# Families of Incarcerated Youth Evaluation
# Arizona Department of Juvenile Corrections
# Annual Evaluation Report

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# Executive Summary

In 2004, the Arizona Department of Juvenile Corrections (ADJC) Families of Incarcerated Youth initiative was funded by the Arizona Parents Commission on Drug Education and Prevention. The Families of Incarcerated Youth initiative seeks to create a total family concept for youth and families involved with ADJC. Congruent with the Parent's Commission mandate, the Families of Incarcerated Youth initiative aims to increase and enhance parental involvement and increase youth and parent education about the risks associated with substance abuse. The primary goals of the Families of Incarcerated Youth initiative are to increase parental involvement and improve family functioning. The five major elements of the initiative are to:

1. Train staff and implement best practices and proven models of family-focused treatment programs
2. Provide family education, training, and incentives
3. Implement assessment tools for identifying family strengths and evaluating family functioning
4. Employ the use of family liaisons to more effectively help families navigate the system and get the services they need
5. Participate in an evaluation of family-focused treatment programs

To help assess the Families of Incarcerated Youth initiative, the Governor's Division for Substance Abuse Policy contracted with LeCroy & Milligan Associates, Inc. in 2005 to perform a program implementation and outcome evaluation. The evaluation effort focuses principally on evaluating one element of the Families of Incarcerated Youth initiative: the use of family-focused treatment programs. ADJC currently utilizes two family-focused treatment programs, Functional Family Therapy (FFT) and Multisystemic Therapy (MST), both of which are model programs found to be effective in reducing adolescent delinquency, violent crime, and substance abuse (Alexander, Pugh, Parsons & Sexton, 1998; Henggeler, 1998).

Established in 1969, Functional Family Therapy (FFT) is an outcome-driven family prevention and intervention program that targets youth, between the ages of 11 and 18, and their families. FFT is a short-term, home-based intervention with an average of 8 to 12 one-hour sessions for mild cases and up to 26 hours of direct service for more difficult cases. Sessions are typically spread out over a 90-

day period. FFT therapists are typically master's level counselors with an average caseload of 12 to 16 families. FFT has been adopted in a number of contexts due to its clear identification of phases. The phases consist of: 1) Engagement and Motivation; 2) Behavior Change; and 3) Generalization; each phase includes descriptions of goals, essential therapist characteristics, and specific intervention techniques (Alexander et al., 1998). During the initial phases, FFT applies reframing to impact negativity within the family with the goal of decreasing resistance and hopelessness and increasing openness to treatment. After the initial phases, FFT applies techniques to enhance behavior change and improve youth and family ability to generalize skills and resources to other areas of life. Fidelity to the FFT model is crucial to the program's success. Treatment fidelity is overseen by FFT Inc. and is achieved through a specific training protocol, oversight and supervision by FFT supervisors and experts, and a sophisticated client assessment, tracking, and monitoring system (CSS, Clinical Services System) that provides for specific clinical assessment and outcome accountability.

Developed in the late 1970s, Multisystemic Therapy (MST) is an intensive family- and community-based treatment approach that addresses the multiple known determinants of serious antisocial behavior in juvenile offenders including individual, family, peer, school, and community factors. MST interventions aim to lessen risk factors by building youth and family strengths. 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" (Henggeler, 1998: 8). MST targets male or female juvenile offenders, ages 12 to 17, who are at a high risk of out-of-home placement, and their families. MST interventions aim to enhance caregiver discipline practices, improve family relationships, decrease youth association with negative peers, improve academic performance, and empower youth and families (Henggeler, 1998). Like FFT, MST is delivered in the youth's natural environment (e.g., home, community) and is family driven, not therapist driven. MST is similar to FFT in other ways but MST places more attention on factors in the youth and family's social network that are linked to antisocial behavior. MST is also more time intensive; for instance, MST delivers several hours of treatment per week and ranges from three to five months in duration. As with FFT, treatment fidelity is critical to achieving desired clinical outcomes; accordingly, intensive quality assurance protocols are built into all MST programs. The quality assurance system includes an initial

week long training, ongoing training of clinical and supervisory staff, ongoing feedback to the therapist from the supervisor and a MST expert consultant, feedback from caregivers involved with MST, and quarterly on-site training boosters. MST aims to maximize successful clinical outcomes by providing multiple layers of clinical and programmatic support and feedback (Henggeler, Melton, Brondino, Scherer & Hanley, 1997).

The first phase of the evaluation effort by LeCroy & Milligan Associates focused on the implementation of the family-focused treatment programs. Evaluation activities included the development of an evaluation plan, development of data collection surveys and interviews, completion of key informant interviews, and a comprehensive review of existing program documents/materials and literature on the family-based therapy programs.

Much of the information contained in this report was collected through qualitative methods, specifically key stakeholder interviews. Data from Touchstone, Tumbleweed, and Pima Prevention Partnership was also gathered and used for reporting on the prevalence and completion status of ADJC referred youth/families. The above-mentioned data sources were supplemented by literature sources, including previous evaluations, and existing program documents. These sources provided a comprehensive understanding of the FFT and MST treatment programs, including treatment goals and phases, target populations, assessment foci, requisite therapist characteristics, therapist training, and quality assurance training and monitoring components that promote treatment fidelity. Information collected was also supplemented with telephone calls, emails, or meetings with key individuals for clarification or confirmation purposes.

The purpose of this report, the first in a series of annual evaluation reports, is to present program implementation, or process, evaluation findings related to the start up of the FFT and MST programs. The report covers the time period of January 2005 (when the Parents Commission funding was reported to have started) through June 2006. This report begins with an overview of the family therapy program models. Information about the family-therapy program providers is also presented, along with program implementation findings (i.e., information on target populations, recruitment and referral processes, preliminary data on youth and families participating in FFT and MST, and

descriptive information on treatment duration, engagement and retention). Programmatic recommendations are also discussed.

Prevalence and distribution information about youth and families participating in FFT and MST was collected and reported. There were 174 youth referred for FFT (a total of 15 cases were never opened) and 42 youth/families referred for MST services (however, 10 referrals were never started). Among all FFT participants whose treatment was initiated, 42% successfully completed treatment. Approximately 50% of youth served by Touchstone, 37% of those served by Tumbleweed, and 24% served by Pima Prevention Partnership completed treatment successfully. Thirteen of the 32 open MST cases successfully completed treatment (41%).

Results from the implementation evaluation revealed positive viewpoints towards the use and value of FFT and MST treatment programs. ADJC staff who participated in meetings and interviews with LeCroy & Milligan Associates expressed satisfaction with the programs and their experiences with treatment providers. Moreover, ADJC staff did not fault the programs for treatment failure but rather attributed failure as a product of the youth and family. Often, it was suggested that youth and their families failed to try therapy, gave up, or were never open or amenable to change.

Evaluation findings provided insight on the implementation and processes of the family therapy programs. While therapists and ADJC staff suggested that FFT and MST are underutilized, youth who were referred to such programs were deemed appropriate. For most, the current referral process works, although there were several recommendations for starting FFT/MST services earlier (e.g., before a youth is released from secure care) and making the referral process within ADJC less "confusing" and "frustrating." Program processes also appeared in compliance with those recommended and/or required by the FFT and MST program creators (e.g., treatment duration, frequency, caseload size).

It is also important to note the quality assurance protocols both therapy programs required as part of being certified FFT and MST sites. FFT and MST sites were required to adhere to the treatment models, and treatment integrity was guaranteed through systematic supervision, monitoring, and tracking. Performance monitoring data was collected by the programs and the program's

creators required use of standard assessment tools which they provided and analyzed, with results reported back to the provider.

