in a JRA institution and scheduled to be released to 4 or more months of parole, reside in one of four designated Washington State counties (King, Kitsap, Pierce, or Snohomish), have a substance abuse or dependence disorder and any of the following: any Axis 1 disorder, a currently prescribed psychotropic medication, or demonstrated suicidal behavior within the last 3 months.

Evaluation Methodology:

This evaluation used a quasi-experimental design. The sample included 104 youths who participated in FIT and served as the treatment group. The control group included 169 FIT-eligible youths who did not participate in FIT because they returned to counties where the project was unavailable; this group received usual JRA parole services. Since the study did not use random assignment, logistic regression was used to determine any significant differences between groups. There were no significant differences for gender, age at release, Native American ethnicity, age at first prior conviction, prior drug convictions, criminal history, or prior person (violent) convictions. However, there were significant differences on four variables: ISCA risk assessment scores, African-American ethnicity, Hispanic ethnicity, and the degree to which a county was either urban or rural. The ISCA is JRA's tool that measures an offender's overall risk for re-offense. Treatment group participants were more likely to be African-American and less likely to be Hispanic. This was expected because the counties that were eligible for the FIT program were more urban, more and ethnically black, and less Hispanic than the non-FIT counties. This evaluation compared the recidivism rates of both the treatment and control groups to determine program effects.

Evaluation Outcome:

The evaluation found that the FIT program has a statistically significant effect on the felony recidivism rate. At 18 months postrelease, the felony recidivism was 34 percent less for FIT youth (27 percent) than for the comparison group (41 percent). However, there was no significant effect on the total recidivism rate (including felony or misdemeanor reconvictions), though the results are in the direction of lowering this rate. There was also no significant effect on the violent felony recidivism rate (which is usually a relatively rare event in the 18-month follow-up period), though the results are in the direction of lowering this rate as well. A cost–benefit analysis of the FIT program indicated that for every \$1.00 spent on FIT, \$3.15 is saved in criminal justice expenses and avoided criminal victimization.

References:

Aos, Steve. 2004. *Washington State's Family Integrated Transitions Program for Juvenile Offenders: Outcome Evaluation and Benefit–Cost Analysis*. Olympia, Wash.: Washington State Institute for Public Policy.

Lifeskills '95

Intervention:

Lifeskills '95 is a curriculum-based parole reentry program designed to treat high-risk chronic offenders postrelease by helping them cope with the problems of everyday life. The program reinforces small successes while addressing a chronic offender's fears of the real world. The approach used by Lifeskills '95 is based on six programmatic principles believed to help with reintegration:

1. Improve the basic socialization skills necessary for successful reintegration into the community.
2. Significantly reduce criminal activity in terms of amount and seriousness.
3. Alleviate the need for or dependence on alcohol or illicit drugs.
4. Improve overall lifestyle choices (social, education, job training, and employment).
5. Reduce the individual's need for gang participation and affiliation as a support mechanism.
6. Reduce the high rate of short-term parole revocations.

The treatment consists of 13 consecutive weekly meetings that concentrate on different coping

skills: 1) Program Introduction, 2) The “Pit”—Dealing With Your Emotions, 3) Unmanageability, 4) Denial, 5) The Problem of Thinking You Can Do It Alone, 6) “Letting Go,” 7) Perceptions, 8) Expectations, 9) Reality, 10) Love, 11) Family Dynamics, 12) Living With Addiction, 13) Continuous Practice. The meetings last 3 hours. The first 1½ are used for lectures, the last 1½ for group discussion. Participants may begin the program during any point in the curriculum.

Evaluation Methodology:

The program was evaluated using a quasi-experimental design with a nonrandomized treatment and a control group. The two groups were made up of parolees released from a secured facility between Feb. 1 and Dec. 31, 1995, who were assigned to the California Youth Authority’s Inland Parole Office. If a juvenile reported a residence that was within a 25-mile radius of the Inland Parole Office at the time of release, the youth was placed in the treatment group. If the address was beyond the 25-mile radius, the youth was in the control group. Coincidentally, n=115 for both the treatment and the control group. The overwhelming majority of participants were male—97.4 percent in the treatment group and 95.7 percent in the control group. The average ages were 20.0 and 20.2, respectively. The treatment group was 40.9 percent African-American, 39.1 percent Hispanic, and 14.8 percent white. The control group was 50.4 percent Hispanic, 24.3 percent African-American, and 20.0 percent white. The treatment group was required to attend all 13 Lifeskills ’95 classes, while the control group was not.

