174201

Blueprints

For Violence Prevention

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BOOK EIGHT
Multidimensional
Treatment Foster Care

174201

Blueprints for Violence Prevention

MULTIDIMENSIONAL TREATMENT FOSTER CARE

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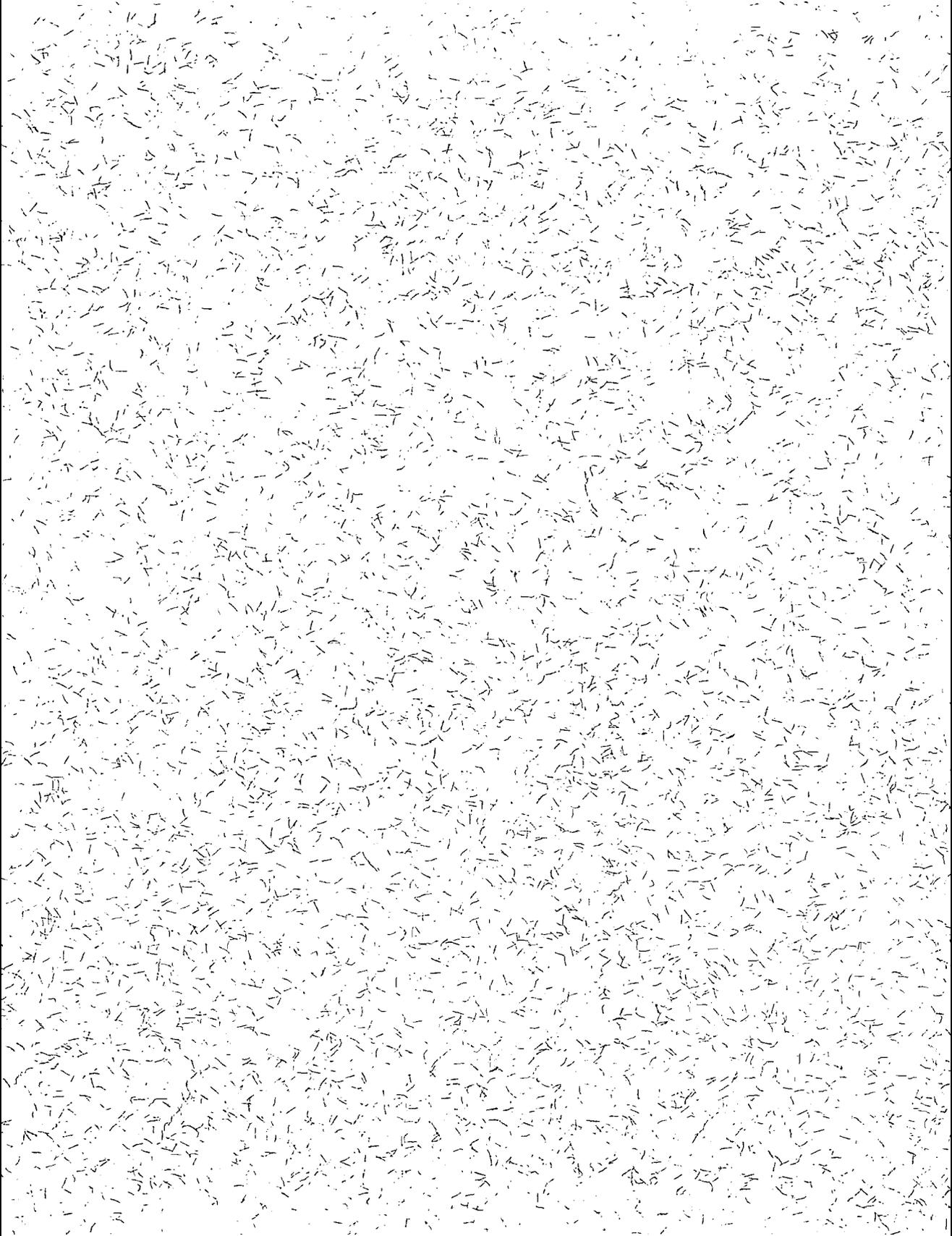
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EDITOR'S INTRODUCTION

Introduction

The demand for effective violence and crime prevention programs has never been greater. As our communities struggle to deal with the violence epidemic of the 1990s in which we have seen the juvenile homicide rate double and arrests for serious violent crimes increase 50 percent between 1984 and 1994,[1] the search for some effective ways to prevent this carnage and self-destructiveness has become a top national priority. To date, most of the resources committed to the prevention and control of youth violence, at both the national and local levels, has been invested in untested programs based on questionable assumptions and delivered with little consistency or quality control. Further, the vast majority of these programs are not being evaluated. This means we will never know which (if any) of them have had some significant deterrent effect; we will learn nothing from our investment in these programs to improve our understanding of the causes of violence or to guide our future efforts to deter violence; and there will be no real accountability for the expenditures of scarce community resources. Worse yet, some of the most popular programs have actually been demonstrated in careful scientific studies to be *ineffective,* and yet we continue to invest huge sums of money in them for largely political reasons.

What accounts for this limited investment in the evaluation of our prevention programs? First, there is little political or even program support for evaluation. Federal and state violence prevention initiatives rarely allocate additional evaluation dollars for the programs they fund. Given that the investment in such programs is relatively low, it is argued that every dollar available should go to the delivery of program services, i.e., to helping youth avoid involvement in violent or criminal behavior. Further, the cost of conducting a careful outcome evaluation is prohibitive for most individual programs, exceeding their entire annual budget in many cases. Finally, many program developers believe they know *intuitively* that their programs work, and thus they do not think a rigorous evaluation is required to demonstrate this.

Unfortunately, this view and policy is very shortsighted. When rigorous evaluations have been conducted, they often reveal that such programs are ineffective and can even make matters worse.[2] Indeed, many programs fail to even address the underlying causes of violence, involve simplistic "silver bullet" assumptions (e.g., I once had a counselor tell me there wasn't a single delinquent youth he couldn't "turn around" with an hour of individual counseling), and allocate investments of time and resources that are far too small to counter the years of exposure to negative influences of the family, neighborhood, peer group, and the media. Violent behavior is a complex behavior pattern which involves both individual dispositions and social contexts in which violence is normative and rewarded. Most violence prevention programs focus only on the individual dispositions and fail to address the reinforcements for violence in the social contexts where youth live, with the result that positive changes in the individual's behavior achieved in the treatment setting are quickly lost when the youth returns home to his or her family, neighborhood, and old friends.

Progress in our ability to effectively prevent and control violence requires evaluation. A responsible accounting to the taxpayers, private foundations, or businesses funding these programs requires that we justify these expenditures with tangible results. No respectable business or corporation would invest millions of dollars in an enterprise without checking to see if it is profitable. No reputable

physician would subject a patient to a medical treatment for which there was no evidence of its effectiveness (i.e., no clinical trials to establish its potential positive and negative effects). Our failure to provide this type of evidence has seriously undermined the public confidence in crime prevention efforts generally, and is at least partly responsible for the current public support for building more prisons and incapacitating youth—the public knows they are receiving some protection for this expenditure, even if it is temporary.

The prospects for effective prevention programs and a national prevention initiative have improved greatly during the past decade. We now have a substantial body of research on the causes and correlates of crime and violence. There is general consensus within the research community about the specific individual dispositions, contextual (family, school, neighborhood, and peer group) conditions, and interaction dynamics which lead into and out of involvement in violent behavior. These characteristics, which have been linked to the onset, continuity, and termination of violence, are commonly referred to as "risk" and "protective" factors for violence. Risk factors are those personal attributes and contextual conditions which increase the likelihood of violence. Protective factors are those which reduce the likelihood of violence, either directly or by virtue of buffering the individual from the negative effects of risk factors.[3] Programs which can alter these conditions, reducing or eliminating risk factors and facilitating protective factors, offer the most promise as violence prevention programs.

While our evaluation of these programs is still quite limited, we have succeeded in demonstrating that some of these programs are effective in deterring crime and violence. This breakthrough in prevention programming has yet to be reflected in national or state funding decisions, and is admittedly but a beginning point for developing the comprehensive set of prevention programs necessary for developing a national prevention initiative. But we are no longer in the position of having to say that "nothing works."

Ten proven programs are described in this series of *Blueprints for Violence Prevention*. These Blueprints (which will be described later in this Editor's Introduction) are designed to be practical documents which will allow interested persons, agencies, and communities to make an informed judgment about a proven program's appropriateness for their local situation, needs, and available resources. If adopted and implemented well, a community can be reasonably assured that these programs will reduce the risks of violence and crime for their children.

Background

The violence epidemic of the 1990s produced a dramatic shift in the public's perception of the seriousness of violence. In 1982, only three percent of adults identified crime and violence as the most important problem facing this country; by August of 1994, more than half thought crime and violence was the nation's most important problem. Throughout the '90s violence has been indicated as a more serious problem than the high cost of living, unemployment, poverty and homelessness, and health care. Again, in 1994, violence (together with a lack of discipline) was identified as the "biggest problem" facing the nation's public schools.[4] Among America's high school seniors, violence is the problem these young people worry about most frequently—more than drug abuse, economic problems, poverty, race relations, or nuclear war.[5]

The critical question is, *"How will we as a society deal with this violence problem?"* Government policies at all levels reflect a punitive, legalistic approach, an approach which does have broad

public support. At both the national and state levels, there have been four major policy and program initiatives introduced as violence prevention or control strategies in the 1990s: (1) the use of judicial waivers, transferring violent juvenile offenders as young as age ten into the adult justice system for trial, sentencing, and adult prison terms; (2) legislating new gun control policies (e.g., the Brady Handgun Violence Prevention Act, 1993); (3) the creation of "boot camps" or shock incarceration programs for young offenders, in order to instill discipline and respect for authority; and (4) community policing initiatives to create police-community partnerships aimed at more efficient community problem solving in dealing with crime, violence, and drug abuse.

Two of these initiatives are purely reactive: they involve ways of responding to violent acts after they occur; two are more preventive in nature, attempting to prevent the initial occurrence of violent behavior. The primary justification for judicial waivers and boot camps is a "just desserts" philosophy, wherein youthful offenders need to be punished more severely for serious violent offenses. But there is no research evidence to suggest either strategy has any increased deterrent effect over processing these juveniles in the juvenile justice system or in traditional correctional settings. In fact, although the evidence is limited, it suggests the use of waivers and adult prisons results in longer processing time and longer pretrial detention, racial bias in the decision about which youth to transfer into the adult system, a lower probability of treatment or remediation while in custody, and an increased risk of repeated offending when released.[6] The research evidence on the effectiveness of community policing and gun control legislation is very limited and inconclusive. We have yet to determine if these strategies are effective in preventing violent behavior.

There are some genuine prevention efforts sponsored by federal and state governments, by private foundations, and by private businesses. At the federal level, the major initiative involves the Safe and Drug-Free Schools and Communities Act (1994). This act provided $630 million in federal grants during 1995 to the states to implement violence (and drug) prevention programs in and around schools. State Departments of Education and local school districts are currently developing guidelines and searching for violence prevention programs demonstrated to be effective. But there is no readily available compendium of effective programs described in sufficient detail to allow for an informed judgment about their relevance and cost for a specific local application. Under pressure to do something, schools have implemented whatever programs were readily available. As a result, most of the violence prevention programs currently being employed in the schools, e.g., conflict resolution, peer mediation, individual counseling, metal detectors, and locker searches and sweeps have either not been evaluated or the evaluations have failed to establish any significant, sustained deterrent effects.[7]

Nationally, we are investing far more resources in building and maintaining prisons than in primary prevention programs.[8] We have put more emphasis on reacting to violent offenders after the fact and investing in prisons to remove these young people from our communities, than on preventing our children from becoming violent offenders in the first place and retaining them in our communities as responsible, productive citizens. Of course, if we have no effective prevention strategies or programs, there is no choice.

This is the central issue facing the nation in 1998: *Can we prevent the onset of serious violent behavior?* If we cannot, then we have no choice but to build, fill, and maintain more prisons. Yet if we know how to prevent the onset of violence, can we mount an efficient and effective prevention

initiative? There is, in fact, considerable public support for violence prevention programming for our children and adolescents.[9] *How can we develop, promote, and sustain a violence prevention initiative in this country?*

Violence Prevention Programs—What Works?

Fortunately, we are past the "nothing has been demonstrated to work" era of program evaluation.[10] During the past five years more than a dozen scholarly reviews of delinquency, drug, and violence prevention programs have been published, all of which claim to identify programs that have been successful in deterring crime and violence.[11]

However, a careful review of these reports suggests some caution and a danger of *overstating* this claim. First, very few of these recommended programs involve reductions in violent behavior as the outcome criteria. For the most part, reductions in delinquent behavior or drug use *in general* or arrests/revocations for *any offense* have been used as the outcome criteria. This is probably not a serious threat to the claim that we have identified effective violence prevention programs, as research has established that delinquent acts, violence, and substance use are interrelated, and involvement in any one is associated with involvement in the others. Further, they have a common set of causes, and serious forms of violence typically occur later in the developmental progression, suggesting that a program that is effective in reducing earlier forms of delinquency or drug use should be effective in deterring serious violent offending.[12] Still, some caution is required, given that very few studies have actually demonstrated a deterrent or marginal deterrent effect for serious violent behavior.

Second, the methodological standards vary greatly across these reviews. A few actually score each program evaluation reviewed on its methodological rigor,[13] but for most the standards are variable and seldom made explicit. If the judgment on effectiveness were restricted to individual program evaluations employing true experimental designs and demonstrating statistically significant deterrent (or marginal deterrent) effects, the number of recommended programs would be cut by two-thirds or more. An experimental (or good quasi-experimental) design and statistically significant results should be minimum criteria for recommending program effectiveness. Further, very few of the programs recommended have been replicated at multiple sites or demonstrated that their deterrent effect has been sustained for some period of time *after* leaving the program, two additional criteria that are important. In a word, the standard for the claims of program effectiveness in these reviews is very *low*. Building a national violence prevention initiative on this collective set of recommended programs would be risky.

Blueprints for Violence Prevention

In 1996, the Center for the Study and Prevention of Violence at the University of Colorado at Boulder, working with William Woodward, Director of the Colorado Division of Criminal Justice (CDCJ), who played the primary role in securing funding from the Colorado Division of Criminal Justice, the Centers for Disease Control and Prevention, and the Pennsylvania Commission on Crime and Delinquency, initiated a project to identify ten violence prevention programs that met a very high scientific standard of program effectiveness—*programs that could provide an initial nucleus for a national violence prevention initiative.* Our objective was to identify truly outstanding programs, and to describe these interventions in a series of "Blueprints." Each Blueprint describes the

theoretical rationale for the intervention, the core components of the program as implemented, the evaluation designs and findings, and the practical experiences the program staff encountered while implementing the program at multiple sites. The Blueprints are designed to be very practical descriptions of effective programs which allow states, communities, and individual agencies to: (1) determine the appropriateness of each intervention for their state, community, or agency; (2) provide a realistic cost estimate for each intervention; (3) provide an assessment of the organizational capacity required to ensure its successful start-up and operation over time; and (4) give some indication of the potential barriers and obstacles that might be encountered when attempting to implement each type of intervention. In 1997, additional funding was obtained from the Division of Criminal Justice, allowing for the development of the ten Blueprint programs.

Blueprint Program Selection Criteria

In consultation with a distinguished Advisory Board,[14] we established the following set of evaluation standards for the selection of Blueprint programs: (1) an experimental design, (2) evidence of a statistically significant deterrent (or marginal deterrent) effect, (3) replication at multiple sites with demonstrated effects, and (4) evidence that the deterrent effect was sustained for at least one year post-treatment. This set of selection criteria establishes a very high standard, one that proved difficult to meet. But it reflects the level of confidence necessary if we are going to recommend that communities replicate these programs with reasonable assurances that they will prevent violence. Given the high standards set for program selection, the burden for communities mounting an expensive outcome evaluation to demonstrate their effectiveness is removed; this claim can be made as long as the program is implemented well. Documenting that a program is implemented well is relatively inexpensive, but critical to the claim that a program is effective.

Each of the four evaluation standards is described in more detail as follows:

1. Strong Research Design

Experimental designs with random assignment provide the greatest level of confidence in evaluation findings, and this is the type of design required to fully meet this Blueprint standard. Two other design elements are also considered essential for the judgment that the evaluation employed a strong research design: low rates of participant attrition and adequate measurement. Attrition may be indicative of problems in program implementation; it can compromise the integrity of the randomization process and the claim of experimental-control group equivalence. Measurement issues include the reliability and validity of study measures, including the outcome measure, and the quality, consistency, and timing of their administration to program participants.

2. Evidence of Significant Deterrence Effects

This is an obvious minimal criterion for claiming program effectiveness. As noted, relatively few programs have demonstrated effectiveness in reducing the onset, prevalence, or individual offending rates of *violent behavior*. We have accepted evidence of deterrent effects for delinquency (including childhood aggression and conduct disorder), drug use, and/or violence as evidence of program effectiveness. We also accepted program evaluations using arrests as the outcome measure. Evidence for a deterrent effect on violent behavior is certainly preferable, and programs demonstrating this effect were given preference in selection, all other criteria being equal.

Both primary and secondary prevention effects, i.e., reductions in the *onset* of violence, delinquency, or drug use compared to control groups and pre-post reductions in these *offending rates,* could meet this criterion. Demonstrated changes in the targeted risk and protective factors, in the absence of any evidence of changes in delinquency, drug use, or violence, was not considered adequate to meet this criterion.

3. Multiple Site Replication

Replication is an important element in establishing program effectiveness. It establishes the robustness of the program and its prevention effects; its exportability to new sites. This criterion is particularly relevant for selecting Blueprint programs for a national prevention initiative where it is no longer possible for a single program designer to maintain personal control over the implementation of his or her program. Adequate procedures for monitoring the quality of implementation must be in place, and this can be established only through actual experience with replications.

4. Sustained Effects

Many programs have demonstrated initial success in deterring delinquency, drug use, and violence during the course of treatment or over the period during which the intervention was being delivered and reinforcements controlled. This selection criterion requires that these short-term effects be sustained beyond treatment or participation in the designed intervention. For example, if a preschool program designed to offset the negative effects of poverty on school performance (which in turn effects school bonding, present and future opportunities, and later peer group choice/selection, which in turn predicts delinquency) demonstrates its effectiveness when children start school, but these effects are quickly lost during the first two to three years of school, there is little reason to expect this program will prevent the onset of violence during the junior or senior high school years when the risk of onset is at its peak. Unfortunately, there is clear evidence that the deterrent effects of most prevention programs deteriorate quickly once youth leave the program and return to their original neighborhoods, families, and peer groups or gangs.

Other Criteria

In the selection of model programs, we considered several additional factors. We looked for evidence that change in the targeted risk or protective factor(s) mediated the change in violent behavior. This evidence clearly strengthens the claim that participation in the program was responsible for the change in violent behavior, and it contributes to our theoretical understanding of the causal processes involved. We were surprised to discover that many programs reporting significant deterrent effects (main effects) had not collected the necessary data to do this analysis or, if they had the necessary data, had not reported on this analysis.

We also looked for cost data for each program as this is a critical element in any decision to replicate one of these Blueprint programs, and we wanted to include this information in each Blueprint. Evaluation reports, particularly those found in the professional journals, rarely report program costs. Even when asked to provide this information, many programs are unable (or unwilling) to provide the data. In many cases program costs are difficult to separate from research and evaluation costs. Further, when these data are available, they typically involve conditions or circumstances unique to a particular site and are difficult to generalize. There are no standardized cost criteria, and it is very

difficult to compare costs across programs. It is even more difficult to obtain reliable cost-benefit estimates. A few programs did report both program costs and cost-benefit estimates. There have been two recent cost-benefit studies involving Blueprint programs which suggest that these programs are cost-effective, but this information is simply not available for most programs.[15]

Finally, we considered each program's willingness to work with the Center in developing a Blueprint for national dissemination and the program's organizational capacity to provide technical assistance and monitoring of program implementation on the scale that would be required if the program was selected as a Blueprint program and became part of a national violence prevention initiative.

Programs must be willing to work with the Center in the development of the Blueprint. This involves a rigorous review of program evaluations with questions about details not covered in the available publications; the preparation of a draft Blueprint document following a standardized outline; attending a conference with program staff, staff from replication sites, and Center staff to review the draft document; and making revisions to the document as requested by Center staff. Each Blueprint is further reviewed at a second conference in which potential users—community development groups, prevention program staffs, agency heads, legislators, and private foundations—"field test" the document. They read each Blueprint document carefully and report on any difficulties in understanding what the program requires, and on what additional information they would like to have if they were making a decision to replicate the program. Based on this second conference, final revisions are made to the Blueprint document and it is sent back to the Program designer for final approval.

In addition, the Center will be offering technical assistance to sites interested in replicating a Blueprint program and will be monitoring the quality of program implementation at these sites (see the "Technical Assistance and Monitoring of Blueprint Replications" section below). This requires that each selected program work with the Center in screening potential replication sites, certifying persons qualified to deliver technical assistance for their program, delivering high quality technical assistance, and cooperating with the Center's monitoring and evaluation of the technical assistance delivered and the quality of implementation achieved at each replication site. Some programs are already organized and equipped to do this, with formal written guidelines for implementation, training manuals, instruments for monitoring implementation quality, and a staff trained to provide technical assistance; others have few or none of these resources or capabilities. Participation in the Blueprint project clearly involves a substantial demand on the programs. All ten programs selected have agreed to participate as a Blueprint program.