There were some program impediments and barriers identified that cut across the various treatment programs. These included:

- Underutilization of the family-therapy programs
- Lack of FFT and MST services statewide
- Inconsistent and delayed referral processes
- Communication barriers
- Negative reactions to treatment by families
- Program-related impediments including utilization of multiple interventions in conjunction with FFT/MST, lack of bilingual treatment staff, and program turnover

Several recommendations surfaced which are based on the implementation impediments/challenges. Recommendations include:

- Enhancing the availability of aftercare services for youth on parole, specifically FFT and/or MST and particularly among youth in rural areas;
- Exploring opportunities for FFT and MST therapists to initiate services earlier (i.e., while a youth is in secure care) so they can help transition the youth in a more efficient manner;
- Investigating opportunities for simplifying the internal ADJC referral process;
- Continuing collaboration between treatment providers and ADJC including frequent and timely interagency communication;
- Exploring strategies for ensuring a “blame free” referral process in which families are aware of their therapy referral; and
- Encouraging the hiring of qualified and culturally competent therapy staff.

The evaluation strategy that will be employed during the coming year is to focus principally on the outcome evaluation. The outcome evaluation will address some intermediate outcomes such as changes in recidivism, substance abuse, academic performance of juveniles, and parent-child relationships.

# Introduction

The Arizona Department of Juvenile Corrections (ADJC) is implementing the Families of Incarcerated Youth initiative that the Arizona Parents Commission on Drug Education and Prevention is funding. The Families of Incarcerated Youth initiative seeks to create a total family concept for youth and families involved with ADJC. Congruent with the Parent's Commission mandate, the Families of Incarcerated Youth initiative aims to increase and enhance parental involvement and increase youth and parent education about the risks associated with substance abuse. The goals of the initiative are to increase parental involvement and improve family functioning, reduce recidivism, and increase community safety. To accomplish these goals, ADJC is working to:

- Educate, train staff, and implement best practices and proven models of family-focused treatment programs [i.e., Functional Family Therapy (FFT) and Multisystemic Therapy (MST)]
- Provide treatment, counseling, and parenting education and training to families
- Place family liaisons at each ADJC safe school to provide information, advocacy, and support to families
- Create and implement Child and Family Teams
- Implement assessment tools to evaluate family strengths and needs
- Participate in an evaluation of the use of family-focused treatment programs

LeCroy & Milligan Associates, Inc. was contracted by the Governor's Division for Substance Abuse Policy (GDSAP) to conduct an evaluation of the family-focused treatment programs that are part of the broader initiative. The purpose is to aid GDSAP and ADJC in assessing key activities related to the implementation of family-focused treatment services, more specifically the incorporation, use, and impact of FFT and MST programs. In designing the evaluation, LeCroy & Milligan Associates incorporated process and outcome features to describe the following:

- Program characteristics
- Implementation and program fidelity
- Demographic data on level of participation and characteristics of participating families
- Demographic data on treatment providers
- Participant satisfaction with family therapy programs
- Baseline assessments of ADJC staff and parents of incarcerated youth regarding their attitudes toward parental involvement
- Impact of FFT and MST on knowledge, attitudes, and intentions regarding parent-child relationships and their impact on recidivism

## Evaluation Strategy

The evaluation of the Families of Incarcerated Youth initiative is designed to inform administrators and program staff about the implementation (process) and impacts (outcomes) of the initiative, specifically the implementation and impact of family-focused treatment programs. A broad perspective has been employed to encompass process and outcome measures that are basic to determining program impacts.

Throughout the three-year evaluation period, several qualitative and quantitative evaluation methods will be used to develop an emerging and comprehensive assessment of program impacts and to make recommendations for program improvements. Data collection methods include interviews with key informants, surveys, case studies, pre- and post-treatment assessments, literature reviews, and reviews of existing data and program documents and materials.

The pace of the evaluation has been dependent upon the progress made within ADJC on implementing their initiative. An evaluation of the impacts of family education and training requires that these programs are in place and being administered to families. Because this initiative is part of a much broader five-year strategic plan designed to address issues related to organizational culture and the continuum of services, ADJC has experienced some delays in implementing the initiative. As a result, the evaluation was organized so that it would occur in phases beginning with a process evaluation in FY2006. The evaluation questions addressed by the process evaluation are provided to Table 1 below. The outcome evaluation will take place in FY2007.

**Table 1: Process Evaluation Questions**

1. What family-focused treatment models and components are being utilized in the Families of Incarcerated Youth initiative?
2. Which providers are implementing programs?
3. What are the characteristics of staff providing family-focused treatment services to ADJC involved families?
4. What are the average caseload ratios of staff providing FFT and MST services? Are the ratios within the best practices guidelines?
5. What methods of quality assurance are used in FFT and MST?
6. What is the target population for FFT and MST?
7. How are families recruited and referred to FFT and MST?
8. How do families become engaged and retained in FFT and MST?
9. What components imply successful completion of the therapy programs?
10. How many families participated in family therapy programs? How many families complete the therapy programs?
11. What have been the impediments to program implementation?

***Data Collection and Analysis Methods***

Data were collected for the process evaluation using three primary methods:

- *A literature review,* which included overviews of the FFT and MST therapy programs, model descriptions, and previous evaluation findings

- A review of *program documents and materials* including training manuals, program brochures, existing data collection forms, and descriptive information on youth and family participants

- *Key informant interviews* with FFT and MST therapists and ADJC parole officers. Meetings with ADJC Community Corrections administrators also helped inform evaluation results, primarily through clarification or confirmation purposes.

Interviews were conducted at FFT and MST provider offices and by phone. Questions focused on the criteria for FFT/MST program referral, the referral and communication processes, overview of the therapy models and goals, descriptive

implementation components, and assessment tools/information. A total of 18 individuals participated in the interviews, including:

- 8 therapists providing FFT treatment services to ADJC involved youth and families, including supervisory level staff
- 4 therapists providing MST treatment services to ADJC involved youth and families
- 6 ADJC parole officers

A structured interview guide was used for all interviews. The guide was adapted to address the different experiences of the different staff positions.

Data from Touchstone, Tumbleweed, and Pima Prevention Partnership was gathered and used for reporting on the prevalence and completion status of ADJC referred youth/families. Information was collected from the inception of the Parents Commission funding in January 2005 through June 2006. Over this time, 174 youth were referred for FFT treatment services while 42 youth and families were referred for MST services.

Given that the Families of Incarcerated Youth initiative is part of a five-year strategic plan, progress on the evaluation has been largely dependent upon progress made within ADJC on implementing their initiative. In early evaluation meetings between LeCroy & Milligan Associates and ADJC staff, ADJC expressed interest in collecting qualitative data from staff and parents of incarcerated youth regarding their attitudes toward parental involvement. The findings were to be used as a benchmark to measure progress in improving attitudes and increasing receptiveness to parental involvement (it also allowed for time for the therapy programs to be implemented before undertaking the process evaluation). The baseline assessments were slated to be the first phase of the evaluation. The parent survey, which was designed after these initial meetings, was put on hold so that ADJC Research and Development could administer their own parent survey. Due to some internal impediments (i.e., staff turnover), ADJC has experienced some delays in administering their parent survey. The staff survey is expected to be administered early in FY2007 and will be included in next year's evaluation report.

Accordingly, data available is somewhat limited. To date, evaluation efforts have concentrated on tracking the progress of the Families of Incarcerated Youth

initiative, researching and preparing for the baseline assessments, and preparing for the process and outcome evaluation of FFT and MST. The upcoming year will concentrate on answering process questions that current data is unable to answer (e.g., descriptive data on FFT and MST program participants) and other related process questions that were not included in this year's report (i.e., participant satisfaction, implementation of family liaisons). Furthermore, the outcome evaluation of the family-therapy programs will be the core of the evaluation effort.

## Report Purpose and Organization

The purpose of this report, the first in a series of annual evaluation reports, is to present program implementation, or process, evaluation findings related to the start up of the FFT and MST programs. This report describes how FFT and MST services have been implemented by addressing the major process questions presented in Table 1 above.