Data was collected through semistructured interviews and surveys of parolees, treatment facilitators, and parole agents. Random drug tests were also performed. Data was collected three times: 1) the 1st week after release, 2) after the treatment was complete (3 months after release), and 3) at the end of the evaluation period (Feb. 28, 1996). During this analysis, n=106 for the treatment group and nine parolees became involved in an additional program and were removed from the sample.

Evaluation Outcome:

Ninety days after release from secure confinement, control group youths were twice as likely as the experimental group to have been rearrested, to be unemployed and to lack the resources necessary to find and maintain a job, to have a poor attitude toward working, and to have frequently abused drugs or alcohol. Control group youths were three times as likely to associate with former gang members, to have “serious problems” with family relationships, to be unresponsive and negative in their commitments to parole, and to associate almost exclusively with negative, unfavorable peer groups.

A year after the evaluation began, the results were just as favorable for the Lifeskills ’95 program. The control group youths were twice as likely as the experimental group to have one or more arrests, to be associated with negative peer groups, and to be unemployed without means of financial support. They were also twice as likely to have failed in their parole, meaning they had their parole revoked owing to a technical or criminal violation, were in jail awaiting a new criminal charge, were in temporary detention awaiting a revocation hearing, or they were missing. Control group youths were three times as likely as experimental group youths to continue their abuse of drugs.

All of these findings were significant.

References:

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SAFE-T

Intervention:

The Sexual Abuse, Family Education, and Treatment (SAFE-T) Program is a specialized, community-based program that provides sexual abuse-specific assessment, treatment, consultation, and long-term support to 1) child victims of incest and their families, 2) children with sexual behavior problems and their families, and 3) adolescent sexual offenders and their families.

The program is initiated with a comprehensive clinical and psychometric assessment that assists in the development of individualized treatment plans for each offender and family. Although the course of treatment depends on the clinical need, availability, and willingness of family members, offenders are typically involved in concurrent group, individual, and family therapy. SAFE-T uses a repertoire of cognitive-behavioral and relapse prevention strategies. Related treatment goals include the enhancement of social skills, self-esteem, body image, appropriate anger expression, trust, and intimacy.

Evaluation Methodology:

The evaluation of the program used a quasi-experimental design with nonequivalent comparison groups. The sample included all 148 adolescent sexual offenders (139 males and 9 females) assessed at the SAFE-T Program between 1987 and 1995. The offenders were ages 12 to 19 at the point of initial contact. Fifty-eight youths were assigned to the treatment group and received at least 12 months of specialized treatment at SAFE-T. Ninety youths were assigned to the comparison group and received only an assessment (n=46), refused treatment (n=17), or dropped out before 12 months (n=27). The follow-up period ranged from 2 to 10 years.

Offenders completed a battery of psychological tests to provide standardized data regarding social, sexual, and family functioning. The tests include the Assessing Environments Scale, the Tennessee Self-Concept, the Youth Self-Report, the Beck Depression Inventory, the Buss Durkee Hostility Inventory, the Socialization Scale for the California Psychological Inventory, and the Multiphasic Sex Inventory–Juvenile Male Research Edition. The study also employed data from the Canadian Police Information Center. Criminal charges were used as the dependent measure. Limitations of the study include 1) a lack of random assignment, 2) an exclusive concentration on official data to estimate recidivism, and 3) the inability to isolate the specific intervention that caused success in each offender.

Evaluation Outcome:

The evaluation results support the efficacy of SAFE-T for reducing the risk of adolescent sexual recidivism. Relative to the comparison group, there was a 72 percent reduction in sexual recidivism for adolescents completing at least 12 months of assessment and treatment. Further, although previous research had found that many treated sexual offenders are likely to be charged with subsequent sexual offenses, participation in the SAFE-T program was associated with a 41 percent reduction in violent nonsexual recidivism and a 59 percent reduction in nonviolent offending.