Blueprint Programs: An Overview

We began our search for Blueprint programs by examining the set of programs recommended in scholarly reviews. We have since expanded our search to a much broader set of programs and continue to look for programs that meet the selection standards set forth previously. To date, we have reviewed more than 450 delinquency, drug, and violence prevention programs. As noted, ten programs have been selected thus far, based upon a review and recommendation of the Advisory Board. These programs are identified in Table A.

The standard we have set for program selection is very high. Not all of the ten programs selected meet all of the four individual standards, but as a group they come the closest to meeting these standards that we could find. As indicated in Table A, with one exception they have all demonstrated

Table A. Blueprint Programs

PROJECT	TARGET POPULATION	EVID. OF EFFECT*	MULTI-SITE	COST/ BENEFIT	SUSTAINED EFFECT	GENERA-LIZABLE	TYPE OF PROGRAM
Nurse Home Visitation (Dr. David Olds)	Pregnant women at risk of preterm delivery and low birthweight	X	X	X	through age 15	X	Prenatal and postpartum nurse home visitation
Bullying Prevention Program (Dr. Dan Olweus)	Primary and secondary school children (universal intervention)	X	England, Canada; South Carolina		2 years post-treatment	Generality to U.S. unk.; initial S.C. results positive	School-based program to reduce victim/bully problems
Promoting Alternative Thinking Strategies (Dr. M. Greenberg and Dr. C. Kusche)	Primary school children (universal intervention)	X	X		2 years post-treatment	X	School-based program to promote emotional competence
Big Brothers Big Sisters of America (Ms. Dagmar McGill)	Youth 6 to 18 years of age from single-parent homes	X	Multisite single design, 8 sites			X	Mentoring program
Quantum Opportunities (Mr. Ben Lattimore)	At-risk, disadvantaged, high school youth	X	Multisite single design, 5 sites; replic. by D.O.L.	X	through age 20		Educational incentives
Multisystemic Therapy (Dr. Scott Henggeler)	Serious, violent, or substance abusing juvenile offenders and their families	X	X	X	4 years post-treatment	X	Family ecological systems approach
Functional Family Therapy (Dr. Jim Alexander)	Youth at risk for institutionalization	X	X	X	30 months posttreatment	X	Behavioral systems family therapy
Midwestern Prevention Project (Dr. Mary Ann Pentz)	Middle/junior school (6th/7th grade)	X	X		Through high school	X	Drug use prevention (social resistance skills); with parent, media, and community components
Life Skills Training (Dr. Gilbert Botvin)	Middle/junior school (6th/7th grade)	X	X		Through high school	X	Drug use prevention (social skills and general life skills training)
Multidimensional Treatment Foster Care (Dr. Paricia Chamberlain)	Serious and chronic delinquents	X	X	X	1 year post-treatment		Foster care with treatment

* "X" indicates the program met this criterion satisfactorily.

significant deterrent effects with experimental designs using random assignment to experimental and control groups (the Bullying Prevention Program involved a quasi-experimental design). All involve multiple sites and thus have information on replications and implementation quality, but not all replication sites have been evaluated as independent sites (e.g., the Big Brothers Big Sisters mentoring program was implemented at eight sites, but the evaluation was a single evaluation involving all eight sites in a single aggregated analysis). Again, with one exception (Big Brothers Big Sisters), all the selected programs have demonstrated sustained effects for at least one year post-treatment.

The first two Blueprints were published and disseminated in the fall of 1997: the Big Brothers Big Sisters Program and the Midwestern Prevention Project. The other eight Blueprints will be published during 1998—four in the spring, two in the summer, and the final two in the fall.

Technical Assistance and Monitoring of Blueprint Replications[16]

The Blueprint project includes plans for a technical assistance and monitoring component to assist interested communities, agencies, and organizations in their efforts to implement one or more of the Blueprint programs. *Communities should not attempt to replicate a Blueprint program without technical assistance from the program designers.* If funded, technical assistance for replication and program monitoring will be available through the Center for the Study and Prevention of Violence at a very modest cost. Technical assistance can also be obtained directly from the Blueprint programs with costs for consulting fees, travel, and manuals negotiated directly with each program.

There are three common problems encountered by communities when attempting to develop and implement violence prevention interventions. First, there is a need to identify the specific risk and protective factors to be addressed by the intervention and the most appropriate points of intervention to address these conditions. In some instances, communities have already completed a risk assessment and know their communities' major risk factors and in which context to best initiate an intervention. In other cases this has not been done and the community may require some assistance in completing this task. We anticipate working with communities and agencies to help them evaluate their needs and resources in order to select an appropriate Blueprint program to implement. This may involve some initial on-site work assisting the community in completing some type of risk assessment as a preparatory step to selecting a specific Blueprint program for implementation.

Second, assuming the community has identified the risk and protective factors they want to address, a critical problem is in locating prevention interventions which are *appropriate* to address these risk factors and making an informed decision about which one(s) to implement. Communities often become lost in the maze of programs claiming they are effective in changing identified risk factors and deterring violence. More often, they are faced with particular interest groups pushing their own programs or an individual on their advisory board recommending a pet project, with no factual information or evidence available to provide some rational comparison of available options. Communities often need assistance in making an informed selection of programs to implement.

Third, there are increasingly strong pressures from funders, whether the U.S. Congress, state legislatures, federal or state agencies, or private foundations and businesses, for accountability. The current trend is toward requiring *all* programs to be monitored and evaluated. This places a tremendous burden on most programs which do not have the financial resources or expertise to conduct a

meaningful evaluation. A rigorous outcome evaluation typically would cost more than the annual operating budget of most prevention programs; the cumulative evaluations of our Blueprint programs, for example, average more than a million dollars each. The selection of a Blueprint program eliminates the need for an outcome evaluation, at least for an initial four or five years.[17] Because these programs have already been rigorously evaluated, the critical issue for a Blueprint program is the *quality of the implementation*; if the program is implemented well, we can assume it is effective. To ensure a quality implementation, technical assistance and monitoring of the implementation (a process evaluation) are essential.

Limitations

Blueprint programs are presented as complete programs as it is the *program* that has been evaluated and demonstrated to work. Ideally, we would like to be able to present specific intervention components, e.g., academic tutoring, mentoring of at-risk youth, conflict resolution training, work experience, parent effectiveness training, etc., as proven intervention strategies based upon evaluations of many different programs using these components. We do not yet have the research evidence to support a claim that specific components are effective for specific populations under some specific set of conditions. Most of the Blueprint programs (and prevention programs generally) involve multiple components, and their evaluations do not establish the independent effects of each separate component, but only the combination of components as a single "package." It is the "package" which has been demonstrated to work for specific populations under given conditions. The claim that one is using an intervention that has been demonstrated to work applies only if the entire Blueprint program, as designed, implemented, and evaluated, is being replicated; this claim is not warranted if only some specific subcomponent is being implemented or if a similar intervention strategy is being used, but with different staff training, or different populations of at-risk youth, or some different combination of components. It is for this reason that we recommend that communities desiring to replicate one of the Blueprint programs contact this program or the Center for the Study and Prevention of Violence for technical assistance.

Our knowledge about these programs and the specific conditions under which they are effective will certainly change over time. Already there are extensions and modifications to these programs which are being implemented and carefully evaluated. Over the next three to five years it may be necessary to revise our Blueprint of a selected program. Those modifications currently underway typically involve new at-risk populations, changes in the delivery systems, changes in staff selection criteria and training, and in the quantity or intensity of the intervention delivered. Many of these changes are designed to reduce costs and increase the inclusiveness and generality of the program. It is possible that additional evaluations may undermine the claim that a particular Blueprint program is effective, however it is far more likely they will improve our understanding of the range of conditions and circumstances under which these programs are effective. In any event, we will continue to monitor the evaluations of these programs and make necessary revisions to their Blueprints. Most of these evaluations are funded at the federal level and they will provide ongoing evidence of the effectiveness of Blueprint programs, supporting (or not) the continued use of these programs without the need for local outcome evaluations.

The cost-benefit data presented in the Blueprints are those estimated by the respective programs. We have not undertaken an independent validation of these estimates and are not certifying their

accuracy. Because they involve different comparison groups, different cost assumptions, and considerable local variation in costs for specific services, it is difficult to compare this aspect of one Blueprint program with another. Potential users should evaluate these claims carefully. We believe these cost-benefit estimates are useful, but they are not the most important consideration in selecting a violence prevention program or intervention.

It is important to note that the *size* of the deterrent effects of these Blueprint programs is modest. There are no "silver bullets," no programs that prevent the onset of violence for all youth participating in the intervention. Good prevention programs reduce the rates of violence by 30-40 percent.[18] We have included a section in each Blueprint presenting the evaluation results so that potential users can have some idea of how strong the program effect is likely to be and can prepare their communities for a realistic set of expectations. It is important that we not oversell violence prevention programs; it is also the case that programs with a 30 percent reduction in violence can have a fairly dramatic effect if sustained over a long period of time.

Finally, we are not recommending that communities invest all of their available resources in Blueprint programs. We need to develop and evaluate new programs to expand our knowledge of what works and to build an extensive repertoire of programs that work if we are ever to mount a comprehensive prevention initiative in this country. At the same time, given the costs of evaluating programs, it makes sense for communities to build their portfolio of programs around interventions that have been demonstrated to work, and to limit their investment in new programs to those they can evaluate carefully. Our Blueprint series is designed to help communities adopt this strategy.

Summary

As we approach the 21st Century, the nation is at a critical crossroad: Will we continue to react to youth violence after the fact, becoming increasingly punitive and locking more and more of our children in adult prisons? Or will we bring a more healthy balance to our justice system by designing and implementing an effective violence prevention initiative as a part of our overall approach to the violence problem? We do have a choice.

To mount an effective national violence prevention initiative in this country, we need to find and/or create effective violence prevention programs and implement them with integrity so that significant reductions in violent offending can be realized. We have identified a core set of programs that meet very high scientific standards for being effective prevention programs. These programs could constitute a core set of programs in a national violence prevention initiative. What remains is to ensure that communities know about these programs and, should they desire to replicate them, have assistance in implementing them as designed. That is our objective in presenting this series of *Blueprints for Violence Prevention*. They constitute a complete package of both programs and technical assistance made available to states, communities, schools, and local agencies attempting to address the problems of violence, crime, and substance abuse in their communities.

Delbert S. Elliot
Series Editor

ENDNOTES

1. Cook and Laub, 1997; Fox, 1996; and Snyder and Sickmund, 1995 for an analysis of trends in juvenile arrests for violent crimes.

2. Lipsey, 1992, 1997; Sherman et al., 1997; and Tolan and Guerra, 1994.

3. The technical definition of a protective factor is an attribute or condition that buffers one from the expected effect of one or more risk factors, but many use the term more generally to refer to anything that reduces the likelihood of violence, whether that effect is direct or indirect.

4. Maguire and Pastore, 1996.

5. Johnston et al., 1996.

6. Fagan, 1996; Frazier, Bishop and Lanza-Kaduce, 1997; Lipsey, 1997; MacKenzie et al., 1992; Podkopaz and Feld, 1996; and Shaw and McKenzie, 1992.

7. Gottfredson, 1997; Lipsey, 1992; Sherman et al., 1997; Tolan and Guerra, 1994; and Webster, 1993.

8. Gottfredson, 1997.

9. Gallop, 1994.

10. Lipton, Martinson, and Wilks, 1975; Martinson, 1974; Sechrest et al., 1979; and Wright and Dixon, 1977.

11. Davis and Tolan, 1993; Dusenbury and Falco, 1995; Farrington, 1994; Greenwood et al., 1996; Hawkins, Catalano and Miller, 1992; Howell, 1995; Howell et al., 1995; Krisberg and Onek, 1994; Lipsey and Wilson, 1997; Loeber and Farrington, 1997; McGuire, 1995; National Research Council, 1993; Office of Juvenile Justice and Delinquency Prevention, 1995; Powell and Hawkins, 1996; Sherman et al., 1997; and Tolan and Guerra, 1994.

12. Elliott, 1993, 1994; Jessor and Jessor, 1977; Kandel et al., 1986; Osgood et al., 1988; and White et al., 1985.

13. Gottfredson, 1997; Lipsey, 1992; Osgood et al., 1988; and Sherman et al., 1997.

14. Advisory Board members included: Denise Gottfredson, University of Maryland; Mark Lipsey, Vanderbilt University; Hope Hill, Howard University; Peter Greenwood, the Rand Corporation; and Patrick Tolan, University of Illinois.

15. Greenwood, Model, Rydell, and Chiesa, 1996; Washington State Institute for Public Policy, 1998.

16. The Center has submitted a proposal to the Office of Juvenile Justice and Delinquency Prevention that would provide technical assistance and evaluation of program implementation for 50 replications of Blueprint programs.

17. At some point it will be necessary to reassess each Blueprint program to ensure that it continues to demonstrate deterrent effects and to test its generalizability to other populations and community conditions. In many cases, this will be done at the national level with federal support for large scale evaluations. For example, the U.S. Department of Labor and the Ford Foundation are currently funding seven Quantum Opportunity Programs with outcome evaluations; and the Office of Juvenile Justice and Delinquency Prevention is funding several Big Brothers Big Sisters Programs with evaluations. Local agencies replicating these Blueprint programs may never have to conduct rigorous outcome evaluations, but some continuing outcome evaluations at some level (national or local) is essential.

18. See Lipsey, 1992, 1997, for a review of issues and problems in estimating effect sizes and the range of effect sizes observed for delinquency prevention programs.
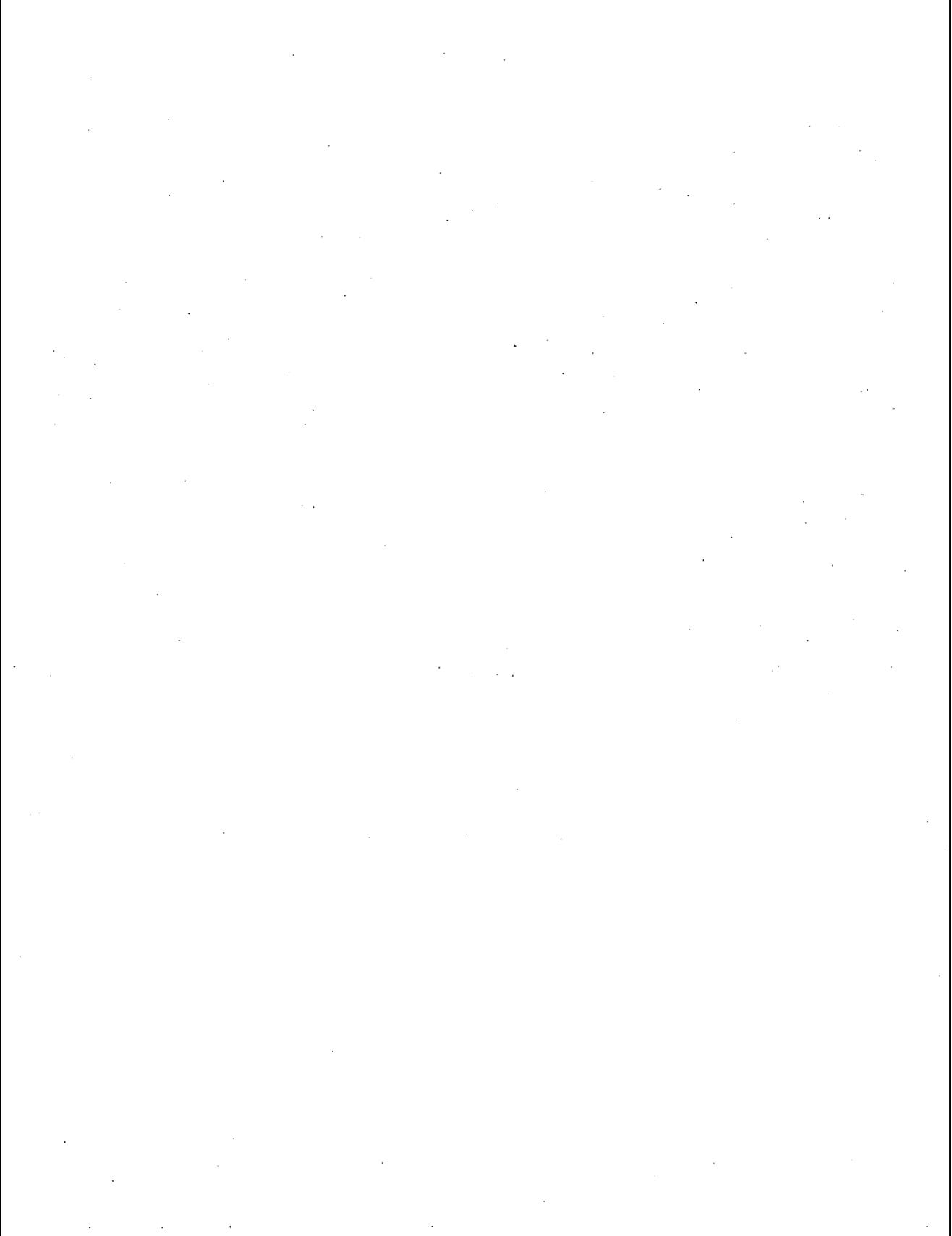
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Model Program Descriptions
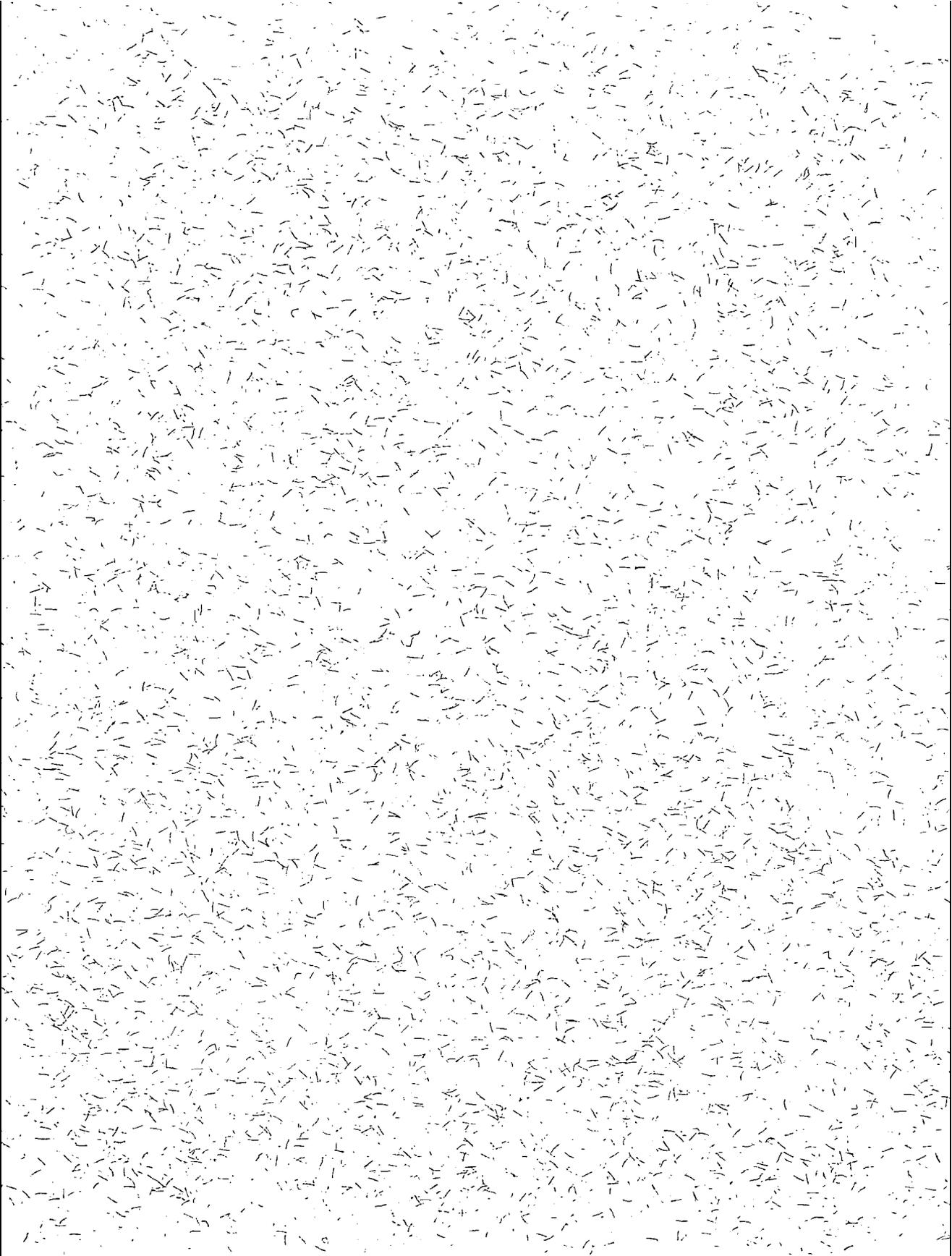
MODEL PROGRAM DESCRIPTIONS

Prenatal and Infancy Home Visitation by Nurses

Nurse home visitation is a program that sends nurses to the homes of pregnant women who are predisposed to infant health and developmental problems (i.e., at risk of preterm delivery and low-birth weight children). The goal of the program is to improve parent and child outcomes. Home visiting promotes the physical, cognitive, and social-emotional development of the children, and provides general support as well as instructive parenting skills to the parents. Treatment begins during pregnancy, with an average of eight visits for about 1 hour and 15 minutes, and continues to 24 months postpartum with visits diminishing in frequency to approximately every six weeks. Screenings and transportation to local clinics and offices are also offered as a part of treatment. Nurse home visiting has had some positive outcomes on obstetrical health, psychosocial functioning, and other health-related behaviors (especially reductions in smoking). Child abuse and neglect was lower and the developmental quotients of children at 12 and 24 months were higher in the treatment group than in the control group for poor, unmarried teens. Follow-up at 15-years postpartum showed significant enduring effects on child abuse and neglect, completed family size, welfare dependence, behavior problems due to substance abuse, and criminal behavior on the part of low income, unmarried mothers. Positive program effects through the child's second birthday have been replicated in a major urban area.