The remainder of the report describes results from the process evaluation. It is organized into the following major sections:

- *Overview of the Family Therapy Program Models*: Includes an overview of FFT and MST treatment programs.
- *Family-Therapy Program Providers:* Provides information about the contracted treatment providers; therapist characteristics; FFT and MST caseloads; and therapist oversight and treatment adherence.
- *Program Implementation*: Includes information about the target population; recruitment and referral process; the numbers of families served and completion status; treatment duration; treatment engagement, retention, and completion; and implementation challenges.
- *Summary*: Summarizes key evaluation findings and presents proposed recommendations.
- *Evaluation Plans for FY2007*

# Overview of Family Therapy Program Models

*Evaluation question addressed:* What family-focused treatment models and components are being utilized in the Families of Incarcerated Youth initiative?

ADJC has been utilizing two family-focused treatment programs: Functional Family Therapy (FFT), developed in Utah, and Multisystemic Therapy, designed in South Carolina and Missouri. FFT and MST are empirically validated, structured family-based interventions for adolescents with disruptive behavior problems (Alexander et al., 1998; Elliott, 1998; Henggeler, 1998). Both programs have been evaluated in rigorous, controlled trials and both have been shown to be effective practices in reducing juvenile offending and improving parent-child relationships. A description of each treatment model follows.

FFT and MST have been selected by the Centers for Disease Control and Prevention, the Center for the Study and Prevention of Violence, and the Office of Juvenile Justice and Delinquency Prevention as two of the few available "best practices" or "blueprints models" for the prevention and treatment of adolescent disruptive behaviors.

## Functional Family Therapy (FFT)

Functional Family Therapy (FFT), established in 1969, is an outcome-driven prevention and intervention program which has been applied successfully to a wide range of problem youth and their families (Alexander & Parsons, 1982). The program grew out of the need to supply at-risk adolescents and families that were underserved, had few resources, and were treatment resistant with individualized and comprehensive therapy services.

FFT is based on early family systemic and behavioral frameworks (Alexander et al., 1998). Interventions are meant to be tailored to the distinctive characteristics of each family and are delivered in a manner that is consistent with the capabilities of each family member (Barton & Alexander, 1977). Program developers recognize that for families to be successful in treatment, therapists must be culturally competent and understand why families are resistant to, and fail to become engaged in, treatment.

FFT can be administered by a wide range of interventionists including paraprofessionals under supervision, trained probation officers, mental health technicians, and degreed mental health professionals. Most FFT therapists are master's level mental health professionals but the criteria to hire varies from site to site (Alexander et al., 1998). A systematic training protocol is required for sites implementing FFT therapy programs. Training for receiving and maintaining site certification includes an initial 3-day clinical training, follow-up training and supervision, a clinical FFT externship for one member of the site (often assigned as the "clinical lead"), supervision consultations with FFT supervisors for the first two years of implementation, adherence to the FFT Assessment Protocol and use of the CSS (a web-based computer client tracking and monitoring system) (Alexander et al., 1998). Training of clinical staff is a critical component of the FFT process and includes a one-year training program consisting of the initial 3 day training, monthly supervision from an FFT supervisor, and three follow-up training courses. FFT team leaders undergo additional training including an externship in FFT while FFT supervisors complete the same training as FFT therapists and team leaders but also complete FFT supervision courses and receive supervision from a certified supervisor. Furthermore, regular supervision occurs which is used to monitor treatment integrity (Alexander et al., 1998).

Target populations include youth, ages 11 to 18, who are at-risk for or presenting problems such as conduct disorder, violent acting-out, and substance abuse. FFT requires 8 to 12 one-hour sessions for "mild" cases and up to 26 hours of direct service for more difficult cases (Alexander et al., 1998). In most programs, sessions are spread out over a 90-day period. Trained FFT therapists typically maintain a caseload of 10 to 12 families, with a recommended minimum of 5 families and a maximum of 16 families (Alexander et al., 1998: 48). According to FFT, full-time therapists can average 64 cases per year.

FFT has three specific intervention phases: Engagement and Motivation, Behavior Change, and Generalization.

FFT utilizes specific phases of treatment that allow therapists to maintain focus in the context of considerable family and individual disruption (Alexander & Parsons, 1982; Alexander et al., 1998). Each phase includes specific goals, assessment foci (used to understand the functional nature of problems within the family and to clarify goals and system relationships), essential therapist characteristics, and specific techniques of intervention.

The focus of early sessions is on implementing interventions that emphasize positive relational aspects of family interactions to disrupt negativity and blaming. In the first phase, *Engagement and Motivation*, therapists are instructed to point out ways in which each member's behaviors and beliefs represent positive aspects of family relationships. Therapists apply reframing techniques to maladaptive behaviors, perceptions, and beliefs in an attempt to decrease resistance, negative communication, and hopelessness, and increase alliance, trust, and motivation for change (Alexander et al., 1998). Although the ultimate goal of intervention in this phase is to create a context in which family members are willing to explore more adaptive ways of interacting with one another, the short-term motivation is to connect with family members in a way that ensures that they will continue attending therapy sessions (Alexander, 1988; Alexander & Parson, 1982).

The second phase of FFT is *Behavior Change*. This phase consists of "targeted interventions to help families function more competently through improvements in communication training, interpersonal relationships, parenting skills, discipline, problem solving, and conflict management" (Alexander et al., 1998: 17). Interventions provided in this phase emphasize positive communication and parenting with the ultimate goal of changing presenting negative behaviors and building positive relational skills. Therapists typically provide families with resources that help guide specific changes in behavior.

In the third phase, *Generalization*, FFT therapists work with families to help them maintain positive changes by instilling in them the skills to prevent relapse and helping them to incorporate community resources for support. Accordingly, final sessions are guided by family needs and their interaction with "multisystemic constraints and resources."

FFT Inc. oversees and supervises FFT implementation in community or agency settings (i.e., mental health clinics, juvenile courts, family preservation programs, family outreach centers). FFT maintains that therapist adherence to the treatment model is necessary in order to achieve participant success. Accordingly, FFT employs a comprehensive protocol that involves ongoing and accurate monitoring and tracking of model implementation. Treatment integrity is guaranteed through (Alexander et al., 1998):

- A review of progress notes to determine if therapists are pursuing the goals prescribed by the FFT treatment model
- Counseling process questionnaires – a 20-item instrument measuring client/family experiences in FFT which families complete after every other treatment session
- Weekly adherence and competence ratings which supervisors use to rate each FFT therapist on levels of model adherence and competence
- Global therapist rating instruments completed by FFT supervisors three times a year
- Working group feedback reports
- Video tape rating (reserved for cases where other methods of quality assurance indicate further assessment is necessary)

Monitoring and tracking is conducted through a web-based computer client system (CSS, Clinical Services System) which tracks session goals, conducts client assessments, and tracks clinical outcomes. The purpose of CSS is to increase therapist competence and skills by keeping therapists focused on the goals, skills, and interventions necessary for each phase of FFT (Alexander et al., 1998).

The data from numerous outcome studies suggest that when applied as intended, FFT can reduce recidivism by anywhere from 25% to 60% compared to randomly assigned or matched alternative treatment youth (Alexander et al., 1998). Evaluations of FFT have also demonstrated improvements in family communication and reductions in family defensiveness and in foster care placement referrals (Barton, Alexander, Waldon, Turner & Warburton, 1985). Furthermore, evaluations of FFT have demonstrated a positive effect on siblings by reducing the likelihood that younger children in the family will become involved in the juvenile justice system. Additional studies suggest that FFT is a cost-effective intervention that can reduce treatment costs to well below that of

traditional services and other family-based interventions (FFT costs range between $1,350 to $3,750 for an average of 12 home visits per family) (Alexander et al., 1998).

## Multisystemic Therapy (MST)

Multisystemic Therapy (MST) was developed in the late 1970s to address limitations of existing mental health services for juvenile offenders including high cost; narrow, individual focus; low therapist accountability; minimal effectiveness; and out-of-home centered facilities (i.e., outpatient clinics, residential treatment centers). The development of MST was informed by empirical evidence (i.e., Bronfenbrenner, 1979) that suggests that antisocial behavior is determined through the reciprocal interplay of the individual and his or her social environment including family, peer, school, and community contexts (Borduin, Mann, Cone, Henggeler, Fucci, Blaske, & Williams, 1995). MST views behavior problems as sustained by dysfunctional transactions within or between any one or a combination of these systems. Thus, the scope of MST interventions is not limited to the individual or the family system but also includes difficulties between other interconnected, extrafamilial systems (i.e., peer, school, and community)[1].