References:

Worling, James R., and Tracey Curwen. 2000. "Adolescent Sexual Abuse Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction." *Child Abuse and Neglect* 24(7): 965–82.

The following is a program Darren Carver recommended for sexually abuse girls:

Trauma-Focused Cognitive Behavioral Therapy

INTERVENTION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

Page 2

SAMHSA Model Programs • <http://model>

INTENDED POPULATION

TF-**CBT** was designed for children 3 to 18 years old who have developed significant emotional or behavioral difficulties following exposure to a traumatic life event. It has been adapted for use in children exposed to events such as traumatic loss of a loved one, physical abuse, domestic and community violence, motor vehicle accidents, fires, tornadoes and hurricanes, industrial accidents, and terrorist attacks. The boys and girls tested came from all socioeconomic backgrounds, have lived in a variety of settings (with parents, other relatives, foster placements, group homes, residential treatment facilities), and came from diverse ethnic groups. TF-**CBT** has been adapted for Hispanic/Latino children, and some of its assessment instruments are available in Spanish.

BENEFITS

- Develops adaptive skills for dealing with stress
- Decreases children's anxiety about thinking or talking about the event
- Enhances accurate and helpful cognitions
- Enhances children's personal safety skills
- Resolves parental distress about the child's experience
- Enhances parental support for their children
- Prepares children to anticipate and cope with traumatic and loss reminders

HOW IT WORKS

Traumatized children may develop extreme fear of anything that reminds them of the traumatic event. This can lead to avoidance of traumatic reminders and extreme emotional and physiological guardedness. Whether or not children have PTSD, these symptoms can significantly interfere with their ability to function and develop optimally. TF-**CBT** helps children talk directly about their traumatic experiences in a supportive environment

where they can become less fearful, less avoidant, and more able to tolerate **trauma**-related thoughts and feelings. This treatment model also teaches children how to examine their thoughts, feelings, and behaviors and how to change these in order to feel better. It also provides children with tools such as relaxation and deep-breathing techniques, problem solving, and safety education to help them manage stressful situations in the future.

A parental treatment component is an important element of TF-**CBT**. With it, parents are assisted in—

- Exploring their own thoughts and feelings about the child’s experience and resolving their personal **trauma**-related distress
- Learning effective parenting skills
- Providing optimal support to their children

Several child-parent sessions are included in the TF-**CBT** intervention, during which the child is encouraged to discuss the traumatic experience

directly with the parent, and both parent and child learn to communicate questions, concerns, and feelings more openly. This intervention is typically provided in outpatient mental health facilities but has been used in hospital, group home, school, community, and in-home settings.

IMPLEMENTATION ESSENTIALS

For successful replication of TF-**CBT**, it is highly desirable that the child’s parent or primary caretaker is available to participate in treatment. Audio-taping treatment sessions, for TF-**CBT**-trained supervisors to review and provide feedback to staff, is also helpful.

Private therapy rooms are required for this intervention, along with drawing and writing supplies, psychoeducational books (a reference list can be provided and site staff can order books appropriate to their clients), and handouts provided with the *TF-**CBT** Treatment Manual*. Other program components that are essential to the successful replication of TF-**CBT** include:

Staff Selection and Training

Staff should be experienced in evaluating and treating a variety of child and adolescent mental health problems. Staff must receive specific 1- to 3-day training with TF-**CBT** treatment manuals they will use.

Program Materials

The TF-**CBT** program offers treatment manuals that address specific types of **trauma** events including ***CBT** Treatment Manual for Traumatic Bereavement*; ***CBT** Treatment Manual for Children* (individual treatment); *Traumatic Bereavement **CBT** Group Treatment Manual for Children*. A “Treatment of **Trauma** in Children” audiotape is also available. Use of pre- and posttreatment assessment instruments to monitor treatment outcome also is important.