Bullying Prevention Program

The anti-bullying program has as its major goal the reduction of victim/bully problems among primary and secondary school children. It aims to increase awareness of the problem and knowledge about it, to achieve active involvement on the part of teachers and parents, to develop clear rules against bullying behavior, and to provide support and protection for the victims of bullying. Intervention occurs at the school level, class level, and individual level. In Bergen, Norway, the frequency of bully/victim problems decreased by 50 percent or more in the two years following the campaign. These results applied to both boys and girls and to students across all grades studied. In addition, school climate improved, and antisocial behavior in general such as theft, vandalism, and truancy showed a drop during these years.

Promoting Alternative Thinking Strategies

Promoting Alternative Thinking Strategies (PATHS) is a school-based intervention designed to promote emotional competence, including the expression, understanding, and regulation of emotions. The PATHS program is a universal intervention, implemented by teachers (after a three-day training workshop) with entire classrooms of children from kindergarten through fifth grades. The curriculum includes a feelings unit (with a self-control and initial problem-solving skills program within that unit) and an interpersonal cognitive problem solving unit. The generalization of those learned skills to children's everyday lives is a component of each major unit. An additional unit on self-control and readiness is provided for special needs classrooms. Studies have compared classrooms receiving the intervention to matched controls using populations of normally-adjusted students, behaviorally at-risk students, and deaf students. Program effects included teacher-, child sociometric-, and child self-report ratings of behavior change on such constructs as hyperactivity, peer aggression, and conduct problems.

Big Brothers Big Sisters of America

Big Brothers Big Sisters of America (BBBSA) is the oldest and best known mentoring program in the United States. Local programs are autonomously funded affiliates of BBBSA, with the national office in Philadelphia. The more than 500 affiliates maintain over 100,000 one-to-one relationships between a volunteer adult and a youth. Matches are carefully made using established procedures and criteria. The program serves children 6 to 18 years of age, with the largest portion being those 10 to 14 years of age. A significant number of the children are from disadvantaged single-parent households. A mentor meets with his/her youth partner at least three times a month for three to five hours. The visits encourage the development of a caring relationship between the matched pair. An 18 month study of eight BBBS affiliates found that the youth in the mentoring program, compared to a control group who were on a waiting list for a match, were less likely to start using drugs and alcohol, less likely to hit someone, had improved school attendance, attitudes and performance, and had improved peer and family relationships.

Quantum Opportunities

The Quantum Opportunities Program (QOP) provides education, development, and service activities, coupled with a sustained relationship with a peer group and a caring adult, over the four years of high school for small groups of disadvantaged teens. The goal of the program is to help high risk youth from poor families and neighborhoods to graduate from high school and attend college. The program includes (1) 250 hours per year of self-paced and competency-based basic skills, taught outside of regular school hours; (2) 250 hours per year of development opportunities, including cultural enrichment and personal development; and (3) 250 hours per year of service opportunities to their communities to help develop the prerequisite work skills. Financial incentives are offered to increase participation, completion, and long range planning. Results from the pilot test of this program indicated that QOP participants, compared to the control group, were less likely to be arrested during the juvenile years, were more likely to have graduated from high school, to be enrolled in higher education or training, planning to complete four years of college, and less likely to become a teen parent.

Multisystemic Therapy

Multisystemic Therapy (MST) views individuals as being nested within a complex of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Behavior problems can be maintained by problematic transactions within or between any one or a combination of these systems. MST targets the specific factors in each youth's and family's ecology (family, peer, school, neighborhood, support network) that are contributing to antisocial behavior. MST interventions are pragmatic, goal oriented, and emphasize the development of family strengths. The overriding purpose of MST is to help parents to deal effectively with their youth's behavior problems, including disengagement from deviant peers and poor school performance. To accomplish the goal of family empowerment, MST also addresses identified barriers to effective parenting (e.g., parental drug abuse, parental mental health problems) and helps family members to build an indigenous social support network (e.g., with friends, extended family, neighborhoods, church members). To increase family collaboration and treatment generalization, MST is typically provided in the home, school, and other community locations by master's level counselors with low caseloads and 24 hours/day, seven days/week availability. The average duration of treatment is

about four months, which includes approximately 50 hours of face-to-face therapist-family contact. MST has been demonstrated as an effective treatment for decreasing the antisocial behavior of violent and chronic juvenile offenders at a cost savings—that is, reducing long-term rates of rearrest and out-of-home placement. Moreover, families receiving MST have shown extensive improvements in family functioning.

Functional Family Therapy

Functional Family Therapy (FFT) is a short term, easily trainable, well documented program which has been applied successfully to a wide range of problem youth and their families in various contexts (e.g., rural, urban, multicultural, international) and treatment systems (e.g., clinics, home-based programs, juvenile courts, independent providers, federally funded clinical trials). Success has been demonstrated and replicated for over 25 years with a wide range of interventionists, including paraprofessionals and trainees representing the various professional degrees (e.g., B.S.W., M.S.W., Ph.D., M.D., R.N., M.F.T.). The program involves specific phases and techniques designed to engage and motivate youth and families, and especially deal with the intense negative affect (hopelessness, anger) that prevents change. Additional phases and techniques then change youth and family communication, interaction, and problem solving, then help families better deal with and utilize outside system resources. Controlled comparison studies with follow-up periods of one, three, and even five years have demonstrated significant and long-term reductions in youth re-offending and sibling entry into high-risk behaviors. Comparative cost figures demonstrate very large reductions in daily program costs compared to other treatment programs.

Midwestern Prevention Project

The Midwestern Prevention Project is a comprehensive population-based drug abuse (cigarettes, alcohol, and marijuana) prevention program that has operated in two major Midwestern SMSAs, Kansas City and Indianapolis, where it has been known locally as Project STAR (Students Taught Awareness and Resistance) and I-STAR, respectively. The goal of the program is to decrease the rates of onset and prevalence of drug use in young adolescents (ages 10-15), and to decrease drug use among parents and other residents of the two communities. The program consists of five intervention strategies designed to combat the community influences on drug use: mass media, school, parent, community organization, and health policy change. The components focus on promoting drug use resistance and counteraction skills by adolescents (direct skills training), prevention practices and support of adolescent prevention practices by parents and other adults (indirect skills training), and dissemination and support of non-drug use social norms and expectations in the community (environmental support). This program has been effective at reducing alcohol, cigarette, and marijuana use among young adolescents, with some effects maintained up to age 23.

Life Skills Training

Life Skills Training is a drug use primary prevention program (cigarettes, alcohol, and marijuana), which provides general life skills training and social resistance skills training to junior high/middle (6th or 7th grade) school students. The curriculum includes 15 sessions taught in school by regular classroom teachers with booster sessions provided in year two (10 class sessions) and year three (five class sessions). The three basic components of the program include: (1) Personal Self-Management Skills (e.g., decision-making and problem-solving, self-control skills for coping with anxi-

ety, and self-improvement skills); (2) Social Skills (e.g. communication and general social skills); and (3) Drug-Related Information and Skills designed to impact on knowledge and attitudes concerning drug use, normative expectations, and skills for resisting drug use influences from the media and peers. Life Skills Training has been effective at reducing alcohol, cigarette, and marijuana use among young adolescents. The effects for tobacco and heavy alcohol use have been sustained through the end of high school.

Multidimensional Treatment Foster Care

Social learning-based Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to residential treatment for adolescents who have problems with chronic delinquency and antisocial behavior. Community families are recruited, trained, and closely supervised to provide MTFC placements, treatment, and supervision to participating adolescents. MTFC parent training emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a preservice training, MTFC parents attend a weekly group meeting run by a program case manager where ongoing supervision is provided. Supervision and support is also given to MTFC parents during daily telephone calls to check on youths' progress. Family therapy is provided for the youths' biological (or adoptive) families. The parents are taught to use the structured system that is being used in the MTFC home. The effectiveness of the MTFC model has been evaluated, and MTFC youth had significantly fewer arrests during a 12-month follow-up than a control group of youth who participated in residential group care programs. The MTFC model has also been shown to be effective for children and adolescents leaving state mental hospital settings.

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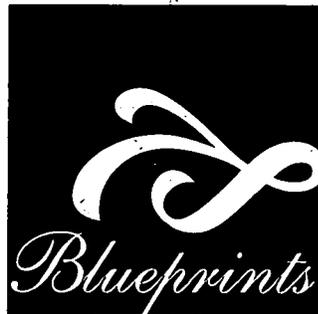
Program Overview
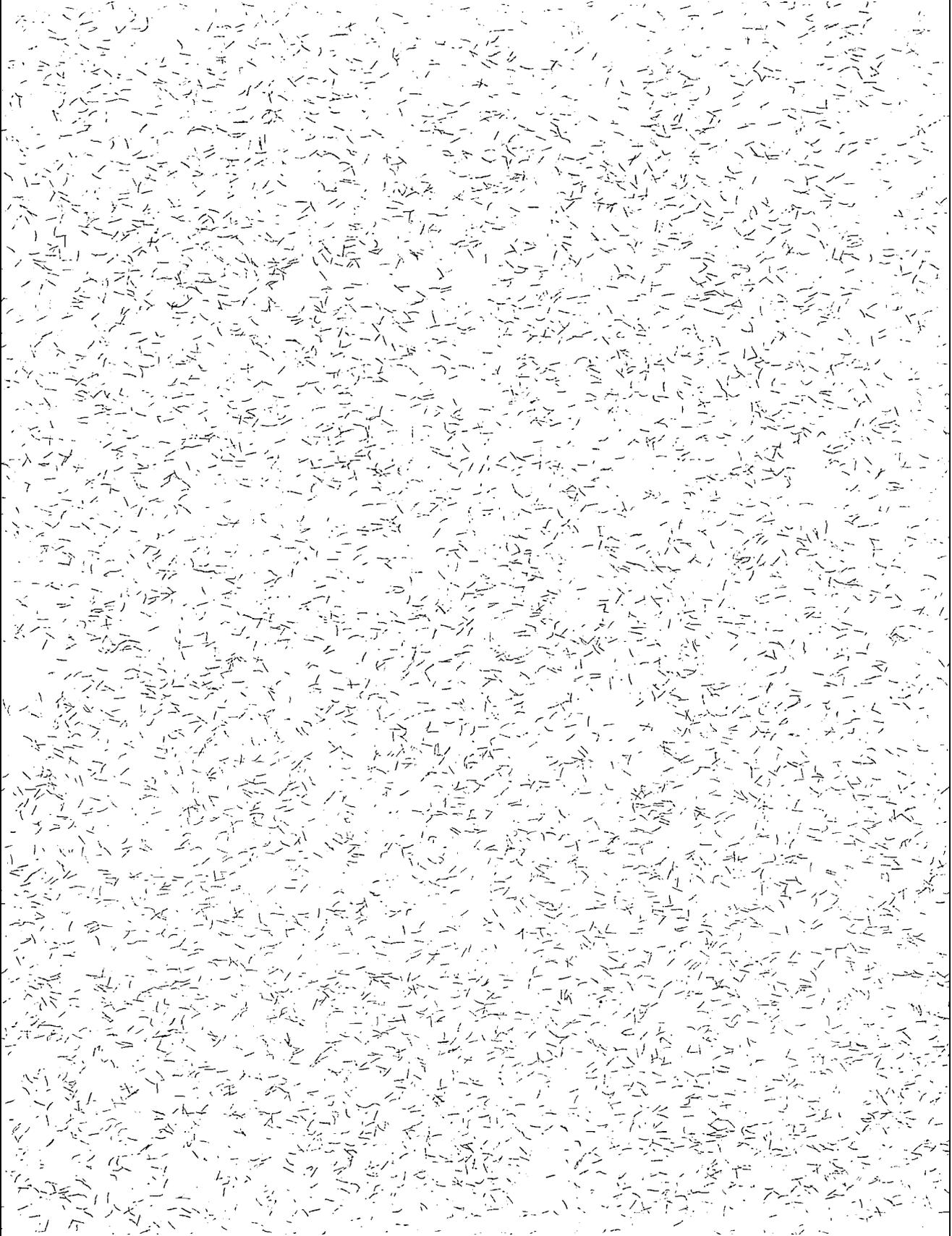
MULTIDIMENSIONAL TREATMENT FOSTER CARE

Program Overview

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

Program Targets:

Teenagers with histories of chronic and severe criminal behavior at risk of incarceration.

Program Content:

MTFC Training For Community Families. Emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a pre-service training and placement of the youth, MTFC parents attend a weekly group meeting run by a program case manager where ongoing supervision is provided. Supervision and support is also given to MTFC parents during daily telephone calls to check on youth progress and problems.

Services to the Youth's Family. Family therapy is provided for the youth's biological (or adoptive) family, with the ultimate goal of returning the youth back to the home. The parents are taught to use the structured system that is being used in the MTFC home. Closely supervised home visits are conducted throughout the youth's placement in MTFC. Parents are encouraged to have frequent contact with the MTFC case manager to get information about their child's progress in the program.

Services to the Youth. Youth participate in a structured daily behavior management program implemented in the MTFC home. Individual, skill-focused therapy is also provided weekly for program youth. School attendance, behavior, and homework completion are closely monitored, and interventions are conducted as needed for youth in the schools.

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

Evidence of Effectiveness:

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

- Spent 60 percent fewer days incarcerated at 12 month follow-up;
- Had significantly fewer subsequent arrests;
- Ran away from their programs, on average, three times less often;
- Had significantly less hard drug use in the follow-up period; and
- Quicker community placement from more restrictive settings (e.g., hospital, detention).

Costs:

The cost per youth is $2,691 per month; the average length of stay is seven months.
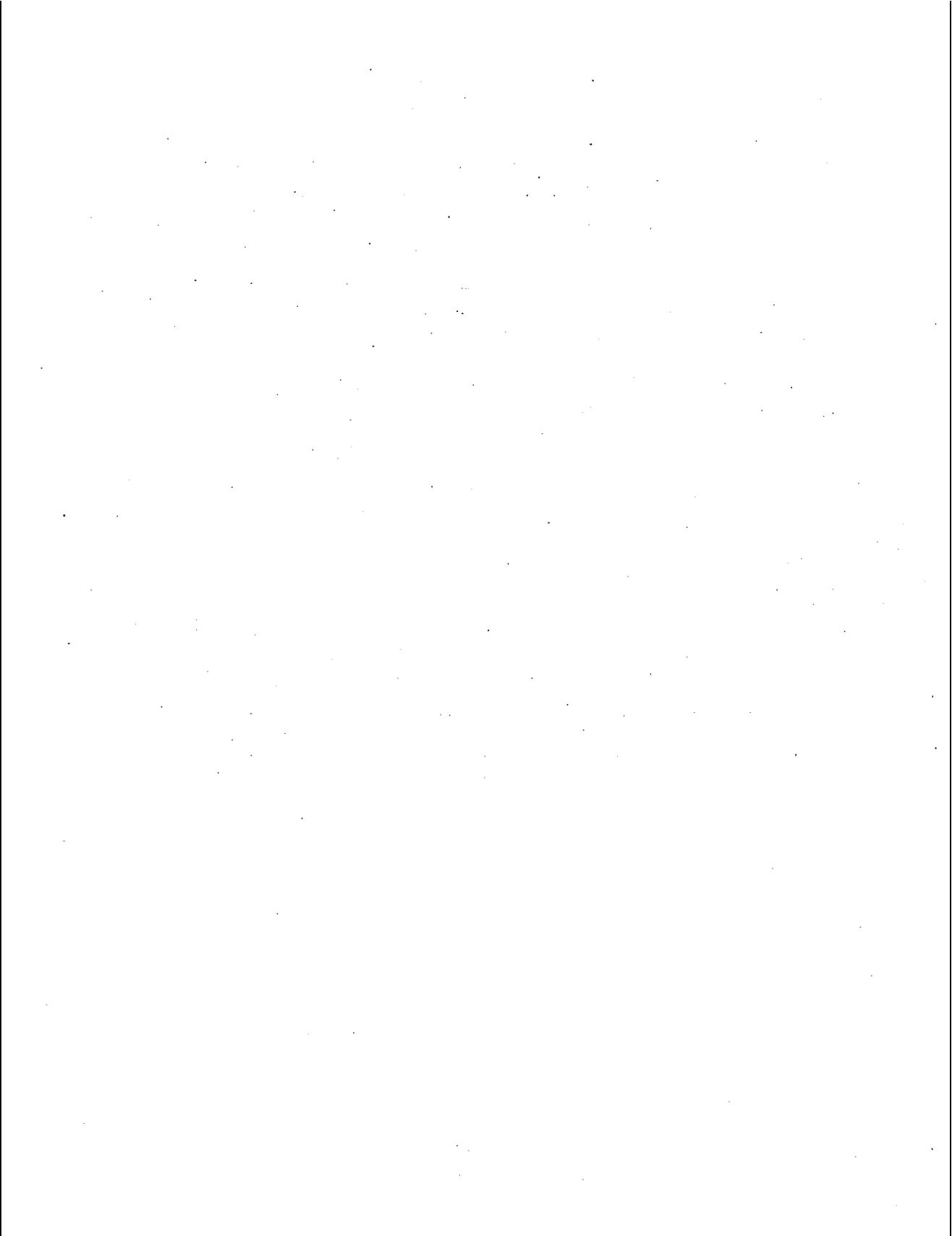
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CHAPTER ONE
Executive Summary
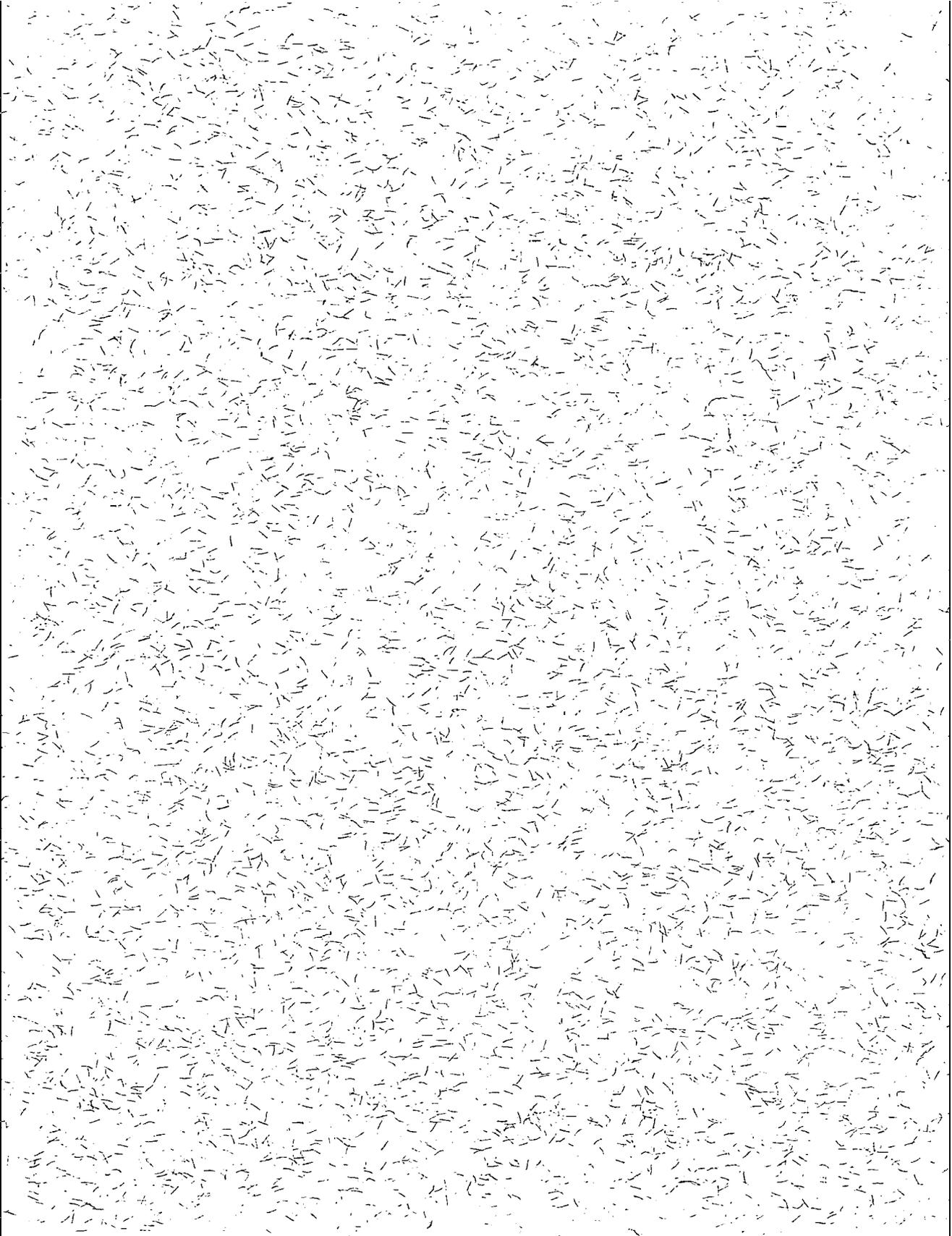
EXECUTIVE SUMMARY

Background

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

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

Theoretical Rationale/Conceptual Framework

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

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

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

Most widely used treatments for delinquency, such as Positive Peer Culture, attempt to use the "group process" to gain a therapeutic effect. The assumption is that the peer group can best motivate and influence youth to change their behaviors and attitudes. However, it seems unreasonable to expect youngsters with histories of serious delinquent behaviors to function as a group and some-

how become good influences on each other or establish prosocial norms or values. It may be that these approaches vastly underestimate the influence that adult-initiated norms and rules of conduct can have in the face of day-to-day involvement in a peer-dominated culture. A more sensible intervention would involve minimizing the influence of peers and immersing the youngster in a nondelinquent culture.