> 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."
>
> *Henggeler, 1998: 8*

The primary objectives of MST are to: 1) decrease rates of antisocial behavior; 2) improve family functioning; 3) achieve outcomes at a cost savings by reducing out-of-home placements; and 4) empower parents with the skills and resources

[1] Accordingly, one major difference between FFT and MST is related to the incorporation of extrafamilial systems. FFT does not typically address additional systems until after the family has begun to change (Alexander et al., 1998) whereas MST engages extrafamilial systems throughout the whole treatment process (Henggeler, 1998).

needed to effectively handle their child's behavior problems (Henggeler, 1998). For instance, MST interventions intend to (Henggeler, 1998: 7):

- enhance caregiver discipline practices;
- improve family relationships;
- reduce youth association with negative peers and amplify association with prosocial peers;
- improve youth academic performance;
- encourage youth involvement in prosocial activities;
- empower youth to cope with family and extrafamilial problems; and
- facilitate youth and families in developing a supportive network to help enact and maintain behavior change.

MST targets chronic, violent, and/or substance abusing juvenile offenders, ages 12 to 17, who are at high risk of out-of-home placement. Consistent with family preservation models of treatment delivery, services are targeted to those in highest need of intervention; family, rather than, therapist driven; delivered to the family as a whole; and provided in the context of the family's values, culture and beliefs (Henggeler, 1998). MST strives to promote behavior change in the youth's natural environment by flexibly scheduling interventions to meet family's needs and delivering interventions in the home or other community locations. The use of a home-based delivery of services helps overcome barriers to service access, increases family retention in treatment, and allows for the provision of intensive services.

MST is typically provided by master's level professionals with low caseloads (four to six families at one time) and 24 hours/day, seven days/week availability. The average treatment duration is three to five months, which includes about 60 hours of individualized, face-to-face therapist-family contact. The time-limited duration of treatment is used to promote efficiency, self-sufficiency, and cost effectiveness.

Given the complexity of the interventions, MST is operationalized through adherence to nine treatment principles (see Appendix A) and an intensive training regime overseen by MST Services, Inc. of Charleston, South Carolina (Henggeler, 1998). Studies have found that high adherence to the MST model predicts favorable long-term outcomes while poor adherence predicts high rates

of recidivism and out-of-home placement (Henggeler et al., 1997, 1999). Accordingly, MST devotes considerable effort to training, supervision, and consultation in order to maximize therapist adherence and fidelity to the MST treatment principles. Training is extensive and consists of a five-day orientation to MST, on-going weekly on-site supervision consistent with the MST model, weekly treatment integrity checks through consultation with an expert in MST, and quarterly on-site booster trainings (1 ½ day trainings). Aside from the trainings and consultation with MST experts, information is also gathered from caregivers and therapists involved with MST.

The first controlled study of MST was published in 1986 in which Henggeler and colleagues found that MST resulted in improved family relations, decreased behavior problems, and decreased association with delinquent peers (Henggeler, 1998). Since this first published study, numerous other studies have concluded that MST is a promising treatment for serious problems of childhood and adolescence. MST has demonstrated reductions of 25% to 70% in long-term rates of rearrest and reductions of 47% to 64% in out-of-home placements; evaluations have also identified extensive improvements in family functioning, decreased incidence of mental health problems, and reductions in child abuse and neglect (Borduin et al., 1995; Henggeler, 1998; Henggeler, Borduin, Melton, Mall, Smith, Hall, Cone & Fucci, 1991; Henggeler, Melton & Smith, 1992; Henggeler et al, 1999). Studies suggest that these successful outcomes are also achieved at cost savings in comparison with other therapeutic programs (MST costs an average of $5,000 per youth) (Henggeler, 1998).

# Family Therapy Program Providers

Evaluation questions addressed in this section:

1. *Which providers are implementing programs?*
2. *What are the characteristics of staff providing family-focused treatment services to ADJC involved families?*
3. *What are the average caseload ratios of staff providing FFT and MST services?*
4. *Are the ratios within best practices guidelines?*
5. *What methods of quality assurance are used with FFT and MST?*

ADJC currently contracts with three treatment providers (Touchstone Behavioral Health, Tumbleweed Center for Youth Development, and Pima Prevention Partnership) for FFT services and one treatment provider (Touchstone Behavioral Health) for MST services. At the time of this report, Touchstone FFT provides services to youth residing in Maricopa, Pima, Yavapai, Coconino, and Pinal Counties. Tumbleweed FFT serves youth residing in Maricopa County while Pima Prevention Partnership FFT serves youth in Pima County. Touchstone has treatment teams in Flagstaff and Phoenix.

**Table 2. Program Description**

| Program Provider | Program Implemented | Locations Served |
|---|---|---|
| Touchstone Behavioral Health | FFT | Maricopa, Pima, Yavapai, Coconino, Pinal counties |
| Touchstone Behavioral Health | MST | Phoenix and Flagstaff |
| Tumbleweed Center for Youth Development | FFT | Phoenix/Maricopa County |
| Pima Prevention Partnership | FFT | Tucson/Pima County |

## Therapist Characteristics

Information about therapists was gathered through one-on-one interviews conducted by the evaluation team with therapists and supervisors employed by each provider. Twelve therapists, including two supervisors and two clinical directors, were interviewed. Of the therapists interviewed, five were male and seven were female.

***FFT Therapists***

Eight therapists that were interviewed had been providing FFT services to ADJC involved families for 6 months to 6 ½ years (averaged just over 3 years experience with FFT). Four therapists held a master's degree while two had completed some graduate school, one had a Bachelor's degree, and one had completed some college. Six therapists held licensure or certification. All FFT therapists had undergone extensive training including an initial 3-day clinical training, follow-up training which includes 3 visits per year of 2 days each, and frequent supervision with FFT supervisors and FFT experts. Three therapists had completed a clinical FFT externship.

***MST Therapists***

MST therapists had been providing MST interventions from 10 months to 2 years (average 16 months). All MST therapists held master's degrees; two were licensed counselors, while one was working on licensure. All MST therapists had undergone significant training including a 5-day training, which must be completed before providing MST services, quarterly booster trainings, and weekly on-site supervision and consultation. MST therapists must also: 1) be accessible 24 hours/day, seven days/week; 2) be assigned solely to the MST program; and 3) must track progress and outcomes on each case weekly by participating in consultation/supervision and completing all necessary paperwork.

## FFT and MST Caseloads

The best practice guidelines for therapist caseloads are 5 to 16 families for FFT and 6 or fewer families for MST (Alexander et al., 1998; Henggeler, 1998). The therapists interviewed for this report indicated that their caseloads were within these guidelines. Most of the FFT therapists averaged one to two ADJC- involved families on their caseloads, which ranged from 5 to 15 families. Most (N=5) FFT therapists had a caseload of 15 families. MST therapists averaged five families on their caseloads, which included one or two ADJC involved families. At the time of the interview, none exceeded the program maximum of 6 families.

## Therapist Oversight and Treatment Adherence

Treatment fidelity is a determination of how well the program is being implemented in comparison with the original program design. Fidelity is generally considered a necessary condition for achieving desired treatment outcomes.