Client Identification

Childhood PTSD is underrecognized and undertreated, and most outpatient facilities already see traumatized children without recognizing this should be an important treatment focus. It is the implementer’s responsibility to develop methods to identify and recruit children with significant **trauma**-related difficulties who can attend 12 to 16 weekly treatment sessions. The *TF-**CBT** Training Guide* includes a component on how to identify and screen children in general clinical populations for **trauma** exposure and

PTSD symptoms.

PROGRAM BACKGROUND

TF-**CBT** was originally developed and tested for sexually abused boys and girls, ages 3 to 14, and their nonabusive parents. Many of these children had sexualized behaviors as well as other behavioral problems, anxiety, depression, and problematic attributions about the abuse. Although these children were from diverse socioeconomic backgrounds, most were from poor or working class urban or rural families and primarily White and

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African American. TF-**CBT** was developed and tested at the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents, in Pittsburgh, PA, with grants from the U.S. Department of Health and Human Services' National Institute of Mental Health and National Center for Child Abuse and Neglect, and the Department of Justice Office for Victims of Crime, the Allegheny-Singer Research Institute, and the Jewish Healthcare Foundation of Pittsburgh.

TF-**CBT** is currently being modified and disseminated for use in broader community settings through the National Child Traumatic Stress Initiative network, which is funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration. Numerous therapy and treatment elements have been incorporated into the design of the TF-**CBT** model, in hopes of avoiding some of the long-term negative effects of child traumatic stress such as increased risk of substance abuse, suicide attempts, relationship difficulties, smaller brains, and lower IQs.

EVALUATION DESIGN

Evaluation of TF-**CBT** has included both open treatment studies, which evaluated pre- to posttreatment improvement, and randomized controlled trials where children were randomly assigned to receive either TF-**CBT** or nondirective play therapy, where the child or parent is empowered to direct the treatment process and content (children 3 to 7 years old), or supportive therapy (children 8 to 14 years old). The latter studies have treated over 500 sexually abused children, including a multisite study that has been conducted in conjunction with Dr. Esther Deblinger of the Center for Children's Support, University of Medicine and Dentistry of New Jersey.

TF-**CBT** is currently being evaluated in a randomized clinical trial for children who experienced traumatic loss as a result of terrorism. This trial is being conducted by Drs. Elissa Brown and Robin Goodman at the New York University Child Study Center. Evaluation in both open and randomized treatment trials has included multiple domains (PTSD, depression, anxiety, behavioral problems; school, family, and social functioning), multiple reporters (child, parent, teacher, therapist, independent evaluator ratings), and assessment of moderating and mediating factors in treatment response.

PROGRAM DEVELOPERS

Judith A. Cohen, M.D.

Anthony P. Mannarino, Ph.D.

Dr. Cohen and Dr. Mannarino have served as principal investigators on 12 grants resulting in the development, testing, and dissemination of the TF-

CBT treatment model. Together they direct the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents in Pittsburgh, PA. Dr. Cohen is a Board-certified child and adolescent psychiatrist and professor of psychiatry at Drexel University College of Medicine. She is the principal author of the *Practice Parameters for the Assessment and Treatment of Children with PTSD* published by the American Academy of Child and Adolescent Psychiatry. Dr. Mannarino is a clinical child psychologist, professor of psychiatry at Drexel University College of Medicine, and chairman of the Department of Psychiatry at Allegheny General Hospital. Drs. Cohen and Mannarino have both served on the Board of Directors of the American Professional Society on the Abuse of Children and have published and taught extensively regarding the assessment and treatment of traumatized children.

CONTACT INFORMATION

To obtain information on training, research, evaluation or technical assistance, contact:
The Center for Traumatic Stress in Children and Adolescents

Department of Psychiatry
Allegheny General Hospital
4 Allegheny Center, 8th Floor
Pittsburgh, PA 15212
Phone: (412) 330-4328
Fax: (412) 330-4377
E-mail: jcohen1@wpahs.org

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S.
Department of Health and Human Services
Betty Elmer Award—Family Resources of Pittsburgh (Drs. Cohen and Mannarino)
Greater Pittsburgh Psychological Association
Legacy Award (Dr. Mannarino)
Outstanding Professional Award—American Professional Society on the Abuse of Children (Dr. Cohen)

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