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

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

By the time an antisocial child has reached school age, three processes are well underway. Parents are responding to him/her negatively; the child uses coercive tactics as his/her main strategy for getting what s/he wants and avoiding what s/he does not want (e.g., chores, homework); and s/he has

deficits in prosocial behavior, having failed to learn the skills necessary to cooperate in the classroom, on teams, or in clubs. There is substantial evidence that aggressive children are likely to be rejected by their peers and that rejected children are more likely to associate with other aggressive, rejected children who tend to reward negative behavior in their interactions with each other. Antisocial aggressive children are also at risk for school failure. The "coercive training" that they received in their families reduces their behavioral and social competencies which sets them up for social and academic failure at school.

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

Brief Description of Intervention

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

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

Because youth who participate in the program have committed several delinquent acts (i.e., an average of thirteen previous arrests in our most recent sample), the level of supervision required is high. Youth are not permitted to have unsupervised free time in the community, and their peer relationships are closely monitored. Over the course of the placement, levels of supervision and discipline are adjusted, depending on the youth's level of progress or lack thereof. Close monitoring of young-

sters at home and at school is a hallmark of the MTFC model. There is heavy emphasis placed on teaching interpersonal skills and on participation in positive social activities, including sports, hobbies, and other forms of recreation.

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

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

Evidence of Program Effectiveness

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

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

The MTFC model has been tested in two studies where the feasibility of using this model in lieu of incarceration for adolescents referred for delinquency was explored. The first study of 32 youth

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

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

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

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

Data was collected on official arrests, including each boy's arrest history prior to entering the study. In addition, confidential self-reports of criminal activity were collected from each boy. The number of days each boy was incarcerated and/or "on the run" was tracked, as was information on school attendance and academic advancement. Mental health outcomes were also assessed. To measure

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

Summary of Results

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

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

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

Figure 1. Mean Number of Arrests
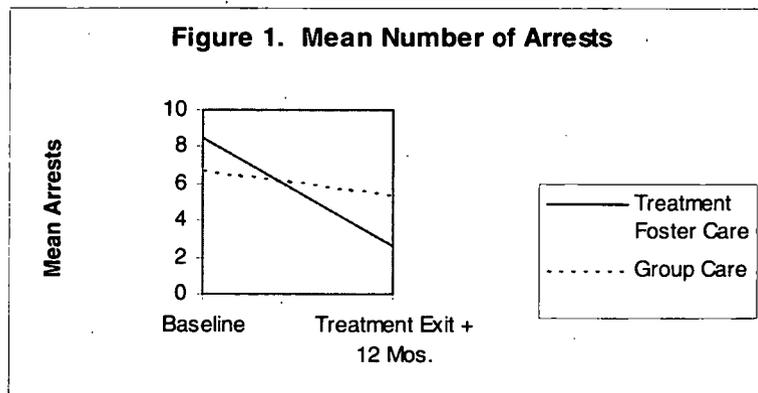
Next, we looked at whether the variables that we thought would mediate the effectiveness of treatment related to arrest rates during the time that boys were in the program and in follow-up. It was found that regardless of placement setting (i.e., MTFC or GC), the mediating variables examined (i.e., supervision, discipline, deviant peers) predicted arrests one year

after boys had completed treatment. In other words, boys in either MTFC or GC who got good supervision; consistent, predictable discipline; and had less association with delinquent peers had fewer arrests in follow-up that those who did not. However, the structure of the GC programs (i.e., boys lived with other delinquent youth) promoted association with delinquent peers. Because of this, for GC boys, scores on the association with delinquent peers measure were higher (more negative), but the scores for effective supervision and discipline were lower than the scores for boys in MTFC. The evidence supports the theoretical rationale—to the extent that the risk factors are impacted, the behavioral outcome (i.e., arrests) will be impacted. This set of findings has implications for all programs which aim to reduce rates of criminal offending in juveniles.
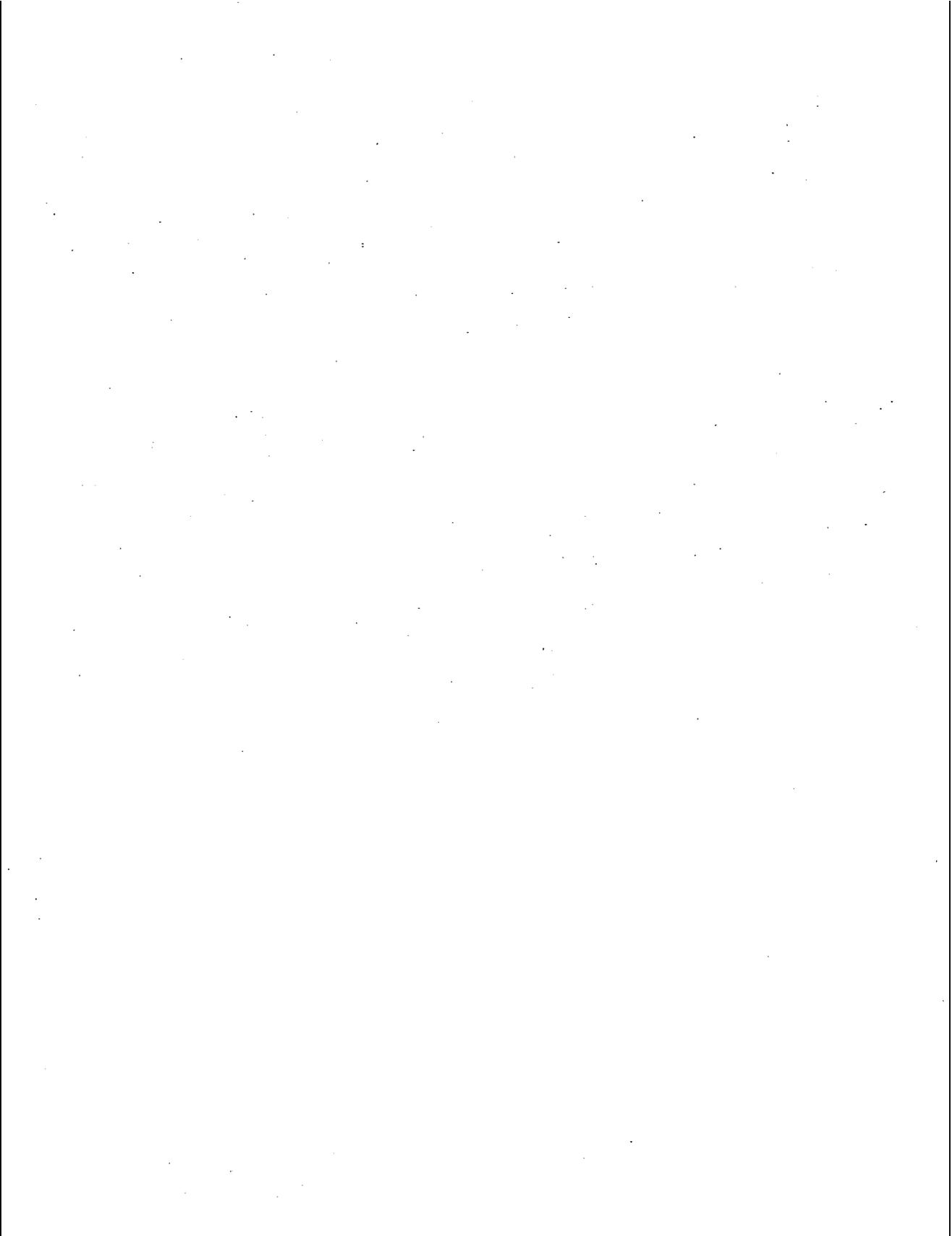
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CHAPTER TWO

**Program As Designed
And Implemented**
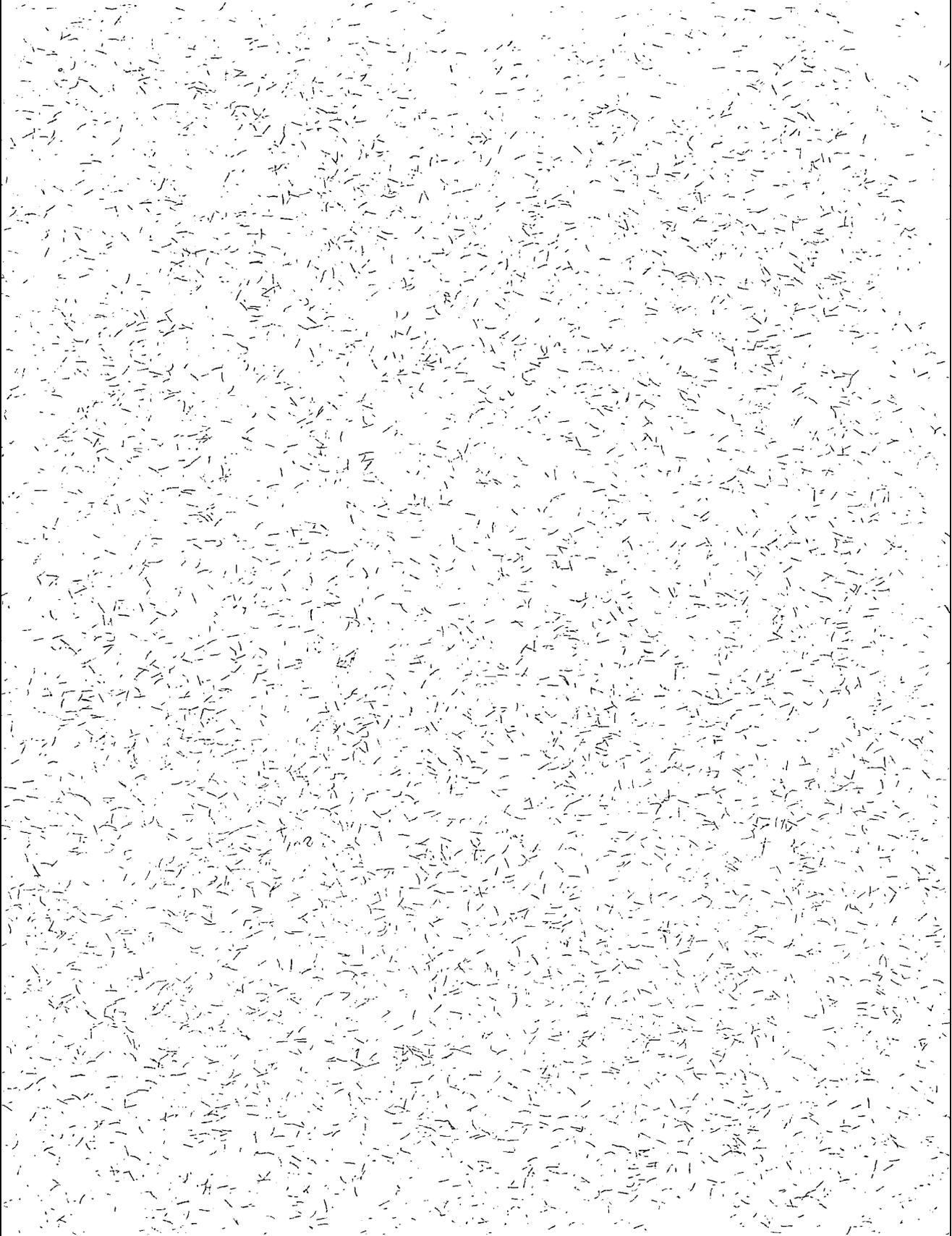
PROGRAM AS DESIGNED AND IMPLEMENTED

Goals and Measurable Objectives

The objectives of the MTFC program are to provide adolescents who are seriously delinquent and in need of out-of-home care with close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult, and to reduce their exposure to delinquent peers. The goals are to decrease delinquent behavior and to increase participation in developmentally appropriate prosocial activities, including school, sports, and hobbies. The MTFC program attempts to:

- ❧ reinforce youths' normative and positive behaviors;
- ❧ closely supervise youth at all times;
- ❧ closely monitor peer associations;
- ❧ specify clear and consistent rules and limits;
- ❧ consistently follow through with consequences for both positive and problem behavior;
- ❧ encourage youth to develop academic skills and positive work habits;
- ❧ support family members[1] to increase their parenting skills;
- ❧ decrease conflict between family members;
- ❧ teach youth new skills for forming relationships with positive peers and for bonding with adult mentors and role models.

Targeted Risk and Protective Factors and Population

Targeted Risk and Protective Factors

Risk factors include:

- ❧ lack of supervision;
- ❧ inconsistent, lax, and/or overly harsh discipline;
- ❧ association with a delinquent peer group;
- ❧ poor school attendance and performance;
- ❧ history of multiple arrests; and
- ❧ early history of antisocial behavior at home and in school.

Protective factors include:

- ❧ a supportive relationship with a mentoring adult(s);
- ❧ involvement in normative social activities, age-appropriate self-care and social skills; and
- ❧ relationships with positive peers.

Targeted Population

The OSLC MTFC program was originally designed in 1983 in response to a state request for proposal for services to serious and violent juvenile offenders that would be an alternative to incarceration in the state training school. During the ensuing years, over 300 such youth have been served using this model. All youth are referred by the juvenile justice system after other home-based interventions have failed. All youth have been supervised by parole or probation officers, and most had participated in outpatient treatment and skills training or competency groups run by the local Department of Youth Services. All

youth have spent time in detention prior to enrolling in the program. Aside from detention stays, youth had an average of 1.76 previous out-of-home juvenile justice type placements.

To provide some idea of the typical male youth participating in MTFC, Table 1 summarizes demographic and family characteristics for the 79 boys who participated in the most recently completed clinical trial.

The females who have participated in the program have presented a slightly different profile. For example, they committed their first offense at an older age than boys (girls age of first offense averaged 13 years of age). They had also committed fewer offenses than boys (an average of 8.4 arrests prior to entering the program) and had been placed out of their family homes before entering MTFC significantly more often than boys (an average of over four times). As might be expected, significantly more of the girls than the boys had been sexually abused, a factor that contributed to their more frequent out-of-home placements. In a recent study we have found that the girls referred to us by the juvenile justice system have experienced numerous changes in adult caretakers during their lives. To examine this, we conduct a life history interview with girls. Although the girls who are participating in the study are an average of only 13 years old, they report that they have had an average of 13.5 changes in parental figures throughout their short lives. That is, they have had different constellations of parent figures taking care of them over 13 times, on average. Many of these parent figures were staff in institutional-type settings such as residential care or foster parents. Many of these changes in parent figures were also accompanied by changes in residency, necessitating changes in schools, peer groups, community activities, and support systems.

Although MTFC primarily targets and has proven to be effective with serious and chronic delinquents, it has been adapted to meet the needs of other populations as well. These adaptations, however, have not been as thoroughly evaluated.

Beginning in 1986, the MTFC model was adapted for youngsters with severe emotional and behavioral problems who were leaving the state hospital. These children were 9 to 18 years old and had been hospitalized for most of the year prior to treatment in MTFC. Based on that work, we began treating youngsters referred from the mental health and child welfare systems who were eligible for Medicaid services. These youngsters range in age from 4 to 18 and typically have experienced a number of previous out-of-home placements due to parental abuse or neglect. During the 1996-97 year, we treated 80 seriously emotionally disturbed children in the Medicaid-funded MTFC program.

In 1996 we began an MTFC program for adolescents with developmental disabilities who also had histories of sexual acting out. This program is small (10 cases), but it appears that the MTFC model, with some adaptations, works well for this population of youngsters.

The most recent research focus of our MTFC approach is on young (12-16 year old) adolescent females who have histories of both criminal behavior and severe emotional problems. In February of 1997, we began a study funded by the National Institute of Mental Health to examine relevant treatment processes and outcomes for this high-risk group. This program is an outgrowth of a previous study where we examined the effectiveness of MTFC for boys versus girls. All of the youngsters had been referred by the local juvenile department for placement in MTFC because of a history of criminal activity. In that study we found that while MTFC was equally effective for boys and girls in terms of reducing criminal behavior in follow-up, girls presented some unique problems in treatment. Girls, compared to boys, had more disrupted childhoods (i.e., they had been placed out of

Characteristics	Group Care (n=42)	TFC (n=37)
Mean Age at Referral	15.1	14.8
Mean Age at First Arrest	12.5	12.8
Mean Number Previous Charges	14.6	12.6
Mean Number Lock-up Days, One Year Pre-referral	89	71
Single Parent Family	54%	59%
Target Youth Adopted	5%	9%
Parent Hospitalized	7%	9%
Parent Convicted of Crime	30%	25%
Siblings Institutionalized	22%	16%
Perpetrator of Sexual Abuse	7%	13%
Drug/Alcohol Abuse	15%	3%
Chronic Truancy	69%	61%
Firesetting	22%	13%
Ran Away from Placement	78%	75%
2 or More of Above	85%	87%
3 or More of Above	63%	56%

their homes significantly more often), they were more likely to run away from placement, and although they got along well with MTFC parents initially, this relationship deteriorated over the course of the placement. These findings prompted us to more carefully and systematically study the unique needs of adolescent females.

About 20 percent of the children and adolescents who have participated in our MTFC programs across all of the different samples, have been ethnic minorities. At this point, we have not conducted formal analyses on the efficacy of MTFC for minority youngsters. Anecdotally, it appears that their are no differences in the responsiveness to the program model due to ethnic differences.

Program as Designed

Intervention Modalities

Intervention modalities are multifaceted and interventions occur in multiple settings. Modalities include behavioral parent training for MTFC parents and biological parents (or other aftercare resources), skills training for youth, supportive therapy for youth and involved adults, school-based behavioral interventions and other academic support, and psychiatric consultation and medication

management, as needed. These treatment modalities are implemented in settings which include the MTFC homes, the biological parent/relative homes, schools, and community settings (e.g., sports activities, church groups, clubs, camps).

Program Content

Recruitment of MTFC Families

MTFC parents are recruited through a variety of methods. Word-of-mouth and newspaper advertising have been the most successful methods. We pay existing MTFC parents a "finder's fee" of $100 for recommending interested families that we later train and place youngsters with. Newspaper adds are most successful if they include a description of the age and gender of the child to be placed, and the amount of the monthly stipend that MTFC parents will be given. Interested MTFC parents are then screened for basic eligibility (e.g., adequate space in their home, no previous criminal history) by telephone, and an application is then sent to them (see Appendix B). Following return of the application, a home visit is conducted by the MTFC recruiter. During the home visit, a complete explanation of the program is provided to prospective MTFC parents, and the training and certification requirements are explained. The purpose of the home visit is to meet the prospective family, to see if their home atmosphere is conducive to caring for a disturbed or delinquent youngster, and to give them more information about the program. Many families who are suitable for "regular" foster care are not good MTFC parents.

> *MTFC foster parents must be willing to take an active treatment perspective, to work with the program in implementing a daily structured program for the youngster, and be willing and able to work with a delinquent or disturbed youngster.*

In MTFC, the parents must be willing to take an active treatment perspective, to work with the program in implementing a daily structured program for the youngster, and be willing and able to work with a delinquent or disturbed youngster. Some of the most successful families who provide "regular" foster care prefer to work independently and often this ability to go it alone is an asset in the regular foster care system where case workers are over burdened and may be unavailable. However, in MTFC we rely on having constant quality communication with the MTFC parents. The youngsters that we are placing in their homes need active therapeutic work. They will not "get better' with just a loving supportive foster home. We want to work with the MTFC parents to design and implement a planned intervention for the youngster placed with them, therefore the foster families that participate in MTFC must be willing to be part of the therapeutic team.