Four primary components should be examined when considering program fidelity:

- Adherence, which refers to whether the program service is being delivered as designed
- Exposure, which includes the number of sessions, length of each session, and the frequency with which program techniques are used
- Quality of program delivery, which relates to a person's skill in using the techniques of the program
- Participant responsiveness

For FFT and MST, treatment fidelity is overseen by each program's national office which enforces administrative and community adherence. Both programs place an extremely strong emphasis on provider accountability and devote substantial resources to quality assurance training and monitoring components that promote treatment fidelity. Specifically, these include:

- Administrative requirements
    - Adherence to the systematic treatment model (manual)
    - Supervisors trained and skilled in the FFT and MST approach
    - Caseload within best practices (FFT: 5 to 16 cases; MST: no more than 6 cases)
    - Clinical training of therapists in FFT and MST
    - Treatment length within FFT and MST outlined requirements
    - Assessments, including computerized systems, progress notes, treatment fidelity assessments, and regular supervision
    - Engaging and retaining families in treatment and sustaining family ability to achieve positive outcomes after treatment completion

- Community requirements
    - The capacity for home-based delivery of services
    - Resources and services available for additional family support

# Program Implementation

Evaluation questions addressed in this section:

1. *What is the target population for FFT and MST?*
2. *How are families recruited and referred to FFT and MST?*
3. *How do families become engaged and retained in FFT and MST?*
4. *What components imply successful completion of the therapy programs?*
5. *How many families participated in family therapy programs?*
6. *How many families completed the therapy programs?*
7. *What have been the impediments to program implementation?*

## Recruitment and Referral Criteria and Process

ADJC targeted the families of youth who were about to be, or had been, released from custody and who demonstrated a need for community-based services to further address his or her delinquency issues and treatment needs. The program is voluntary, so youth and families consented to participation.

As identified by parole officers who were interviewed by the evaluation team, factors determining youth appropriate for community-based services, specifically FFT and MST, include:

- A youth's risk score
- Their history of and current needs (based on a completed needs assessment)
- Treatment progress while in secure care
- History of parent-child conflict

Parole officers also indicated more "staff determined" factors for referring to FFT or MST such as:

- Families who are unable to get to an office for counseling
- Parents/families who are Spanish speaking "since other community treatment programs often lack bilingual staff"[2]
- One or more sibling who has (or had) involvement with the juvenile justice system
- Families who are interested in treatment

FFT therapists interviewed for this evaluation also noted that youth with consistent caregivers who were open and available to attending sessions was a target characteristic. Furthermore, youth with an IQ above 70 were preferred.

> FFT and MST therapists felt that ADJC referred youth that were appropriate for such intensive therapy services.

When asked what risk factors have been identified with youth and families commonly referred for FFT and MST services, the therapists that were interviewed noted the following parenting, family, and youth issues:

- Parenting Issues:
    - No or poor supervision
    - Ineffective discipline practices or poor parenting skills
    - Low warmth
- Family Issues:
    - Multigenerational involvement in crime/delinquency, particularly numerous siblings with court involvement
    - High parent-child conflict
    - Parents who are "weary and wary"
    - Parental substance abuse
    - Families not connected to resources

[2] However, several Parole Officer's suggested there were not enough bilingual therapists for FFT which could impact the programs ability to adequately handle referrals and work with families.

- Families with low social support
    - Poverty (when exacerbated by other risk factors)
- Youth Issues:
    - Youth with inadequate decision-making skills
    - Educational disruption
    - Youth behavioral problems

No criterion precluded a youth from program referral or participation as long as they were between the ages of 11-18 for FFT and 12-17 for MST and were exhibiting acting out behavior.

Youth and families were referred to family-focused therapy programs in one of two ways, depending on whether or not the youth were in custody.

***Youth in Custody***

A multi-disciplinary team (MDT) is established to help coordinate, develop, plan, and execute a youth's treatment plan. Representatives of the MDT include the supervisor of the program/cottage the youth is placed in; a psychology associate; a youth program officer (YPO-III), case manager; education representatives; youth corrections officer (YCO) staff; recreation representatives; parole officer and/or family service coordinator; family members; and the youth. The MDT convenes monthly to provide updates on a youth's progress while in secure care.

The MDT may determine at the monthly meeting, or at a Transition Staffing (held 45 to 60 days prior to a juvenile's minimum release date), whether a youth is appropriate for FFT or MST treatment services. If the MDT determines a youth should be referred for FFT or MST services, the parole officer makes the formal request by completing the necessary paperwork and supplying the request to the Parole Supervisor for review. The parole supervisor reviews the request and either approves or declines the request. Upon approval of the request, the parole supervisor submits the request to Community Corrections for final determination. If approved, the service request is forwarded to the service provider. (ADJC staff, personal communication; http://www.juvenile.state.az.us/Policy/Files/Procedures/PR432101.htm; http://www.juvenile.state.az.us/Policy/Files/Procedures/pr430107.htm).

### *Youth on Parole*

When a youth is out in the community on parole and is experiencing problems, the parole officer might identify FFT or MST services as appropriate. If FFT or MST is identified as a potentially helpful intervention given the level of the youth's behavioral problems and intensity of family conflict, the parole officer completes a service request and submits it to the parole supervisor. The supervisor reviews the request and either approves or declines the request. Upon approval of the request, the parole supervisor submits the request to Community Corrections for final determination. If approved, the service request is forwarded to the service provider (ADJC staff, personal communication).

When asked which factors determine whether families are referred to FFT or to MST, parole officers suggested that youth referred to FFT are more stable, demonstrate fewer behavioral problems, report less parent-child conflict, and reveal less "chaotic" environments. MST costs more than FFT so it is often reserved for families who are exhibiting extreme "chaos and dysfunction." One parole officer noted he asks families which service they prefer given the intensity of MST versus other treatment programs.

Similarly, when asked which factors determine which treatment provider families are referred to, parole officers noted three factors– *location, service availability, and history/experience with the provider*. Parole officers noted that for some locations, there is only one provider. For instance, Touchstone is the only provider that serves rural areas; accordingly, they receive referrals for youth in outlying counties and areas (e.g., Pinal, Yavapai, and Coconino Counties). The second factor noted was service availability. Touchstone Behavioral Health is the only service provider that currently provides MST services; accordingly, all MST referrals are contracted solely with Touchstone. A third factor was previous experience and satisfaction with a specific treatment provider. Some parole officers indicated that they preferred to refer youth to providers they were more familiar with.

Overall, FFT and MST therapists were not familiar with the referral process. Instead, they commonly became aware of referrals when assigned to a family by their supervisor. A few therapists, including supervisory level staff, indicated that parole officers make the referrals but most were not able to provide specific

details on how families are determined appropriate for FFT or MST interventions. Consequently, several therapists indicated they would like more information on how referrals are processed within ADJC as they felt it might provide them with a better understanding of the risk factors ADJC identifies as essential for treatment referral.

Therapy providers and ADJC staff suggested that the FFT and MST programs were underutilized. Parole officers and therapists indicated that the use of FFT and MST is based largely on parole officer buy-in and/or familiarity with the program and their treatment goals. An additional explanation given was the unavailability of treatment services throughout the state (currently, FFT is provided to youth in only five of Arizona's 15 counties, while MST is largely concentrated in Flagstaff and the Phoenix area). The data in Table 3 supports concerns about the underutilization of the programs. According to ADJC Community Corrections, there were an average of seven referrals for FFT per month and just less than one referral for MST per month during the time period of July 2005 through April 2006. This would have resulted in approximately 70 youth referred for FFT and 10 youth referred for MST.

**Table 3. Average Number of Referrals to FFT and MST Program by ADJC, July 2005-April 2006**

| | |
|---|---|
| FFT | 7.2 referrals/month |
| MST | 0.9 referrals/month |

## Family Engagement and Retention

Success of family treatment programs has commonly been attributed to therapists' ability to engage and retain youth and family members in treatment given that youth with behavior problems are notoriously difficult to engage and retain in treatment (Henggeler et al., 1996). In fact, it is estimated that as many as 50% to 75% of youth referred to treatment fail to initiate or complete an adequate course of treatment (Kazdin, 1987).