In the 15 years that we have run the program, we have had MTFC families from all walks of life. Both single parents and married couples with and without children of their own have been successful MTFC parents. Although we have conducted no formal research on selection factors, the individual and family characteristics that seem related to success in working with our most difficult youth include an ability to take another person's perspective, a good knowledge of child and adolescent development (often acquired through raising one's own children), and a healthy sense of humor. The recruiter makes an informal assessment of these characteristics during the home visit. Families who appear to be unsuitable are referred to the local child welfare office to participate in providing "regular" foster care or are discouraged from continuing in the process.

Pre-Service Training of MTFC Parents and Overview of the Point/Level System

MTFC parents participate in a 20-hour preservice training where an overview of the model is presented (see Appendix C). During the pre-service training, a four-step approach to analyzing behavior is taught, procedures for implementing the individualized daily program are demonstrated and discussed, methods for working with the child's biological family are reviewed, and MTFC policies and procedures are explained. Training methods used are both didactic and experiential. During the training we place a great deal of emphasis on methods and techniques for reinforcing and encouraging youth. Prospective MTFC parents who are resistant to giving a youngster extra support and attention for doing what they are supposed to do are encouraged not to continue. Many well-intentioned people feel that providing daily incentives for achievement undermine the individual's basic motivation. Because daily encouragement is such an important component of our MTFC programs, we are insistent that families share or at least do not oppose this philosophy.

Throughout the screening and training process we are getting to know the MTFC parents and their family and living situation so we can appropriately match them with a program youngster. Demographics play a part. For example, if the youth has a history of sexual acting out, we would not place him/her in a home where younger children are present. Even if the MTFC parents are grandparents and have younger grandchildren visiting, these placements are not made. Many MTFC youth have histories of not doing well with other children (e.g., fighting or otherwise victimizing them), so we are careful to consider the MTFC family constellation before making placements. The system for matching MTFC parents with youngsters is an informal one. We discuss possibilities with the MTFC parents, interview them on who comes and goes in their home, look at their schedules and typical daily activities, find out about their hobbies and interests, and then make the best match we can between available families and youth.

In some cases, the match simply doesn't work. This can be for a variety of reasons and usually happens with new or inexperienced MTFC parents whose expectations do not match reality when a child is finally placed with them. In these cases, we move the child to another MTFC home. Other reasons that we have had to move youth, through no fault of their own, are that the MTFC parents divorce, they get an employment transfer, or a parent becomes severely ill. In all of these instances moves are planned fully and made as quickly as possible. As State certified foster parents, MTFC families have the same liability coverage as any foster parent, and the program carries no extra insurance to cover them.

Following the preservice training, a match is made between prospective MTFC parents and youth. The MTFC parents are given all of the information that the program has on the youth, including the case file to review so that they are fully informed about the youth's history. The youth's individualized daily program is developed by the case manager in concert with the MTFC parents. The daily program specifies the schedule of activities and behavioral expectations and assigns a number of points the youth can earn for satisfactory performance. The points are a concrete way that MTFC parents provide the youth with positive feedback about their progress. The goal of the point program is to give MTFC parents a vehicle for providing the youngster with frequent positive reinforcement for normative and prosocial behavior, and to give the youngster a clear message about how they are doing.

The daily individualized program that is implemented in the MTFC home involves the use of a three-level point system by which the youth are provided with structured daily feedback. Points are earned

throughout the day for expected activities including going to class on school days. Points are lost for rule infractions including small "violations" such as not minding or having a surly attitude. The economy of the point system is set up to emphasize positive achievements, including participating in the developmental tasks associated with youngsters in this age group. We train MTFC foster parents to take points away in a matter-of-fact, or even slightly sympathetic way. They are specifically taught to refrain from lecturing or arguing and on methods to disengage if the youngster initiates an argument.

Level one lasts for approximately three weeks or until the youth earns a total of 2100 points. On level one, the youth earns points for routine daily activities such as getting out of bed on time in the morning, getting ready for school, doing a quick chore, doing homework, having a mature attitude, attending classes at school, and having a cooperative attitude in school (which is monitored through a school card, discussed later), and other behaviors that are designated by the MTFC parents and the program staff. Points earned one day are traded for privileges on the following day. On level one, daily point totals are also tracked to determine when the youth is eligible to advance to level two. On level two, points are accumulated over a week's time and applied to an expanded list of privileges that can be earned during the following week. On level three, privileges are expanded further and include opportunities for youngsters to be involved in community activities without direct adult supervision. In Appendix D a number of examples of point programs are provided.

The question of how violent youth behavior in the foster home is handled often comes up when we talk to interested parties about implementing the MTFC model. We train MTFC parents to take a number of steps to prevent or minimize the probability of youth violence. The strategy to avoid violence focuses on teaching MTFC parents to not engage an agitated or angry youth verbally or physically. The MTFC parent is trained to give the youth space to cool off before trying to problem solve or deal with problem issues and to call the case manager. MTFC parents are taught not to try to physically stop a youth from leaving the home. Instead, if the youth leaves they are to immediately call the case manager who will, in turn, report the incident to the proper authorities. At the first sign of violent behavior the MTFC parent is instructed to call the case manager, or in cases of eminent emergency to call 911. Using these and other procedures that emphasize not engaging with angry youth, we have only very rarely had problems with youth violence in the program foster homes.

Preparing for Placement and The First Days

Before placement, a case manager is assigned to each youth and his/her MTFC family. One of the case manager's first tasks is to review a prototype of the daily point and level system with the youth while s/he is in detention. At that meeting the case manager asks the youth what would be the most difficult aspect of the program for the youth, and youth are praised for identifying what would be a challenge to them. They are then told to think about whether they would like to participate. At that point, most youth indicate that they would, probably because participation means leaving detention and remaining in the local community (many alternative programs are located in other cities throughout the State). MTFC is appealing to most youth as it means that they will be living in a family setting and will be able to remain close to family members. However, if youth indicate that they are not interested, the case manager in no way tries to convince them that MTFC is right for them. We tell them to have their parole/probation officer talk to them about alternatives. All youth come to the program from detention where they are being held pending placement in a program (MTFC or an alternative which is usually some variety of residential or group care). All youth are chronic offenders who have been designated by the court as being in need of placement in an out-of-home corrections program.

The case manager also holds a pre-placement meeting with the youth's parents to explain how the program works and to get their approval and consent to participate.

On the day of the placement, the case manager arranges for the youth to be discharged from detention and picks up the youth and drives him/her to a meeting with the MTFC parents at the program office. This will be the first contact between the youth and the MTFC parents. At this initial meeting attended by the MTFC parents and the youth, the level one point program is reviewed by the case manager. The youth is then sent home with the MTFC parents and the program begins.

The case manager telephones the MTFC parents later that day to see how things are going. Then three days after placement, a meeting is convened by the case manager with the MTFC parents and the youth to officially review how the placement is working out. However, the case manager will have talked to the MTFC parents daily so will be well aware of the status of the placement. The purpose of this meeting is to clarify the program expectations and to reinforce the positive beginning that the youth has made in the program. A protocol exists for the meeting that contains the following four components:

1. First, the case manager asks the MTFC parents in front of the youth how things are going, and the MTFC parents speak about the youth's positive qualities.

2. Next, the youth meets privately with his/her individual therapist. The therapist asks what the youth thinks his/her biggest challenge in the program will be (e.g., *You have now been in the program for a few days, what do you think will be the hardest part for you?*). The therapist expresses confidence in the youth's ability to succeed and says that they will work together with the youth to help him/her be successful in the program. They then return to the meeting with the case manager and the MTFC parent.

3. In front of the case manager and the MTFC parents, the therapist complements the youth on his/her ability to identify potentially difficult areas and expresses confidence that the youth has what it takes to make the program work.

4. The case manager asks about whether the MTFC parents have taken away any points for minor misbehavior or rule violations. If so, the case manager asks how the child accepted the point loss. If not, the case manager instructs the MTFC parents to take at least one point away within the next 24 hours, even if they have to make up a reason to do so. The purpose of this is explained to both the youth and the MTFC parent as an opportunity to allow the youth to get used to getting feedback prior to having to deal with a more serious problem. Although it may seem contrived to remove a point even if there is no real violation of the rules, we find this procedure helpful for several reasons. The point program is the main mechanism that MTFC parents use on a daily basis to give the youth both rewards and consequences for minor rule breaking. The theoretical model that the program is based on supports the idea of providing small consequences for minor misbehavior rather that letting things escalate and then providing a major or forceful consequence. The fact is that most of the youth in MTFC have not learned to accept a simple "no" when they non-comply or otherwise misbehave. At the same time MTFC parents are often hesitant to take away that first point because things have been going well and they do not want to break the spell. They want the youth to like them and to show that they like him/her. Having the case manager push the issue of the first point loss is helpful to both the

youth and the MTFC parent. For the youth, the message is "We don't expect you to be perfect. You will mess up, there will be a consequence, and life will go on—it's no big deal." For the MTFC parent, the point loss is taken out of their hands. "Your job is to make sure that this youngster gets accurate, fair, and frequent feedback, and not to let problems build up. S/he has to experience that losing a point is not a big problem—it's routine. They will make and loose points everyday."

One goal of this meeting is to clarify for the youth the role of the case manager as the authority person, the role of the therapist as the youth's ally, and the role of the MTFC parent as the youth's support person and helper. Another goal is to reinforce the youth's positive initial adjustment to the program, which occurs in most cases. It is common to have an initial "honeymoon" period at the beginning of the placement.

Ongoing Consultation and Supervision of the MTFC Parents

Consultation to the MTFC parents is a cornerstone of the model. Without ongoing consultation, our experience is that difficult-to-manage adolescent problem behaviors (particularly extreme negative behaviors) quickly shape adults to behave in non-therapeutic ways. For example, given adolescent sulking or noncompliance, the "natural" adult reaction includes anger and irritability. These types of adult reactions set off a chain of events and interactions where the probability of continued misbehavior on the part of the adolescent is increased and the adult responds, in turn, by avoiding teaching or relating non-positively to the teenager. Ultimately, the relationship and placement are in jeopardy. Preservice training alone cannot maintain MTFC parents' motivation or competence to perform the skills taught nor is it sufficient to address the range of intervention strategies necessary to effectively treat the complex behavioral problems of these youngsters.

> ☙
>
> *Consultation to the MTFC parents by the case manager is a cornerstone of the model.*

Case managers act as consultants to the MTFC parents. They provide consultation each week in a group meeting with MTFC parents and during daily telephone contact. Group meetings focus on development and review of the youths' daily programs, feedback to MTFC parents on their strengths and on areas needing improvement, feedback from MTFC parents on how the program can increase the effectiveness of the support it provides, and coordination of special services such as tutoring or psychiatric consultation. Goals of the group meetings are to support and motivate MTFC parents and to develop a professional team approach to youths' care. The case manager provides consultation and on-call crisis intervention to MTFC parents on a 24-hour basis.

Daily telephone contact is structured through the use of the (MTFC) Parent Daily Report Checklist (PDR), a brief (5 minute) interview designed to measure the occurrence of problems during the past 24 hours (see Appendix E). In addition to getting data on problem occurrence, the PDR is used to track the number of points that the youth has gained and lost during the past 24 hours, to get information about any school problems, or any incidences that might have an effect on the youth's treatment (e.g., a negative telephone contact with biological parents). PDR data is always collected for the past 24 hour period of time. That way, the MTFC parents are not asked to recall over long periods of time. This short recall has been shown in research studies to relate to the accuracy of the

information being obtained. PDR data from the previous week are used during weekly group meetings as a starting point to talk about case problems/progress and to help the case manager systematically track case progress over time.

Individual Treatment for the Youth

An individual therapist is assigned to each youth. Unlike many treatment models where individual therapy is the central focus of treatment, in MTFC the therapist's role is to support the youngster's adjustment in the MTFC home where the main treatment effect is expected to occur. The therapist's job is to provide support for the adolescent and to help him or her acquire and practice the skills needed to relate successfully to adults and peers.

Beyond these specific goals the individual therapy focuses on other issues raised by the youth or the therapist relevant to the youth's current adjustment or past experiences. The therapist invites the youngster (but does not push him or her) to discuss topics such as a past abuse, particularly as it pertains to patterns of interaction or thinking that the youth currently finds troublesome or dysfunctional. Many of the adolescents who participate in MTFC have had quite a lot of individual therapy in the past, and they report that the therapy was not helpful and that it made their problems worse. Our approach is to make the therapist available to the youth to respond to the youth's agenda regarding discussion of past trauma or difficulties.

> *An individual therapist is assigned to each youth.*
>
> *The role of the therapist is that of an ally and a coach.*

Youth who exhibit extremely dangerous problems such as fire setting are intensively supervised in MTFC. These topics may or may not be dealt with in the individual therapy, depending upon whether the clinical team judges that such attention would be productive. Youth who have been charged with sex offending are sometimes enrolled in outpatient treatment provided by a local expert outside of the MTFC program, depending on the court's requirements for them.

Typically, the therapist first meets the youth at the meeting held three days after placement, described earlier. Following that, a weekly appointment is set up between the youth and the individual therapist. During the first three or four sessions the goal of the therapist is to get to know the youth; what his/her interests are; and if the youth is willing to talk about it, the factors which led to placement in the program. Some youth are quite resistant to individual therapy, having had bad experiences in the past, or anxious about being pressured to talk about problems. The tone of these initial sessions should be kept light, and if the youth seems closed or anxious the therapist is encouraged to do activities with the youth rather than sitting in the office talking.

The therapist explains his or her role as being an ally—*"someone to help you navigate your way through the program."* The therapist explains that if the youth wants to change something on his/her point program, or earn a particular privilege, the therapist will help him/her negotiate that with the case manager. It is important that the therapist convey to the youth that he or she can help the youth work within the system, but also that the basic rules of the program are firm (e.g., the requirements for supervision will not be relaxed until the youth proves himself/herself by advancing to level three).

During weekly clinical meetings the case manager meets with the individual therapist and family therapist, and areas are identified to work on in the individual therapy. For example, if a youngster

is engaging in a lot of arguing in the MTFC home, the therapist might be given the task to talk to the youth about his/her behavior (*"I noticed that you lost a lot of points last week for arguing. What is that all about?"*). Often the youth will say that s/he does not know the reason that a problem is occurring or say that the MTFC parents are being unfair (*"They are just picking on me."*). The therapist then frames the problem in a neutral way and offers to help the youth (*"Let's you and I work to figure out a way that you can avoid losing points."*). In doing so, the therapist is placing him or herself on the youth's side and opening the door for having the youngster develop and practice more adaptive skills. Possibly the arguing, on further examination, will be framed as the youth having a hard time dealing with hearing "no" or being disappointed. In that case, the therapist will set up situations in the session where s/he and the youth role play, saying and hearing "no" from each other. This is done with humor and a light touch. The purpose is to pre-teach the youngster so that they can practice reacting differently in the coming week. The therapist might also offer a reward to motivate change in a problem behavior during the coming week.

> *Not arguing when you hear 'no' might be a difficult change for you. It takes a lot of self control and after all, when you are used to doing things one way, it's hard to break old habits. Let's see, last week you lost a total of 26 points for arguing. If you can cut that in half, that would be 13 points or less lost for arguing this week, I'll take you out for a burger next session. What do you say?*

Sometimes, especially in the first month of the program, the individual therapist is used in a strategic way to stabilize the youth. For example, if the youth is at high risk to run away the therapist might do several things. First, ask the youth to call him/her prior to running. Second, the therapist might tell the youth that the program staff is concerned that the likelihood that the youth will run is high, maybe because s/he has a history of running or because the youth has talked about running. The therapist might then tell the youth that s/he has a bet with the case manager that the youth will not run.

> *I told them I thought you had what it takes to stick it out. In fact, I bet them five dollars you wouldn't run. Now I'm gonna look stupid if you do, plus I'll loose the money. How about if you stick around, and we can spend the money on something fun like video games.*

This intervention often works, and we have had no instances of the youth collecting the bet and then running. Running away is an impulsive behavior that many youth engage in as a response to stress or uncertainty. Most often, when the youth can experience an initial period of accomplishment and success in the program, they will not run from future challenges that they face.

The individual therapist's role is that of an ally and a coach. The therapist provides a sympathetic ear but is careful not to reinforce the youth's problem behavior (e.g., making excuses or complaining) during therapy sessions. The individual therapist keeps the case manager informed about what transpired during the sessions and is careful not to make promises to the youngster that have not been first cleared with the case manager. In the example given above of offering the youngster a hamburger for decreasing arguing, the therapist and the case manager would have discussed that intervention in the weekly clinical meeting, and the case manager would have cleared that, in turn, with the MTFC parents. This process cuts down on the MTFC parents feeling like the program is going around them and possibly undermining their family plans or schedule (e.g., feeding the youth before dinner).

Family Treatment

Family therapy sessions are individual during the time the youth is in the MTFC placement and may be delivered in either a group or individual format in aftercare. The goal of family treatment is to help the parents prepare for the youth's return home and specifically to become more effective at supervising, encouraging, supporting, and following through with consequences with their youngster. One mechanism for accomplishing this is to teach parents to use the point and level system that is part of the youth's daily program in the MTFC home. The first session or so is devoted to the family therapist assessing the strengths in the family and areas that need to be improved. The family therapist tries to understand the barriers to effective parenting that have interfered with the parent-child relationship in the past. Parents are asked about and supported in their view of the evolution of the problem. By the time the youth enters the program most parents feel highly discouraged and defeated. Further, they may feel like they have been blamed for the youth's problems and present in a highly defensive and guarded way. During the initial sessions, it is important for the family therapist to be supportive to the parents and sympathetic to their situation.

> *The goal of family treatment is to help the parents prepare for the youth's return home and specifically to become more effective at supervising, encouraging, supporting, and following through with consequences with their youngster.*

During the child's stay in the program, the parents are encouraged by both the therapist and the case manager to have frequent contact with staff to be updated on their child's progress. As the adults who know the child the best, the parents are asked to have continual input into their child's treatment. Parents are given both the therapist's and case manager's 24-hour telephone numbers.

Home visits begin as soon as the youth reaches level two (usually three weeks after placement), and visits are scheduled at least twice monthly throughout the duration of the placement. The first visit is typically short (two to four hours), followed by a day-long visit, and eventually weekend visits are arranged. Negative indicators for a home visit include a parent who is unable or unwilling to closely supervise the youth during the visit. In these rare instances, visits take place in the program offices or in another supervised setting. The case manager is responsible for approving and scheduling all home visits. Prior to the first visit, the family therapist reviews the program supervision expectations with the parent (Appendix F).

One of the major aims of the visits are to give the parents an opportunity to demonstrate to the youth that they are working as part of the treatment team and that when the youth returns home, there will be some changes. To clearly illustrate this to the youth and to help parents develop or refine specific parenting skills that will be crucial for their child's continued success when they return home, the parents are taught to practice using a version of the point and level system. The family therapist works with the parents to develop a modified version of the point system to implement during visits. This typically is shorter and less complex than the system being used in the MTFC home, especially initially. Initial home point programs typically include one or two behaviors for which the youth can earn points, and parents are encouraged to take away points for noncompliance, arguing, or other problem behaviors (see an example in Appendix G). At first, the home point program involves the parents only giving and taking points; the consequences are followed through in the MTFC home. Eventually the home point program becomes more articulated and includes having the parents give

and take away privileges. By the time the youth returns home, the daily point system in which they are participating in the MTFC home and in the home of their parents should ideally be identical. The use of the same or a highly similar point program in the MTFC home and the family home is aimed at helping the youth to generalize treatment gains across settings. Program staff are on-call to parents during home visits and parents are encouraged to call if the youth breaks basic supervision rules or refuses to comply. In those instances, the visit is ended.

Other components of family therapy typically include a focus on problem solving and communication skills, methods for de-escalating family conflict, and instruction on how to advocate for school services for the youngster. All parents who have youngsters in MTFC are strongly encouraged to participate in the family therapy. The case manager aggressively pursues reluctant parents to encourage their participation. Examples of strategies to get parents involved include paying for a taxi or for mileage to and from sessions, having sessions in the family homes, providing day care for the families' other children, making repeated telephone contacts to report on the youth's progress in the MTFC home. As a result of these methods, although initially many parents are resistant, the vast majority end up attending family sessions regularly (over 85 percent). Since the youth is in the custody of the MTFC program, and it is our practice to provide them with intensive supervision and treatment, home visits are tied to the parent's participation in the family therapy so that they can be made aware of the conditions under which the child needs to be supervised during these visits. If parents refuse to see a therapist, they could have supervised visits that would also be attended by a program staff member. Approximately 15 percent of the youth who are in MTFC have no parent, relative, or other aftercare resource available at the time they are placed in the program. In those instances, we develop a long-term placement with the assistance of the child protective services agency.

Liaison with Schools

Youth attend public schools. They transfer to the school district where the MTFC family lives. Although school has been an area of major difficulty for virtually all of the youth enrolled in MTFC, we find that with close supervision and follow-through most youth can do surprisingly well in public school settings. Prior to enrolling the youth in school, we set up an initial meeting with the appropriate school staff (usually the counselor or vice-principal) to acquaint them with the basic features of the program and to reassure them that program staff will be on-call to help deal with any problems that occur.

In order to monitor in-school performance, attendance, and behavior, youth carry a school card that lists each class. For each class period, there is a place for teachers to rate the youth's behavior as acceptable or unacceptable, to note whether homework has been completed, and to sign their names (see Appendix H). School cards are collected daily by the MTFC parents, and teacher ratings are converted into points earned or lost on the daily program. To check on possible forgeries, MTFC parents also call the school at least weekly to check on attendance. MTFC program staff are on-call to schools to remove youngsters should they become disruptive. In addition to these standard program features, school-based interventions are conducted on an as-needed basis.

Cutting class and aggression during unstructured school activities (e.g., lunch, time between classes) are the most common problems. We have designed specific interventions for these and other school-related problems that are supervised by the case manager. Depending on the size of the program, it is helpful to have a staff position for a school liaison/interventionist.

Aftercare Support

Once the youngster has returned home, parents are invited to participate in an aftercare group with other parents that meets weekly. Together with parents, we have developed an aftercare curriculum and manual entitled *Success Begins At Home*. The table of contents for this is in Appendix I. The manual includes two parts: a leader guide and a parent guide. A case manager or therapist and an MTFC parent or biological parent serve as co-leaders of the group. The format of the aftercare sessions includes focusing on a specific skill (e.g., setting up effective consequences), time for discussion of current problems and progress, and description of a home practice assignment. In order to engage parents in the group, we have used a number of methods to help motivate attendance and completion of the home practice assignments such as serving a meal at the session and having a weekly drawing for movie tickets. During aftercare, case managers remain on-call to families, as needed. PDR calls with parents continue, beginning with daily calls and moving to weekly calls by six months post-placement.

Typically there are three phases of aftercare. In the first phase, the basics of supervising the youth in the community are reviewed and set up for the parent. This includes working out the details of the home point and level system, setting up the school card and making sure teachers are on-board, and specifying an after school plan where the youth is supervised. Parents are often fearful during this phase; they expect that the youth is "fixed" and have to be brought along on the concept that the youth has made a lot of progress but still needs much structure and support from them. During phase two, typically youth test the waters by breaking the parent's rules or developing problems in school. Although parents have been warned by MTFC staff that this is going to occur, they typically become demoralized and overreact by being overly negative with the youth or severe in the consequences that they want to give. MTFC staff need to convince the parents that the daily point and level system will work, to not give up, to show the youth that they are sticking with the program, and that there are set consequences for misbehavior. During phase three, if the youth is doing reasonably well it becomes easy for parents to begin to let things slide. They ignore small problem behaviors because things are going well, and they do not want to rock the boat. It is program staff's job to get them to continue to provide consequences and encouragement on a daily basis to their child. Staff work with parents to learn how to problem solve around supervision and relations with peers. Parents are likely to lapse into old patterns of lecturing and staying engaged in arguments. Parents are encouraged to call the case manager or family therapist to access support and another adult opinion to bounce ideas off of. Aftercare services remain in place as long as the parents want. Practically, this is usually about one-year. As families become more adept at problem solving they want fewer sessions and rely more on telephone consultations.

The most common questions and concerns that parents have in aftercare are:

- How many points should be taken?
- How long should the consequence be?
- Not wanting to face a difficult confrontation with their youngster alone;
- Venting about the youth or the system;
- Deciding whether or not a consequence is needed; and
- Dealing with the juvenile department or the school.

Planning and Implementation

Needs Assessment

Communities which have an interest in providing a comprehensive treatment strategy to delinquent youth and a desire to fund alternatives to incarceration and residential group homes might consider MTFC. It is cost-effective and places the child in the least restrictive setting possible.

Key Contacts

During the planning stage for implementation of the program in a criminal justice setting, contacts need to be made with juvenile court directors, parole and probation officers, and the juvenile court judge. Some of these individuals may find the idea that community families can provide effective treatment for tough juvenile offenders hard to accept. When the program was first initiated in 1983, parole and probation staff were quite dubious about the applicability and feasibility of the model. Now they are among the program's most ardent supporters. The fact is, these youngsters are markedly easier to deal with on an individual basis than they are in group settings, and many times juvenile corrections personnel have only had experience with individual youth in the context of groups.

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> *MTFC may be a viable program for communities which have an interest in providing alternatives to incarceration and residential group homes for delinquent youth.*

We have found that an effective way to introduce the program to juvenile justice administrators and community agency staff is to send a letter briefly describing the program model and saying that the program director (or other appropriate personnel) will telephone to make an appointment with them during the following week. The program description should be a one page overview describing the approach including information on the population the program is targeting, outcomes, and cost or funding information, if relevant. During the subsequent meeting, their questions, concerns, and the specific role that they or their staff might play in implementation can be addressed.

Interagency Linkages and Collaboration

Juvenile Parole/Probation. Depending on how the local system is organized, the involvement of parole/probation officers can be important to the success of the program. They can facilitate placements, serve as back-up when youth violate program rules, and provide a "law enforcement" presence. When the program was first set up, there were several initial meetings with parole/probation staff in order to understand their priorities and concerns. During the youth's placement in the program there is regular in-person and telephone contact with parole/probation staff, providing them with case updates. Parent Daily Report (PDR) data is also shared with parole/probation staff.

Back-up services provided by parole/probation can range from routine monthly check-ins with the youth to monitor progress, reinforce program rules, and remind the youth of the court presence, to a more active partnership where the parole/probation officer assists in problem situations. For example, it is helpful to have the option to use juvenile detention as a back-up if the youth becomes highly noncompliant, aggressive, or commits a law violation. Depending on the nature of the infraction, the parole/probation officer can admit the youth to detention for a brief stay. We find that the occasional use of a short detention stay (one to two days) can be helpful for some youth.

We do not typically call parole/probation when the youth fails to complete daily tasks such as chores, has behavioral problems such as refusal or arguing, or violates minor rules; in those instances, we let the program model work. The youth is given a consequence which may be simply losing points or, for larger or chronic problems, completing a work chore or other prescribed task. If the consequence requires some time to complete (e.g., doing a work chore that spans two days), the youth is dropped a level until the consequence is completed. This approach is sufficient for the majority of youth problems. Involvement of parole/probation is helpful in instances where there has been repeated problems and the youth just doesn't seem to "get it." For example, consider the case of a youth cutting a class, being given a work chore, completing that work chore, and then cutting again the next day. This is a problem that we often deal with, and an example follows of working with the parole/probation officer that has been effective in helping send home the message that it is not acceptable to be truant, even for short periods of time.

> *Jeff had obviously forged his math teacher's signature. The MTFC parent called the school to check and, sure enough, he had skipped math. He was given an 80 minute work chore to complete, and he did so (math class is 40 minutes and the consequence was to do two minutes of work for every minute unsupervised). The next day, when checking with the attendance officer, the MTFC parent found out that, again, he had skipped. This time it was two classes. The MTFC parent called the case manager who said to bring Jeff into the office that day after school. The case manager then called the PO (parole officer), and they agreed on a plan designed to make an impression on Jeff as to the seriousness of this problem.*

> *After the case manager, the MTFC parent, and Jeff had met for a brief period of time, the PO came in the room, unannounced, and stated that he had heard about the truancy. He informed Jeff that he was planning to take him to detention. He said, "After you sit there for a while, we can see if you can return to the program." The MTFC parent respectfully asked if Jeff might not be able to have another chance since he was doing so well in the home otherwise, and she talked about Jeff's other positive achievements. The PO said that cutting classes was not acceptable and that Jeff didn't seem to understand this. Jeff responded by saying that he got it now and that he would not cut again. The PO cautiously agreed not to proceed with Jeff to detention. Instead, he said he would defer to the MTFC parent's request, but he would be watching carefully to see how Jeff did in school. Jeff didn't cut another class during his placement in MTFC.*

This is an example of how a cooperative partnership with parole/probation can be used to underline the importance of a specific behavioral expectation and reinforce the program goals. In addition, this intervention, which we have used variations of several times, sets the MTFC parent up in the helper/advocate role and has the bonus effect of increasing the bond between MTFC parents and youth.

In our jurisdiction, the issue of temporary or permanent revocation of youth is ultimately up to the parole/probation officer. The program staff needs to work to gain and maintain the confidence of parole/probation so youth are allowed to continue in the program, even given that they misbehave or break rules in order to have the program methods work to teach them what is acceptable and what is not.

Juvenile Court Judge. In our area, juvenile court judges rotate each year so we need to acquaint each new judge with the goals of the program and with our operating procedures. We have a one-page description of the program (Appendix J) that we send prior to meeting with the judge.

Schools. It is important to have good working relations with the schools. Once school personnel know that program staff can be relied on to provide back-up, they are usually more than willing to be cooperative with the program. The daily school card was designed so that it is quick and easy for teachers to fill out. Frequent telephone contact is maintained with key teachers to monitor youths' progress, or if it is suspected that school cards are forged.

School staff are encouraged to call program staff at the time that they are having a problem with the youth. MTFC staff (case manager, therapist, or school liaison) are available to go to the school and pick the youth up in critical situations. If a youth is suspended or expelled, they spend school hours in the MTFC offices completing homework assignments or work chores. It has been found, in these instances, that removing the youth from the MTFC home during the day is more effective in that the youth is less likely to escalate and become more negative if their consequences are supervised at the office than at the MTFC home.

Police. Our experience has been that police are very supportive of this approach. In fact, we have had success recruiting police officer families as MTFC placements. Brief presentations to officers on the model can serve a dual purpose—familiarizing them with an alternative to group home or training school placements for juvenile offenders, and recruiting potential MTFC parents.

Child Protective Services. In cases where there has been reported parental abuse or neglect, the child has a Child Protective Service (CPS) worker assigned. Coordination of the family treatment with the goals of CPS is critical.

Funding and Program Costs

Our strategy has been to try to diversify funding sources so as not to be entirely dependent on a single funding source. The state juvenile corrections division provides the primary contract for services for the juvenile offender population. The rate is $77 per day per youth. MTFC parents are initially paid $28 per day out of those funds, or $868 per month. More experienced MTFC parents earn up to $33 per day, or $1,023 per month. In addition, we bill Medicaid for the family therapy since payment for that program component is not funded by corrections (approximately one hour per week) at the rate of $76 per hour bringing the total program cost to $2,691 per month per youth. The average length of stay is seven months, so the cost per youth is $18,837. This cost includes the provision of all services from the program director to the case managers, therapists, recruiter, and foster parent trainer.

In our program for seriously emotionally disturbed children referred from CPS, we have a partnership between child welfare and mental health that funds services. Child welfare funds the MTFC home using their special rate foster care funds. Special rates for MTFC parents range from $500 to $1,200 per month, depending on CPS's assessment of the difficulty of the case. We bill Medicaid at the rate of $76 per hour for therapy services (family and individual) and for case consultation. Those costs average $1,000 per month per child, and the average length of stay is nine months.

The State Division of Developmental Disabilities funds the program for adolescents who are developmentally delayed and who have had problems with sexual acting out or sex offending. That contract pays $130 per day per youth.

These costs compare favorably to the daily and monthly costs of residential and group care placements or to placements in hospital or state training school settings. With the exception of research costs, none of the costs discussed in this blueprint have been federally financed.

Staffing and Supervision

Overall, staffing may be full- or part-time.

The **Program Director** oversees all clinical and management aspects of the program, obtains funding, designs and monitors evaluation activities, and serves as a back-up for case managers. The director conducts the weekly clinical meetings, reviews the weekly PDR, and sets the direction for development of and changes in program policies and practices.

Case managers are familiar with adolescent development and developmental psychopathology and are trained in social learning principles. Levels of formal education vary from a bachelor's degree with extensive experience to a Ph.D. in psychology or related fields. The case managers' tasks are complex in that they balance the agendas of all of the team members to provide youth with integrated treatment plans. Key characteristics of successful case managers include being excellent problem solvers who are practically oriented and flexible thinkers. They also have to possess outstanding interpersonal skills. They are the key contact with the MTFC parents, provide supervision and direction for the therapists, and are the liaison with individuals in the community (e.g., the juvenile court judge, parole/probation officers, and teachers) who have contact with or influence on the child. Case managers have a maximum case load of ten and are supervised weekly by the program director.

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> **Case Manager**
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> *Oversees Children's Progress and Problems*
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> ᔫ *Reviews daily PDR*
> ᔫ *Conducts foster parent meetings*
> ᔫ *Coordinates therapy and foster care*
>
> *Supports and Supervises Foster Parents*
>
> ᔫ *24-hour crisis intervention*
> ᔫ *Schedules respite*
> ᔫ *Revises treatment plan as needed*

They should be at least half-time and preferably full-time, otherwise they are not available on a daily basis which is necessary.

Therapists are typically master's level individuals who have been trained in family and individual therapy with adolescents or in related fields. Therapists are supervised by the case managers and in weekly clinical meetings by the project director. A therapist can do one clinical hour (face to face) for every two hours that they are paid. So a full-time therapist could do 20 therapist sessions per week.

MTFC parents are supervised by the case managers during daily telephone contacts and weekly group meetings.

The **foster parent recruiter** is the person responsible for advertising, recruitment, and for conducting the initial screening and home visit. It is helpful to have a person with some experience in advertising who has good interpersonal skills. The recruiter is the first program person that potential foster parents have contact with, so this person needs to have a complete understanding of the goals and methods of operation of the program and a good familiarity with the types of youth being served by the program.

The **PDR caller** is the person who contacts the MTFC parents on weekdays by telephone and collects information about the youth's behavior during the past 24 hours. It is important that this person be someone with whom MTFC parents feel that they can confide. Former MTFC parents are often employed as PDR callers.

The **MTFC Parent Trainer** organizes and conducts the preservice training for potential MTFC parents. S/he also assists the case manager in providing continued consultation and support to MTFC parents during placements. The MTFC trainer needs to have an excellent grasp of how to implement the point and level system and to be familiar with issues related to providing foster care services. We employ a former MTFC parent in this role.

Training of Staff

All program staff are given a three-day orientation to the approach which includes a combination of didactic instruction, role plays, and case examples. New staff are expected to read available treatment manuals, descriptions, and research publications. In addition, all clinical staff (case managers, therapists) attend the next scheduled MTFC parent training session. New clinical staff (e.g., therapists and case managers) are instructed in the assumptions underlying the point and level system and in the logistics of implementing it. They are also given a number of case examples of how the point and level system can be tailored to fit individuals with different types of clinical profiles and how it is used to address specific types of problems. We also provide new staff with instruction on the roles and duties of the various MTFC team members relative to the youth, the MTFC family, and each other. New staff attend the relevant clinical supervision and weekly MTFC parent meetings to see first hand how the program is implemented. They then sit in on ongoing cases or watch videotapes of treatment sessions (both individual and family).

Recruitment and Selection of Target Population

Referrals come to the program from the juvenile court, child welfare, or mental health systems. In most instances, children and adolescents referred to MTFC have failed in other placement settings. Youth who cannot be maintained in group or residential care or in "regular" state supported foster care are often successful in MTFC. Prior to placement, an appointment to meet with the child and his or her parents is made. Referrals are screened to determine that there is no less-restrictive environment that would be appropriate and to determine that the youngster is not so dangerous as to compromise the MTFC family's safety. For delinquent youth, the initial contact usually takes place in detention. A protocol is available for this contact. Briefly, the case manager gives the youth an overview of the program including discussing how the daily program point and level system works, asking the youth what would be the most difficult aspect of participating, and getting a history of the problems from the adolescent's perspective. The structure and rules of the program are stressed. The youngster is told to think about the possibility of being placed in the program, and the case

manager recontacts him/her within a week. Most youngsters say immediately that they want to participate—not surprising given that they are usually incarcerated at the time of the interview, and participation in the program represents greater freedom.

For the juvenile justice population, youth are excluded from placement in MTFC who, in the judgement of the juvenile department staff, need to be treated in a secure (locked) setting because they present too great a danger to the community. These youngsters are usually confined to the state training school. Other excluded youth are those who require inpatient drug and alcohol treatment. All youth who are eligible for treatment in group or nonsecure (unlocked) residential settings are appropriate for placement in MTFC.

The case manager meets with the parents who are given an overview of the program's policies and procedures and are asked for a history of their child's problems. Parents are told that their work with the program staff will be a key aspect of the treatment plan and that they will be asked to participate in weekly sessions. The goal of this first meeting is to reassure the parents that the staff will work with them to try to solve the problems their child has been presenting. It is made clear that it is not the intention to blame them for these problems and that they are seen as key players in their child's treatment. It is important to recognize that this is a difficult situation for parents and that they are probably uncomfortable having their child placed with another family. Program policies and procedures regarding visitation and contact are discussed. If parents agree that the program is appropriate for their child, the placement is arranged. Throughout the child's placement, parents are encouraged to communicate frequently with the case manager and are given a telephone number where they can reach the case manager 24 hours a day.

Implementing the Intervention

MTFC is an intensive intervention lasting six to nine months. It takes place on a daily basis in the MTFC home and in the child's school and community. Boys and girls who participate are closely supervised by MTFC parents and program staff. They are not allowed unsupervised free time in the community. As they progress through the program, levels of structure and supervision are eased. It is important that this be a gradual process based on the child's compliance with higher levels of structure. Three levels of supervision are defined that are parallel to the three-level point system described earlier.

> *Level one.* The youth is within adult supervision at all times; they are driven to and from school and are not allowed out of eyesight of supervising adults except when sleeping. Points earned on level one during one day are used to "buy" privileges on the following day. Level one usually lasts for three weeks or until the youth earns 2100 points.

> *Level two.* Youth earn points for a full week, and those are applied to privileges for the following week. On level two, youngsters can earn limited free time in the community, given good compliance with program rules. Free time is limited in that settings are prescribed (sports activities and other supervised activities are okay, hanging out is not); youth are required to state exactly where they will be and with whom, and MTFC parents and program staff check on their whereabouts. Level two typically lasts for four months.

☚ *Level three.* The structure is lifted somewhat, and less-structured peer activities are encouraged. Participants are not allowed to associate with peers who have criminal histories or who are not well supervised by their own parents. During level three, visits to home are more frequent and for longer durations. Level three usually lasts for one and a half to three months.

The three steps in the level system are designed to help youth gradually internalize the prosocial behaviors that they are engaging in during treatment. The level system does this by gradually lowering the amount and intensity of supervision that youth experience over time, by increasing the delays in gratification and immediacy of rewards that they experience, and by increasing the types and amount of external activities that they are eligible to participate in. The goal here is to prepare youngsters for life in the "real world' upon their return home. However, once youth do return home, it is still necessary for parents or other caretaking adults to provide close supervision and immediate consequences. Without these aftercare supports, gains made in treatment are not expected to be maintained, especially if youngsters begin to again associate with a delinquent peer group. Given a period of success during the program and a supportive environment in aftercare, youth are successful at internalizing gains.

Implementation Problems

Probably the most significant problem in implementing an MTFC program is recruiting and maintaining a group of competent, well-trained MTFC parents. A number of recruiting strategies have been used over the years, and now two primary methods for recruitment are relied upon— newspaper advertising and word of mouth from existing MTFC parents. Recruitment and training are activities that need to be conducted continually. We have a full-time foster parent recruiter who recruits homes for the 90 children per year that we serve.

The best way to overcome the initial hurdles of recruiting foster parents is to work consistently and doggedly on a number of activities that are judged as being likely to pay off. Recruitment becomes easier over time, once the program is established and the first set of MTFC parents are recruited and youth are placed with them. Some MTFC parents come to the program because they are interested in a specific child that they have gotten to know through other means in the community and who is now being referred to the program. In addition to advertising and using current MTFC parents as "natural recruiters," some activities that we have found to aid in recruitment are presenting the model to community groups, talking to community contacts and friends, and going to agencies that serve other populations of youth and adults to present to their staff the possibility of becoming MTFC parents. A dedicated, enthusiastic recruiter is the key. A good recruiter takes his/her job with them during off hours when they go to community functions, parties, or school functions.

The retention level of foster parents is another way to ease the recruitment problem and to strengthen the overall capability of the program to deal with difficult youth over time; experienced MTFC parents can handle more difficult youth. Our experience is that about 20 percent of MTFC parents will serve one youth only, 25 percent will serve two youth, and 53 percent will provide placements for three or more youth.

Another implementation problem is developing methods which enable the treatment staff (case managers and therapists) and MTFC parents to communicate frequently and effectively. People who

are used to working in outpatient settings tend to work in isolation. In MTFC, the quality of the teamwork is crucial to the success of the cases. Both formal (e.g., weekly clinical meetings, weekly meetings with MTFC parents, review of the PDR data) and informal (e.g, therapist's and case manager's offices in close proximity with each other) systems of communication that help to promote good quality communication between team members have been developed.

Monitoring Implementation and Treatment Integrity

It is the program director's responsibility to monitor the program's treatment integrity. This is done through periodic review of the youth's daily point and school cards, weekly monitoring of the PDR data, conducting program evaluations, and through supervising the case managers.