FFT and MST therapists suggested that engagement begins prior to first contact with youth and families and includes any activity that helps facilitate participant willingness to show up for and participate in treatment. The majority of therapists felt that ADJC involved families were often more difficult to engage, at least initially, than non-ADJC involved families. According to one therapist, ADJC involved families had so often been exposed to "numerous interventions and treatments that they have become hopeless and resistant." Furthermore, although participation in FFT and MST is voluntary, therapists suggested that ADJC referred families often found themselves feeling that treatment was really "system mandated, not family mandated." Accordingly, families either became fearful (and thereby less open) that therapy was a trap designed to catch their child if they failed, or families became resistant to an intervention that was "forced" upon them. Accordingly, therapists noted a number of strategies and activities they employed to engage families:

- Demonstrating respect for families
- Understanding where the family is coming from and letting them guide the process
- Understanding family dynamics before suggesting change
- Validating feelings for all participants and then reframing them in a positive, strength-based manner
- Having parents/families do the work to show them they can do it on their own
- Praising positive aspects of parenting and/or positive treatment successes to enhance rapport, trust, alliance, and hope
- Being flexible, available, nonjudgmental, straightforward, and honest
- Showing a genuine interest in the family
- Sharing family goals
- Using humor to make families feel more comfortable, non-threatened
- Listening
- Promising to work hard
- Showing up

The difficulties of retaining families for therapy programs are well known and well documented. Traditional therapy programs customarily require families to leave the family system and enter the community system for services (i.e., not offered in the home). Logistical barriers such as busy schedules and lack of supportive resources, including transportation and childcare, combined with psychological barriers such as fear of being stigmatized and cultural and language differences often contribute to low attendance and retention in such therapy programs.

FFT and MST were developed with the understanding that home-based intervention services are most helpful to ensuring successful treatment. Accordingly, FFT and MST are provided in the youth's natural environment, at a time that is most convenient for families. As described by FFT and MST therapists, the location of intervention services has a "significant impact on treatment success." Therapists noted that in-home services reduced most of the logistical barriers common with traditional therapy programs, including public displays of one's "best behavior," transportation difficulties, and childcare problems. While some therapists noted that home locations could be chaotic and distracting, providing treatment in the home helped facilitate the provision of treatment services by observing families in their natural environment.

***Factors that Contributed to Program Attrition***

Although providing treatment in the home has been found to enhance treatment engagement and retention, families still drop out of therapy programs. Several predictors of program attrition have been discussed in the research, many of which represent demographic, interpersonal, and other contextual variables, including parental stress, youth's degree of antisocial behavior, adverse parenting practices and parental psychopathology, and economic factors (Henggeler et al., 1996; Henggeler, 1998). Knowledge of these factors is essential so that sources of resistance can be anticipated and addressed before dropout occurs.

When asked what factors led to treatment drop out, FFT and MST therapists noted youth and family attitudes and expectations and logistical issues. More specifically the following key characteristics and conditions were mentioned:

Attitudes and Expectations:

- Youth not committed to changing their delinquent ways
- Exhausted and/or overwhelmed parents
- Families with a negative outlook on services that they can't move past
- Lack of engagement/alliance with the therapist
- Treatment turns out not to be what the family wants/expected
- Treatment is not a family priority (family has other concerns such as employment, health concerns, poverty)
- Youth/family are not willing to open up and build trust within the family system
- Youth or parents are not stable (i.e., exhibiting mental health problems which impact daily functioning)

Logistic Difficulties:

- Conflict with schedules (i.e., parent work schedule)
- Family relocations/moves
- Youth out of the home for 30 days or longer (i.e., locked up, ran away, committed to inpatient treatment)
- Youth recommitted (this was particularly noted with youth in rural areas and/or with cases where there has not been enough time for the therapy program/intervention to work)
- Youth ages out of treatment

Moreover, challenges or barriers which affected service delivery to families, including an inability to successfully complete treatment, included:

- Caregiver difficulties such as substance abuse and/or unmanaged mental health issues
- Families demonstrating low warmth
- Families, particularly parents, experiencing high stress
- Families who lack basic needs
- Cultural barriers
- Youth with a past history of intrafamilial abuse
- Youth/families residing in rural areas (Often, this was associated with a lack of available resources for these families including transportation, employment, and prosocial activities to fill youth's time. However, it was also noted that some rural families are more difficult to engage)

- Families, particularly parents, who “blame the system”
- Lack of frequent communication with PO’s

### *Factors that Contributed to Program Completion*

According to MST therapists, MST typically ended in one of three ways: 1) families consistently met their goals for 3 to 4 weeks; 2) families demonstrated a lack of treatment progress or dropped out of treatment; or 3) families were removed from the program (e.g., aged out, placed in residential treatment programs, parole violation, etc). As indicated by MST therapists, successful treatment completion depended on the following:

- Youth and their families meeting identified goals
- Youth is in the home
- There are demonstrated improvements in family relationships and family communication
- Youth demonstrates decreased interaction with negative peers
- Families are able to sustain management of goals without MST intervention (i.e., have developed necessary skills/resources to address problems as they arise)

According to FFT therapists, successful treatment completion includes the following components:

- Youth/families successfully complete FFT’s three phases of engagement and motivation, behavior change, and generalization
- Therapists and families can see family dynamics shift/change
- Youth do not relapse, but if they do, they are able to employ more socially appropriate skills to handle relapse
- Families are instilled with more problem solving skills and know where to get help when they need it
- Youth and families demonstrated increased coping skills
- Parents have a better understanding of youth’s behavior and provide more supervision
- Ultimately, families have met their substantive goals and have seen improvement

"Successful" families, as identified by both FFT and MST therapists, were characterized by:

- Their high level of engagement
- Parents' improved parenting skills
- Their ability to access and utilize social supports
- High affect
- Parents who want their child at home

## Families Served

The numbers of families who participated in FFT and MST programs are presented in Table 4 on the following page. These numbers encompass program participants since the beginning of implementation of Parents Commission funding (January 2005) through June 2006. During this time, 174 youth and families were referred for FFT program services while 42 were referred for MST[3]. Among all of those referred, most youth were referred to Touchstone Behavioral Health.

Table 4 shows that 67 of the total 174 youth referred for FFT successfully completed treatment. Among those whose treatment was actually initiated, 50% of youth served by Touchstone, 37% of those served by Tumbleweed, and 24%of youth receiving services from Pima Prevention Partnership successfully completed treatment. Thirteen of the 42 youth referred to MST completed treatment. Among those whose treatment was initiated (N=32), 41 percent were deemed by the program to have successfully completed treatment.

[3] This information may not reflect all youth served by the treatment providers as information from Pima Prevention Partnership only reflects youth billed to ADJC during FY2006. Accordingly, the number of youth referred to FFT may in fact be higher.

**Table 4. Status of Participants Referred for Family Therapy Programs**

| Provider | Completed Successfully | Dropped Out | Active Case | Case Not Opened | Other | Total Referred |
|---|---|---|---|---|---|---|
| ***Functional Family Therapy*** | | | | | | |
| Touchstone Behavioral Health | 46 | 2[a] | 22 | 11 | 22[b] | 103 |
| Tumbleweed Center for Youth Development | 14 | 18[c] | 4 | 4 | 2[d] | 42 |
| Pima Prevention Partnership | 7 | NA | NA | NA | 22[e] | 29 |
| Sub totals: | **67** | **20** | **26** | **15** | **46** | **174** |
| ***Multi Systemic Therapy*** | | | | | | |
| Touchstone Behavioral Health | 13 | 4[f] | 3 | 10 | 12[g] | 42 |
| Sub totals: | **13** | **4** | **3** | **10** | **12** | **42** |
| **Totals:** | **80** | **24** | **29** | **25** | **58** | **216** |

[a] Reported as "family refused services" (i.e., started treatment but decided they did not want to participate)

[b] Includes parole violation (N=7), youth incarcerated (N=6), youth AWOL/runaway (N=4), youth placed in residential treatment center (N=2), and change in treatment eligibility (e.g., placed in adult system N=1; other change in eligibility which may include interstate compact client which is terminated, N=2).

[c] Reported as "dropped out" per treatment provider (specific explanations for drop out not provided, e.g., youth AWOL, incarcerated, parole violation, etc.).Note one youth was referred for FFT twice, dropped out both times, and is counted twice in this instance.

[d] Includes one youth who was transferred to substance abuse treatment and one youth who moved.