ENDNOTE

[1] Throughout this description, we use "MTFC parents" to describe the foster families that are hired by the program to provide placements and treatment for the youth. When we say "parents" or "families" we are referring to the youth's biological or adoptive parent or other relative or individual who will have legal custody of him/her when s/he exits from the program.
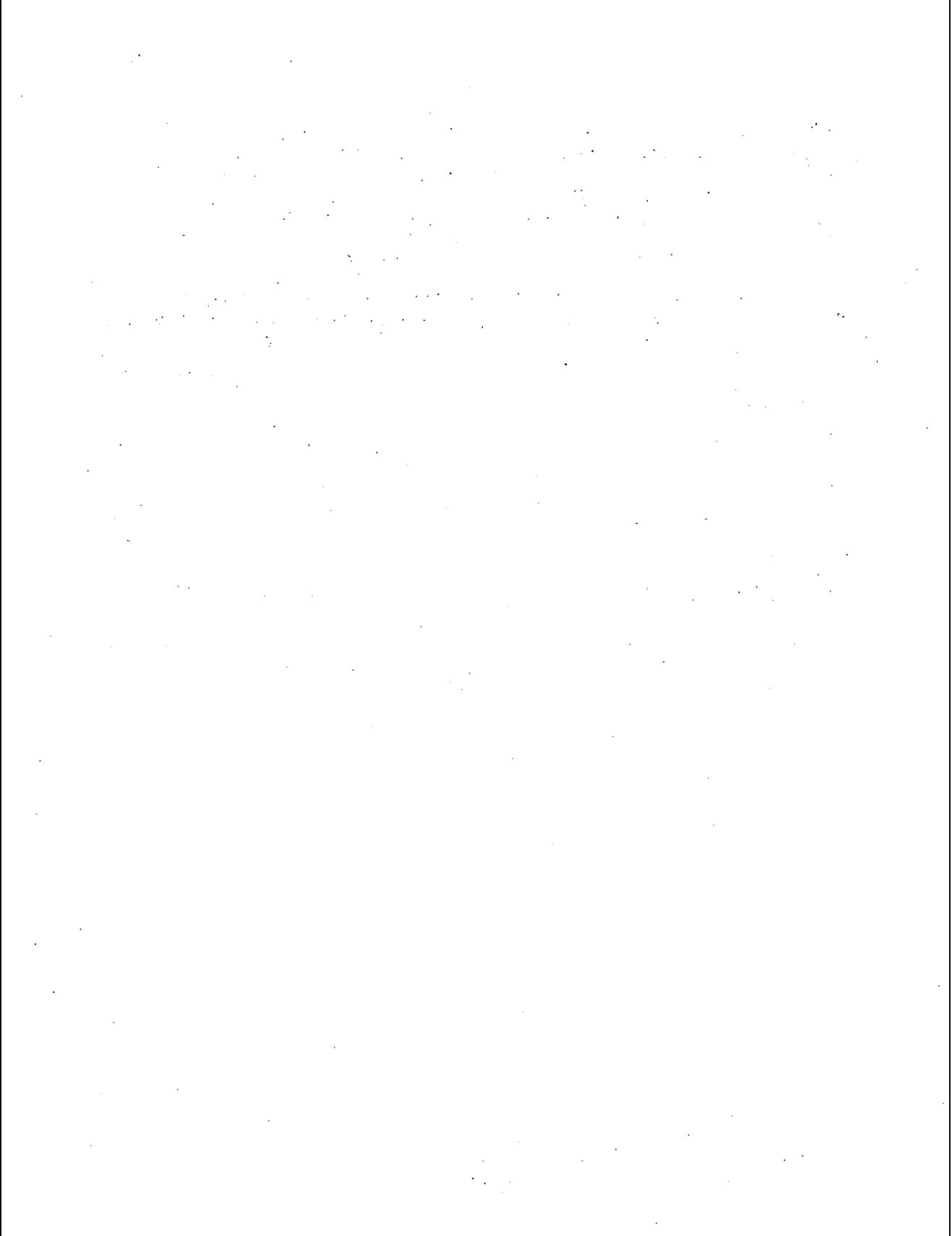
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CHAPTER THREE
Evaluation
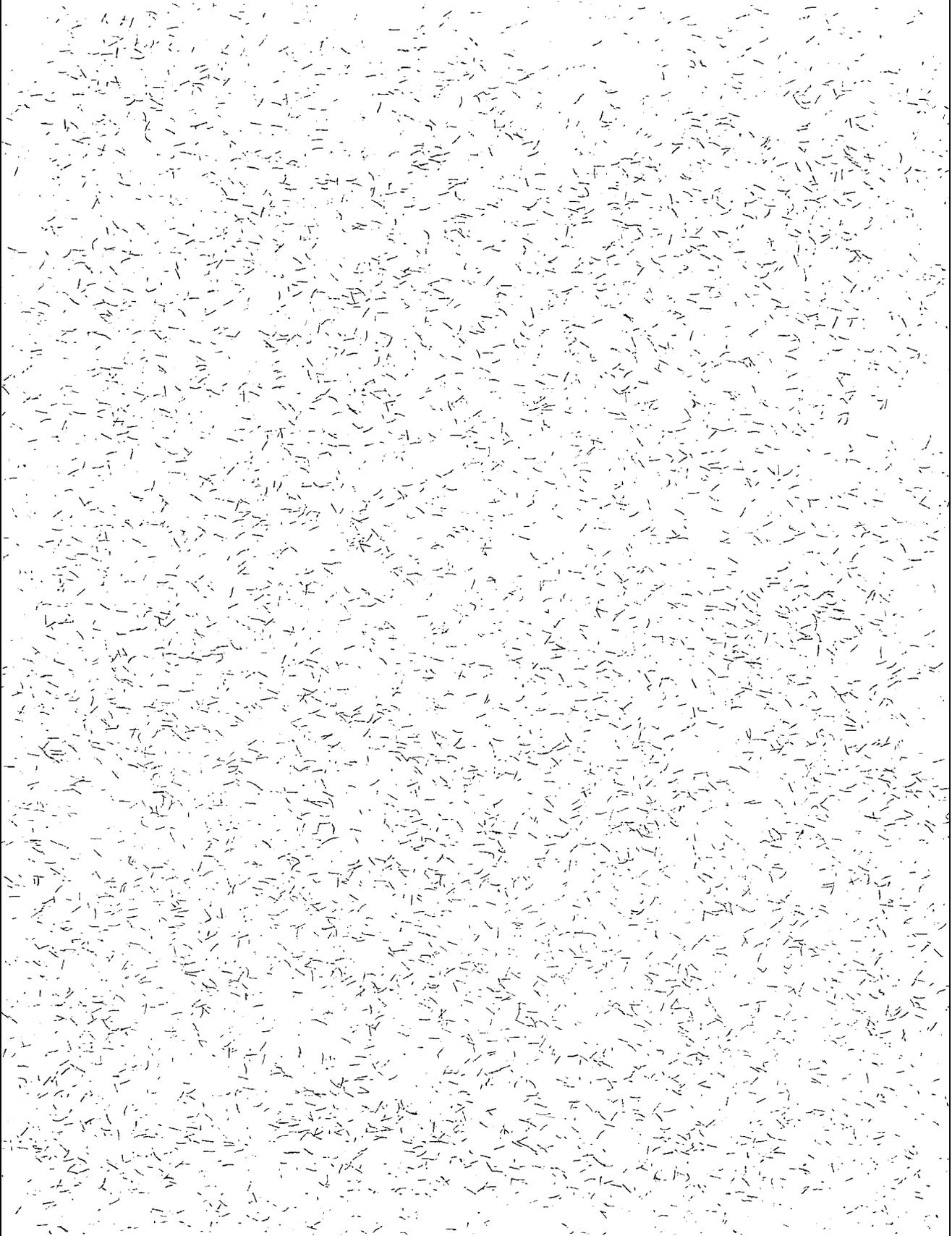
EVALUATION

Four studies have been conducted on the effectiveness of the OSLC MTFC approach (Table 4 provides an overview of these four studies). Studies 1 and 2 demonstrate the effectiveness of MTFC with serious and chronic delinquent youth. Study 3 shows that MTFC can provide an alternative community placement for youth who are ready to leave the state mental hospital. Study 4 describes the importance of providing training and support to foster parents.

Study 1

The largest and most comprehensive test of the MTFC model included evaluations of treatment processes as well as outcomes. Seventy-nine 12- to 17-year-old male juvenile offenders with an average of 13 prior arrests and 4.6 prior felonies, who were mandated into out-of-home care by the juvenile court, were randomly assigned to treatment in MTFC or Group Care (GC). Group Care was comprised of eleven group care programs located throughout the state of Oregon that had from six to fifteen youth in residence. Although programs differed somewhat in terms of their theoretical orientations, variations of the positive peer culture approach were most often used. The GC youth participated in individual and group therapy as part of their programs, and most attended in-house schools. Family therapy was also provided.

All boys were screened for eligibility to participate in the study by a committee of juvenile court personnel who decided whether youngsters would be placed in the state training school or some less-restrictive out-of-home care setting. Decisions for community placement were based on the level of threat the youth was perceived to present to the community. Training school placement slots were "capped" meaning that each new commitment required the release of a current training school student. Therefore, there was pressure to use community placements whenever feasible. All boys had committed several misdemeanor and felony offenses. The lowest number of previous offenses for the sample was five offenses, and the highest was 55 previous offenses. Table 1 (described earlier under Targeted Population) provides the demographic and family characteristics of the 79 study participants. All subjects had been detained in the year before entering the study; the average number of days spent in detention was 76. All of the boys had previously been placed out of their homes at least once (70 percent had one prior out-of-home placement, and 30 percent had at least two prior placements).

Boys were assessed at baseline, three months after placement, and then every six months for two years. Delinquent and criminal activity was assessed by official arrest data recorded by the Oregon Youth Authority before and after referral and by self-reported delinquency data using the Elliott Self-Reported Delinquency Scales (collected at referral and at six and twelve months post referral). At the three-month assessment, four factors were examined that were hypothesized to predict treatment outcomes (specifically, subsequent arrests) regardless of the boy's placement setting (MTFC or GC). In other words, to the extent that these four factors were operating well, it was predicted that boys would do better in follow-up. The four factors were supervision, discipline, positive relationship with a caretaking adult, and not associating with deviant peers.

At the three-month assessment, it was found that, on average, boys in the MTFC group received better scores on being supervised, had more consistent discipline, better relations with adults, and fewer associations with delinquent peers than did boys in GC, although there was variation within settings on these

factors as well. Other findings from the three-month (i.e., during treatment) assessment were that although caretakers in both MTFC and GC settings reported that boys engaged in about the same average number of problem behaviors per day (i.e., 3.6 and 3.7 per day, respectively), boys' reports of the problem behaviors that they engaged in were significantly different in the two groups (MTFC boys reported 2.9 per day; GC boys reported 6.6 per day). In MTFC, boys and caretakers agreed much more about how many problem behaviors occurred than did boys and caretakers in GC. Agreement between boys and caretakers on the occurrence of problems is probably helpful, if not necessary, for providing boys with consistent consequences for their misbehavior. Boys in MTFC received consequences more often than boys in GC according to both boy and caretaker reports in both settings. Agreement between MTFC boys and their caretakers was also higher on reports of the amount of unsupervised time boys had each day than it was for GC boys and their caretakers.

At this point, outcome data are available for one year after boys completed their treatments. At treatment exit plus one year, boys in MTFC had significantly fewer arrests than did GC boys (MTFC mean = 2.6 offenses, GC mean = 5.4 offenses). Significantly more MTFC boys than GC boys had no further arrests after treatment (41 percent versus 7 percent). Also, MTFC boys were incarcerated significantly less often (53 versus 129 days) and spent more time living at home or with relatives than did GC boys. Program completion was higher for MTFC boys than GC boys (73 percent versus 36 percent).

Self-report data at the twelve-month posttest indicates that MTFC youth reported fewer delinquency and criminal acts than control youth (Table 2).

Table 2. Elliott Self-Report Scales *(sample n = 79)*

	Mean	**Standard Deviation**	**F**	**p**
General Delinquency				
Group Home	28.9	32.4		
MTFC	12.8	20.5	6.5	.01
Index Offenses				
Group Home	8.6	11.9		
MTFC	3.2	7.2	5.3	.03
Felony Assaults				
Group Home	2.7	3.8		
MTFC	1.2	2.7	4.1	.05

The role that supervision, discipline, and peer and adult relations play in predicting future arrests is currently being examined. It is clear from our data that the association with delinquent peers was the single most powerful direct predictor of continued offending. Whether youth associate with delinquent peers appears to depend on the quality and quantity of supervision and discipline they receive from their adult caretakers. In addition, the relationship with adult caretakers is a protective factor that buffers boys from delinquent peers (through the processes of supervision and discipline) and, in turn, from subsequent arrests.

Study 2

In a 1990 study, the rates of incarceration for 32 boys and girls who participated in MTFC compared to those who had received treatment in other community-based programs was examined. The community comparison condition included placement in group homes, residential care, or in drug and alcohol treatment facilities. The youth who participated in this study were girls and boys from 12-18 years of age. Fifteen percent were ethnic minorities. Table 3 shows that the youth in the experimental group (i.e., received MTFC) were comparable to but somewhat more at-risk than their counterparts in the control group.

All participants had been committed to the state training school but were placed in community-based programs as an alternative to incarceration. This study used a matched comparison design where youth were matched on age, sex, and date of commitment to the state training school. A computer program was developed that yoked MTFC youth with other youth who had gone through the state system. The program matched state system youth to MTFC cases on age, sex, and date of commitment to the state training school. State Children's Services Division researchers assisted us in designing the yoked matching program, and they then ran the program on all youth who had participated in state-funded juvenile justice programs to determine who the best matches to the MTFC youth were. Outcomes examined were the number of days spent incarcerated in state training schools during the first two years post treatment, and program completion (versus expulsion or run away) rates.

Results showed that youngsters in MTFC spent significantly fewer days in lock-up during the one year and two year follow-up; a difference in cost favoring MTFC (estimating incarceration costs at $100/day) of $122,000 over a two-year period. In addition, significantly fewer MTFC youth were ever incarcerated following treatment. Although, on average, youth in both groups spent the same amount of time in treatment, more MTFC participants completed their treatment programs (75 percent of the MTFC youth compared to 31 percent of the control youth), and there was a significant relationship between the number of days in treatment and the number of days of subsequent incarceration for youth in the MTFC (but not in the comparison) group. The 25 percent of the MTFC youth who did not complete treatment either ran away from their placements (three youth) or were revoked due to commission of an offense while in treatment (one youth). This suggests that treatment dosage is related to post-treatment incarceration and provides indirect evidence for the effectiveness of actual treatment.

Table 3. Demographic and Risk Factors

Demographic and Risk Factors	Experimental	Control
Age	14.56	14.56
Sex	10 Males, 6 Females	10 Males, 6 Females
Mean # of Prior Out-of-Home Placements	1.75 (range 0-8)	1.31 (range 0-5)
Family Risk Factors:		
Family income below poverty level	50%	63%
Divorce between natural parents	100%	75%
Three plus siblings	38%	67%
Adopted	31%	0%
Parent hospitalized (current or previous)	6%	6%
Parent convicted of felony		
(current or previous)	13%	6%
Siblings institutionalized		
(current or previous)	13%	13%
Family available for aftercare	63%	69%
Child Risk Factors:		
Physically abused (reported)	38%	44%
Sexually abused (reported)	13%	13%
Chronic runaway (> 3 priors)	44%	50%
Suicide attempts	25%	19%
Child Dangerousness:		
Sexually abusive—adjudicated	19%	19%
Previous felony charge	69%	63%
Dangerous to others	25%	31%
Dangerous to self	38%	25%
Child School Adjustment:		
Chronic truancy	75%	75%
Below grade level (at year 1)	56%	63%

Study 3

In the third study, the effectiveness of MTFC versus treatment as usual in the community for 20 children (8 males and 12 females, ages 9-18) leaving the state mental hospital was compared. Subjects that were judged ready for a community placement were referred from the state mental hospital and then randomly assigned to the MTFC program or to existing alternatives in their communities (e.g., residential treatment centers, parents' or relatives' homes, or further hospitalization). Prior to their current hospitalization, the youth had an average of five previous out-of-home placements. The most common diagnosis was Conduct Disorder (ten cases), followed by Schizophrenia (five cases), and Borderline Personality Disorder (four cases). All but six of the twenty subjects had dual diagnoses. Participants had been hospitalized for an average of 245 days during the year prior to referral.

All cases were assessed after referral and then followed up three and seven months later. The proportion of time subjects spent in a community versus a hospital setting and measures of social functioning were examined. Measures included the Parent Daily Report Checklist that examined rates of problem behaviors, the Behavior Symptom Inventory, a nationally validated self-report inventory, that examined the presence/absence of psychiatric symptoms, and tracking of rehospitalizations.

Results showed that youngsters in the MTFC group were placed out of the hospital significantly more quickly than those in the control condition. The mean length of time between referral to the study and placement outside of the hospital for the MTFC group was 81 days; the mean length of time to placement for control youth was 182 days. In fact, during the seven-month follow-up period, three of the control condition youngsters remained in the hospital the entire time due to no appropriate aftercare resource being identified. All ten of the MTFC youngsters were placed in family settings. Control youth tended to be placed in institutional settings. There were no differences found on rehospitalization rates or on rates of child reports of psychiatric symptoms. Significant differences favoring those in MTFC were found on adult reports of daily rates of child problem behaviors.

The shorter time from referral to placement found for the experimental subjects has obvious cost implications. At the time of the study, the hospital program cost was $6,000 per month, the experimental program cost was $3,000 per month. Placement in the experimental condition saved an average of $10,280 per case in hospitalization costs. This study also demonstrated that the MTFC model can be applied to populations of severely emotionally disturbed youngsters.

Study 4

In study number four, the impact of conducting weekly foster parent groups, based on those used in the MTFC program, on placement disruption rates for children in "regular" foster care were examined. "Regular" foster care refers to state foster homes where children were placed due to severe parental abuse and/or neglect. Seventy-two foster families, with children from four to seven years of age, from three Oregon counties were randomly assigned to one of three conditions: 27 families to assessment only (AO), 14 to payment only (PO), and 31 to enhanced training and support groups (ETS). In the ETS group, foster parents were taught, in weekly group meetings with other foster parents, behavior management strategies and to use a version of the Individualized Daily Point Program to help them deal with child behavior problems. Each foster family in the enhanced condition was telephoned three times a week by the group facilitator to provide support and trouble-shoot

problems as they occurred. Foster parents in the ETS condition were also paid an increased monthly stipend ($70) for participating in the study. In the PO group, foster parents did not participate in the enhanced services but did receive the increased payment of $70 per month. In the AO group, the foster parents did *not* receive the extra services and they did *not* receive the increased monthly stipend. The goal of this study design was to tease out the effects of the enhanced support and training services over and above the effects of increasing payments to foster parents.

Measures used included the Parent Daily Report Checklist to assess rates of child behavior problems, to track disruptions (failed placements) in foster care, and to track rates of foster parents dropping out of the system (those who decided to no longer be foster parents). In the ETS condition, fewer foster parents dropped out of the program (less than 10 percent). The PO group foster parents had the next lowest drop-out rate (14 percent), and the AO foster parents had the highest drop-out rate (26 percent).

In terms of child outcomes, children whose foster parents participated in the enhanced condition had significantly fewer failed placements and significantly more non-disrupted days in care than did children in either of the other two groups. In addition, children in the ETS group showed the largest drop in rates of problem behaviors at the three month follow-up. There were, however, initial differences between the three groups initially on the rate of problem behaviors, with ETS children showing significantly higher levels of problems at baseline.