[e] PPP information was reported by ADJC and not by the treatment provider. Accordingly, this information only represents whether the youth was successful or not, as defined by ADJC. The numbers reported in the "Other" column represent youth who were not successful. Specific reasons for unsuccessful completion were not available by the date of this report.

[f] Considered by Touchstone as "incomplete, not successful" (i.e., unable to complete MST treatment, but if given the opportunity, Touchstone staff felt there was more MST could do) (N=3), or withdrawal due to parent refusal (N=1)

[g] Includes 2 youth placed in residential programs, 4 administrative withdrawals for non-clinical reasons (e.g., parent refusal, client violated parole) , 2 youth who completed treatment but were deemed unsuccessful, 1 youth who completed treatment deemed partial success, 1 youth who was returned to custody, 1 youth who was removed by PO, 1 youth who was terminated because they turned 18, and 1 youth terminated due to AWOL/runaway.

**NOTE:** Information reported in this table was provided from all treatment providers except Pima Prevention Partnership. The information reported for PPP was gathered from ADJC and is reported on only those youth billed during FY2006.

## Impediments to Implementation

Key issues related to the implementation of FFT and MST services were explored in this year's evaluation effort. FFT and MST therapists and ADJC staff (particularly parole officers and two ADJC administrators) were asked what challenges they have encountered in implementing the family-focused therapy programs. The information garnered from interviews and evaluation meetings revealed challenges and lessons learned. Other impediments were identified throughout the evaluation process. Identified issues are explored in detail below.

It is important to note that all ADJC parole officers interviewed noted they were satisfied with FFT and MST program services, despite personally having few, if any, of their youth succeed in the program. The blame for treatment failure was not placed on the programs but, rather, on the youth and families for not trying, giving up, or not being open and amenable to change. All of the interviewed parole officers had, at one time or another, referred youth to such services. Several of the parole officers noted they continued to refer families to such programs because of changes they have seen in youth on their caseload. FFT and MST program strengths noted by parole officers consisted of:

- Frequent assessment of FFT/MST principles and therapist adherence
- Program staffs' knowledge of at-risk behaviors and how to work with such families
- Success of the programs to reach, engage, and intervene with families
- Staff and passion for their work
- The outcome-driven nature of FFT and MST (i.e., program accountability)
- Intensity of services for families in need
- Program flexibility including easy access for family participation (e.g., home-based delivery of service, convenient meeting times)
- Staff allowing interventions as much time as they need

Overall, parole officers felt FFT and MST were strong intervention services, which were convenient, well-known, and outcome-driven. FFT and MST therapists also demonstrated a commitment and conviction to treatment principles/models. Despite identified strengths, challenges in the implementation and use of FFT and MST were identified. These challenges include program availability, program use, referral process, communication

barriers, family interest/involvement, and program-related impediments. Each of these are discussed below.

***Program Availability***

FFT and MST services were not available statewide. Services were only offered to youth residing in Maricopa, Pima, Pinal, Yavapai, and Coconino counties (MST had treatment teams in Phoenix and Flagstaff areas). In counties where FFT and MST are unavailable, ADJC administered or oversaw other forms of community services (e.g., counseling, mentoring). *One recommendation provided by ADJC staff is to enhance coverage of service areas to target youth in counties that lack needed aftercare services including FFT and MST.* Several parole officers felt that rural counties, in particular, lacked prevention and intervention resources and services and even noted that rates of violence and substance abuse in such areas are "catching up" to rates reported in urban areas. Accordingly, these PO's felt the implementation of FFT and MST services in rural areas could help impact the success of youth under ADJC care.

***Program Use***

One concern that was raised by therapy providers was related to the use of FFT and MST services. Several therapists felt that FFT and MST were not used as much as they could by ADJC, and also noted that there were several parole offices/officers that did not seem to refer families such services. One therapist noted that if a parole officer had not used family-focused interventions recently, they tended to "forget about" such available services. This sentiment was also noted by ADJC administrators and parole officers who thought the use of FFT and MST was based largely on officer buy-in. Accordingly, *ADJC staff suggested that the treatment providers/therapists promote the use of their services to enhance PO use and buy-in* (e.g., quarterly/semi-annual presentations or trainings, providing parole offices with brochures, making calls to parole officers who haven't used the services, etc).

Similarly, FFT and MST therapists noted concern for the extent of information or understanding parole officers and/or others who refer youth to their services have regarding FFT and MST. *Several therapists echoed the idea by ADJC staff that more marketing of the treatment models might enhance referrals to the therapy programs as well as family's interest in, and understanding of, such programs.* Two FFT/MST

therapists suggested that some families appeared not to have full information about the programs when they were referred (i.e., that they had been referred, what was required of them, how often services were, that they were home-based services, etc[4]). Consequently, this caused families to decline participation without complete awareness of the benefits, or decline participation once they were enrolled in the program. This created problems for the programs by leading to a higher dropout rate than otherwise would have occurred and not supplying families with the advantage of home-based family therapy. Consequently, *it was recommended that presentations be made to ADJC staff and at ADJC staff trainings on FFT/MST, and that brochures be provided to families before a referral is made to enhance recruitment and engagement of appropriate families.*

### *Referral Process*

The reported limited use of FFT and MST raises a third impediment to the use and implementation of these interventions – the referral process. Several FFT and MST therapists suggested that it is preferable to start intervention services while youth are still in ADJC secure care and indicated that both programs can be initiated before a youth is discharged. However, referrals were often made after a youth had been released from secure care (and was in the community exhibiting problematic symptoms). In addition, some FFT/MST therapists indicated that there seemed to be a lag between when a parole officer notified the provider of an impending referral and the provider actually receiving the referral. *By initiating services while a youth is in secure care, therapists suggested they would have more time to meet the youth and family, identify goals, plan, and help transition the youth in a more efficient manner.* Accordingly, this would provide a more proactive versus reactive stance, and could help prevent youth from (re)establishing negative peer relationships, experiencing difficulties in school, being exposed to drugs and alcohol without effective resistance skills, and diminishing youth and family hope for change. The therapists also suggested that early involvement with youth and families could help initiate "parole plans that are individualized and realistic" given the therapists' understanding of the level of family dysfunction, as well as family capabilities (e.g., transportation difficulties, location of residence, family understanding of legal rights, awareness of community resources, etc).

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[4] In fact, a couple of therapists recalled a few cases where the family was unaware that they had even been referred to the treatment program until the therapist contacted them.

Two parole officers noted that the ADJC referral process is complicated, particularly in regards to the computerized submission of referrals (via ADJC's Intranet). As a result, they felt the referral submission process might leave some parole officers feeling frustrated and thereby less likely to submit such referrals. *It was suggested that a one-page paper referral, as is reportedly used with other program referrals, would be much easier and might lead to more parole officers following through on referring youth to FFT or MST services.*

***Communication Barriers***

A central issue that was mentioned in the interviews is the communication processes between FFT/MST providers and ADJC. That communication, according to those interviewed, consisted of FFT and MST therapists submitting monthly reports. Both parties initiated weekly or biweekly phone calls to discuss compliance issues, significant family and youth problems, and general progress.

Communication between therapists and parole officers is crucial as each party comes from two philosophically different, yet equally important, frameworks (for instance, parole officers often place emphasis on community safety, while therapists work with youth and their families to prevent relapse); accordingly, both parties are often privy to information that the other party may not be. While understanding that therapist and parole officers' work schedules often hampered the communication process, it was noted that enhanced communication between and among the agencies would be beneficial.

The importance of interagency communication was highlighted by the significance of having the parole officer's perspective when working with a youth and his or her family. For instance, it was noted that frequent and timely input on youth's compliance with parole (e.g., results of urinalysis testing, fulfillment of parole plan requirements) can benefit delivery of therapy services by allowing therapists to focus on issues and problems as they arise. Conversely, therapists could inform parole officers on youth's progress in treatment, particularly regarding what setbacks occurred and how relapse can be viewed as a natural response to therapy. Furthermore, recurrent contacts allow both parties to explore options for families who might be experiencing setbacks.

Accordingly, maintaining frequent communication allows parole officers to stay involved in youth's progress and enhances the quality of services youth and families receive because therapists are armed with current information on how youth are doing. Open lines of communication are also important when two philosophically different, yet equally important, ideas come into contact (e.g., justice system vs. treatment system). *It was thereby suggested that parole officers and treatment providers continue frequent communication attempts with an increased understanding of the importance of following up on such communication when it involves issues that could affect/impact youth's treatment* (e.g., AWOL, UA results, etc). This could be done by making it a priority to inform the other party as soon as a critical treatment issue arises (e.g., within 48 to 72 hours).

***Family Involvement***

Families' involvement in, and reaction to, treatment was also identified as a barrier to implementing FFT and MST treatment services. While FFT and MST were developed with a consideration for youth and families' resistance to outside treatment interventions, it was noted that families often entered treatment feeling as if they are trying to be "fixed." Thus, according to the therapists, they often felt blamed or even humiliated. Further, this often made families harder to engage in treatment initially and may even have led to early treatment dropout. Considering that, f*amilies' resistance to treatment should be addressed with a "blame free" referral process where youth and families do not feel they are being referred to FFT or MST as a means of "enforcement." The referral should also be made with the knowledge of the family* (it was reported that some families were unaware of their referral to FFT or MST until contacted by a therapist). Accordingly, it is important that more information be provided to parole officers about the requirements of FFT and MST programs (e.g., duration, frequency, etc). This should lead to families feeling like they have a choice in participating in FFT/MST, are not being blamed, and are not overwhelmed with services.

Some therapists also noted additional challenges in trying to provide services to youth residing in rural areas. Oftentimes, these areas lacked resources and services and logistical barriers (i.e., transportation) often compromised the youths' progress. For instance, a youth without transportation might experience difficulty getting to the closest town for UA testing or employment. Furthermore, it was suggested that youth in rural areas were not fully aware of

their rights, often fell through the cracks, and experienced more difficulty following through on treatment plans (often due to logistical barriers mentioned above). Accordingly, these families were harder to engage and retain in treatment programs thus supporting the need to expand services to youth in such areas.

***Program-related Impediments***

Another identified barrier was related to the utilization of multiple interventions when implementing FFT/MST. It was noted by therapy providers that FFT and MST are meant to be the sole therapeutic intervention offered to families at one time to avoid families getting "mixed messages" and experiencing the overwhelming impact of receiving multiple treatment services (e.g., family has scheduling conflicts with appointments, requires additional time off work, and becomes overburdened/overwhelmed with services). Similarly, FFT/MST therapists noted that FFT and MST often accomplished what other interventions were intended to including exploring employment and educational issues, problem solving and resistance skills training, finding prosocial activities for the youth, and referring for community resources and services (e.g., AA, NA, etc). Consequently, *therapists recommended a "grace period" where FFT/MST is the sole therapeutic intervention assigned to a family.* This would allow therapists sufficient time to engage families without overwhelming them.

Parole officers noted the great need for more bilingual, particularly Spanish-speaking, staff that could provide FFT and MST services. One parole officer noted that some family members were asked to translate information during family therapy sessions. Several parole officers felt language barriers might prevent youth and families from receiving or being referred to intensive family-based services and, even more, might lead families to drop out of such programs. Accordingly, *the need for qualified bilingual and culturally competent staff is critical.*

A final challenge to program implementation was related to the administration of services. It was noted that turnover is sometimes a problem with intensive family-based treatment programs. This was related to low pay and demanding work schedules. With the expensive training for the therapy programs, it becomes costly to the agency when they lose a qualified, trained therapist.

# Summary

This annual report provides a summary of implementation activities that have occurred in the Families of Incarcerated Youth initiative. The first phase of the Family Focused Treatment evaluation focused on the implementation of the family-focused treatment programs. This included developing an evaluation plan, constructing data collection tools, conducting key informant interviews, and reviewing program documents/materials and literature on the family therapy programs.

Data gathered reports on the prevalence and completion status of ADJC referred youth and families. While 174 youth were referred for FFT and 42 youth referred for MST (of which 159 families and 32 families, respectively, initiated services), one key finding was that ADJC staff and therapists felt family-therapy services were underutilized. The lack of program usage produced discussions about the lack of available services for youth, particularly those residing in rural areas. Furthermore, the recruitment and referral process appeared to be somewhat inconsistent (i.e., some PO's have referred youth multiple times to FFT or MST while some PO's have never referred youth to such programs) and time delayed (i.e., lags between notification of referrals and receipt of the referral, therapy unable to start until youth is released from secure care). Moreover, some ADJC staff felt the referral process was "complicating" and "frustrating." These issues, along with PO buy-in, likely contributed to the underutilization of the therapy programs.

Results from the implementation evaluation revealed positive viewpoints towards the use and value of FFT and MST treatment programs. Furthermore, program processes appear in compliance with those recommended or required by the FFT and MST program creators. Each program collects performance monitoring data and requires the use of standard assessment tools which are at the core of guaranteeing treatment fidelity.

Impediments to the implementation of FFT and MST included underutilization of the family-therapy programs, unavailability of FFT and MST statewide, inconsistent and delayed referral processes, communication barriers, negative reactions to treatment by families, and program-related impediments such as

lack of bilingual treatment staff and program turnover. Accordingly, recommendations for strengthening program implementation include:

- Enhancing availability of aftercare services for youth on parole, specifically FFT and/or MST and particularly among youth in rural areas;
- Working with FFT/MST therapists to initiate services earlier (i.e., while a youth is in secure care) so they can help transition the youth in a more efficient manner;
- Exploring options for simplifying the internal ADJC referral process;
- Continuing collaboration between treatment providers and ADJC;
- Highlighting the importance of interagency communication to ensure everyone is kept informed;
- Exploring strategies for ensuring a "blame free" referral process in which families are aware of their therapy referral; and
- Encouraging the hiring of qualified and culturally competent therapy staff.

## Evaluation Plans for Next Fiscal Year

This evaluation report covered the implementation processes for the Families of Incarcerated Youth initiative, specifically the incorporation and use of FFT and MST. The impact of FFT and MST on youth and families will be the subject of the second evaluation report. This Year 2 evaluation will attempt to address the questions presented in Table 5. Quantitative and qualitative evaluation methods will be used and will include staff interviews, participant surveys, pre- and post-treatment assessments, and review of existing data and program documents and materials.

**Table 5. FY2007 Evaluation Questions**

Process Questions:

1. What are the characteristics of the families (youth and parents) participating in the family therapy programs?
2. What are the characteristics of families who remain in the therapy programs and how do they compare with those who fail to complete family therapy programs?
3. How satisfied are families with their involvement in the therapy programs?
4. What are the characteristics of the family liaisons? What has been their role in the Families of Incarcerated Youth initiative? Were any barriers experienced in implementing family liaisons (and if so, what were they)?

Outcome Questions:

1. What changes are seen in parents' knowledge of parenting practices and the importance of parental involvement?
2. What improvements are seen in parents' skills related to parenting and parental involvement?
3. What improvements are seen in parent-child interactions including improvements in family communication?
4. What changes are seen in the academic performance of participants?
5. What were the rates of substance abuse among juvenile participants? What changes are seen in juveniles' attitudes towards substance abuse?
6. What was the recidivism rate for juvenile participants? What characteristics predict juvenile recidivism?
7. What characteristics of families predict treatment completion? What characteristics predict treatment engagement?
8. What program characteristics (e.g., length of treatment, treatment location, program models, therapist caseload) predict treatment compliance?

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# Appendix A

The nine MST treatment principles include:

- The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context
- Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change
- Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members
- Interventions should be present-focused and action-oriented, targeting specific and well-defined problems
- Interventions should target sequences of behavior within or between multiple systems that maintain unidentified problems
- Interventions should be developmentally appropriate and fit the developmental needs of the youth
- Interventions should be designed to require daily or weekly effort by family members
- Intervention effectiveness is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.
- Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering care givers to address family member's needs across multiple systemic contexts.