Table 4. Summary of Four Studies Evaluating the Effectiveness of MTFC

Location	Subjects	Comparison/Control Group	Assignment Procedure	Follow-up Period	Risk/Protective Factors	Outcomes	Reference
Eugene, OR	79 boys with an average of 13 offenses; ages 12-17	2 groups: 37 MTFC & 42 other residential group homes	Random	1 year (so far)	Delinquent peers, Supervision, Discipline, Relationship w/caretaking adult	MTFC boys had fewer arrests & days incarcerated & higher program completion than control group.	Chamberlain & Reid, 1997
Eugene, OR	32 youth (20 M & 12 F) committed to state training school; ages 12-18	2 groups: 16 MTFC & 16 other residential	Matched on age, gender, & date of commitment	2 years	Supervision, Family processes	MTFC youth spent fewer days incarcerated, & more completed their programs than controls.	Chamberlain, 1990
Eugene, OR	20 youth (8 M & 12 F) from Oregon State Hospital; ages 9-18	2 groups: 10 MTFC & 10 treatment as usual in community	Random	7 months	Family support	MTFC youth were placed out of hospital more quickly, & more MTFC youth placed in family homes than control youth.	Chamberlain & Reid, 1991
Eugene, OR	72 "regular" foster care families; children ranged from 4 to 7	3 groups: 31 Enhanced Treatment Svcs (ETS), 14 Payment Only (PO), 27 Assessment Only (AO)	Random	3 months	Behavior management training for foster parents	ETS parents' retention rates higher than in PO & AO. ETS children had fewer problem behaviors & failed placements than PO & AO children.	Chamberlain, Moreland, & Reid, 1992

Blueprints

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CHAPTER FOUR
Program Replication
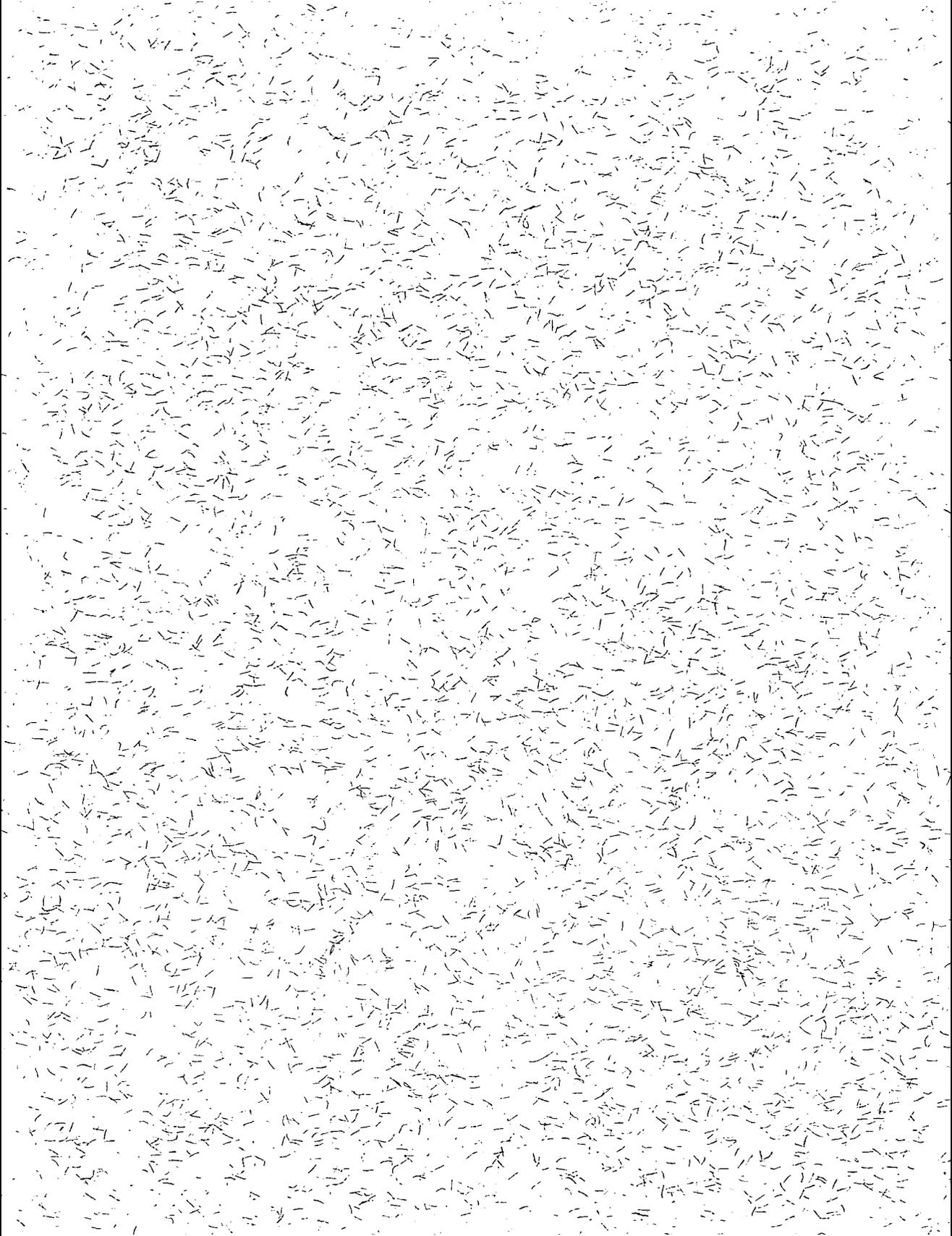
PROGRAM REPLICATION

Description

We are now at the point in the evolution of this program model where we are mounting systematic, well-evaluated, replication studies. There are two replications of the OSLC MTFC model in progress. The first, the Early Intervention MTFC program, focuses on adapting the MTFC model for working with severely abused and neglected three to seven year old children who are currently in state foster homes, and who are exhibiting significant behavioral and emotional disturbances and developmental delays. The second replication focuses on adapting the model to address the specific needs of adolescent females who have criminal histories and severe emotional/behavioral difficulties.

Early Intervention Treatment Foster Care (EITFC)

This program was designed as a downward extension, in terms of age, of the OSLC MTFC model. The program includes children who are between the ages of three and seven. They have been removed from their parents' care by the state child protective services agency due to neglect and maltreatment, and have been referred to OSLC because of extremely challenging behavior that has typically led to disruption from one or more prior foster homes. Problems seen most often in this population include extreme and prolonged tantrums, poor social skills resulting in difficulty forming positive relationships with adults and peers, oppositional and defiant attitudes towards authority, hypervigilance, emotional lability, and enuresis. In addition, many of these children have developmental delays due to in-utero drug exposure and inadequate early environments.

Many of the standard components of the OSLC model are used in the EITFC program. Foster parents receive extensive training and ongoing support. This includes daily phone contact from program staff and a weekly support group. The child is separated from the environment in which problem behaviors developed and placed in a home in which there is a clear system of limits and consequences, and there is a focus on building upon a child's natural strengths and capabilities.

Several changes and adaptations, however, were made in this replication. First, the behavior management techniques required modification in order to be more developmentally appropriate. The central concept of using a balance of encouragement to teach positive behaviors and limit setting to decrease negative behaviors was retained, but the immediacy of reinforcement and delivery of consequences has changed. Whereas with older children the contingencies can be delayed in time for anywhere from minutes to hours, in the EITFC program, contingencies occur as quickly after a behavior as possible. Foster parents use stickers, star charts, "kid bucks," and other tokens as positive reinforcers. Time out and withdrawal of privileges are the primary tools for limit setting.

In addition to these adaptations, several program components have been added. First, much of the service delivery occurs in the home of the foster family. This allows program staff to work with foster family and child in a more naturalistic milieu. It also allows staff to make sure that the child is being treated appropriately. A second program component that has been added is the assessment of developmental delays. All children in the program are screened for delays when placed in the foster home. Those who are found to be at risk based on this screening are administered a comprehensive programmatic assessment to determine specific areas in need of remediation. An early intervention specialist then works with the child and the foster parents using a standardized curriculum of activi-

ties specifically designed to produce change in problem areas. Finally, all children in the program participate in a weekly two-hour play group in which they learn social skills and other things that will help them succeed as they transition to primary school.

The program treats approximately fifteen children per year. A one-year pilot study was initiated in March of 1997 to evaluate the effectiveness of the program. A variety of measures are being collected related to outcome, including physiological measures of emotion regulation through a chemical contained in saliva called cortisol.

MTFC for Adolescent Girls

In February, 1997, we began a research grant funded by the National Institute of Mental Health to evaluate the effectiveness of MTFC versus treatment "as usual" in the community for adolescent girls. We are also interested in examining key treatment processes that contribute to successful/unsuccessful outcomes. Over the next five years, 130 girls, ages twelve to sixteen, will participate. Girls who are referred to the study have had contact with both the criminal justice and the mental health systems; to be eligible for participation they have to have at least one previous arrest and be judged (by the county mental health clinic) to be severely emotionally disturbed. All participating girls will undergo an intensive assessment at baseline, an assessment two months after they are placed, and follow-up assessments at six-month intervals for four years. The program has been modified somewhat to address the specific needs of these youngsters. Compared to their male counterparts, girls tend to participate in more self-destructive behaviors, to run away more often, and to engage in high-risk sexual behaviors. Treatment targets also include dealing with relational aggression which is a more common expression of aggression in girls than in boys. Relational aggression involves using the relationship as a tool to threaten or punish other individuals. Examples would be spreading rumors about a peer's reputation with whom you were angry, snubbing or excluding an individual, or pitting people against each other (e.g., foster mother and father). MTFC parents are taught to track and provide consequences for instances of relational aggression that occur in the home and to reinforce the girl for dealing with conflict or distress in a straightforward, above-board way.

In addition to participating in individual and family treatment, girls take part in a skill and image development group. MTFC parents will be given specialized training in methods for dealing with adolescent females. So far, implementation problems have been surprisingly few. We have been able to recruit excellent MTFC homes and have added additional staff who are specializing in working with this population. Because this study is in progress, no evaluation data are available at this time.

Future Directions

The next step is to replicate the MTFC model at other sites with interventionists outside of OSLC. The model is well defined and the components well specified. We have trained a number of practioners to implement the model within our community programs over the past fifteen years. We have shown in four studies that outcomes for those who participate in the MTFC program are superior to outcomes for control group youth and families. The findings are the clearest for the juvenile justice population where we have concentrated most of our research efforts. Severely disturbed youth leaving the state hospital seem to benefit as well. There is every reason to believe that the MTFC intervention model might have broader and more inclusive applications to the general foster care population. Given that the research shows that youth coming out of the foster care system are at

greatly increased risk for delinquency, the MTFC intervention model is a likely candidate for improving outcomes for children in foster care. Previous work has shown that MTFC is effective with severely delinquent youth and that the MTFC intervention targets variables that have been shown to relate to the development and maintenance of delinquency.
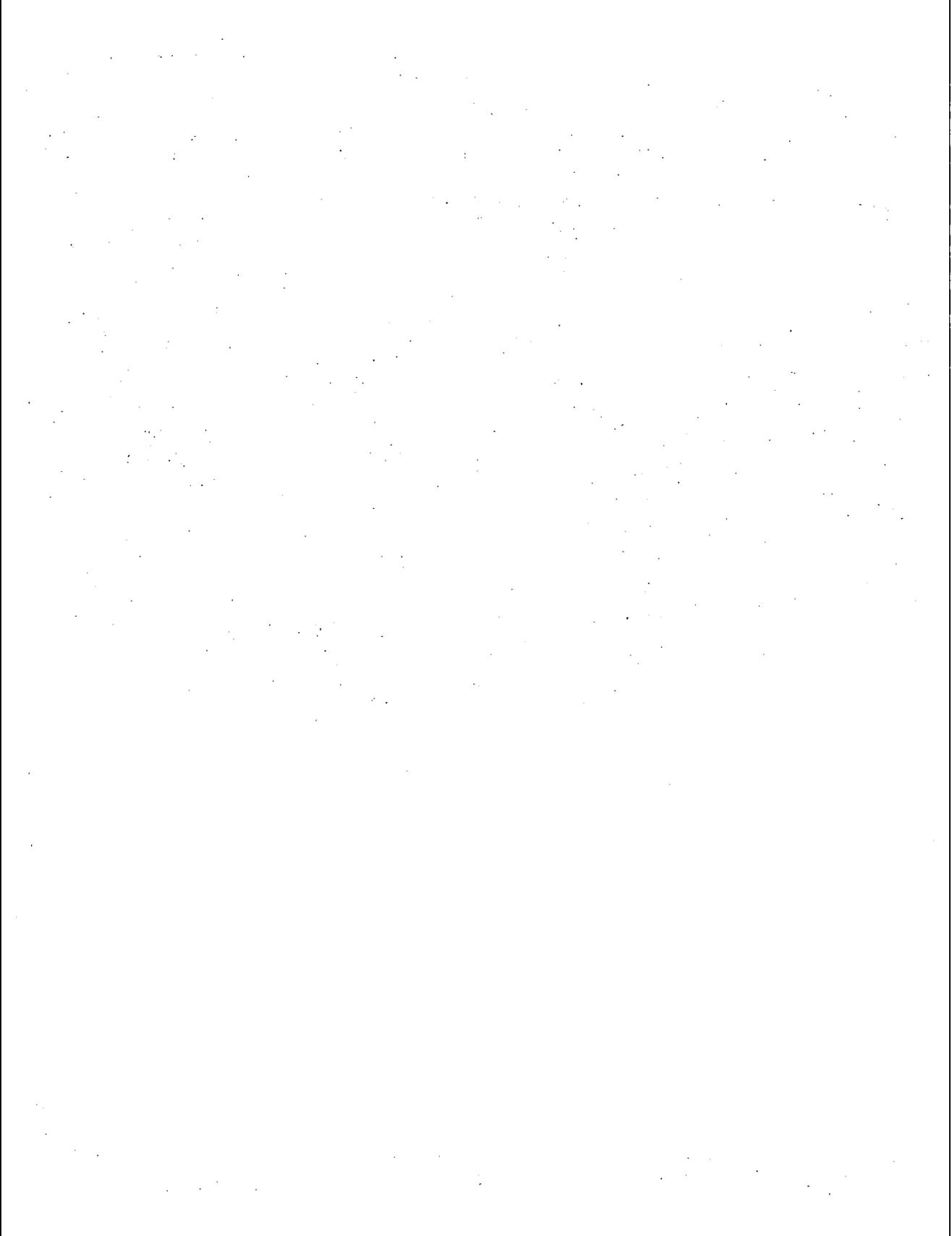
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Appendices
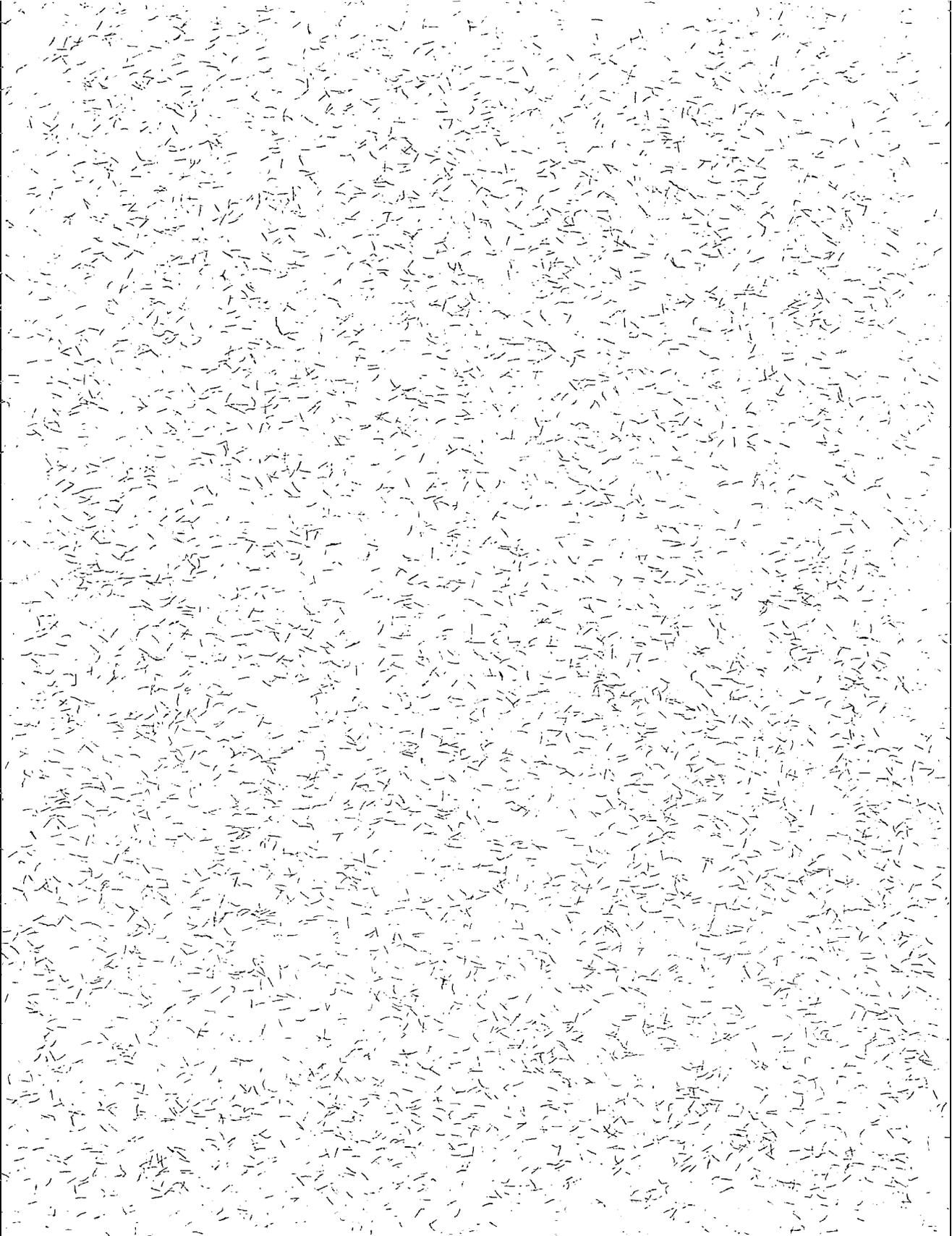
APPENDIX A

References by Document Section

Full citations are located at the end of the document.

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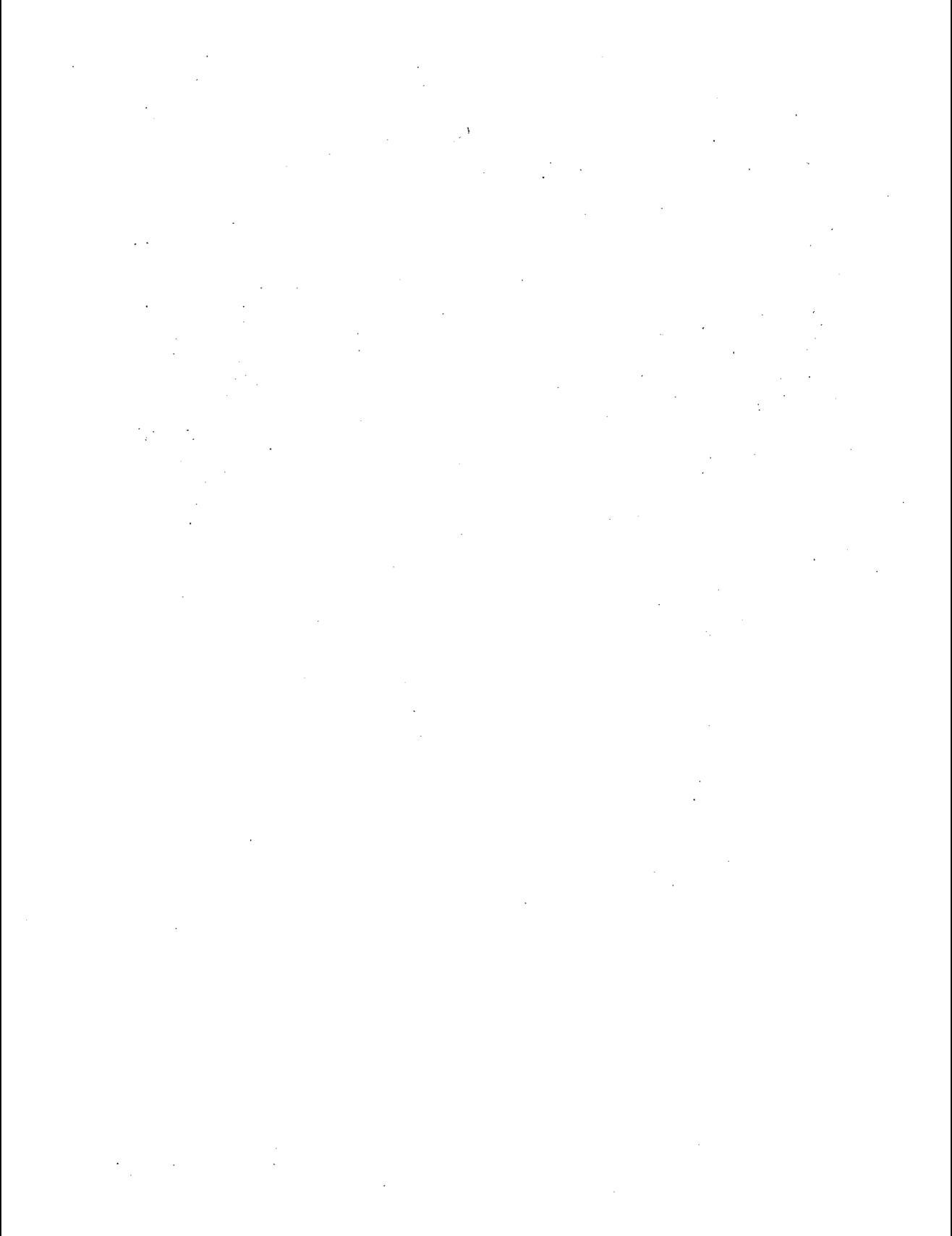
APPENDIX B

Application

Dear

Since 1983, the Oregon Social Learning Center has provided treatment foster care for over 300 boys and girls. Children referred to the programs have behavioral and emotional problems. With the help of families like yours, we provide placement and treatment for children in the context of a healthy family home. It is our belief that a home-style placement provides the child with the best opportunities to learn and change.

Being a Treatment Foster Parent is a demanding but immensely rewarding job if you have a desire to help a troubled child and enjoy parenting. Treatment Foster Parents work as members of a professional team that includes a case manager, a therapist for the child, and a therapist for the child's natural parents or relatives.

Foster parents participate in a pre-service training course designed to equip them with specific behavior management skills which are effective in helping troubled youth. Once a child is placed with you, you will receive ongoing training and support, including daily phone contact and a weekly support group meeting. Program staff will be available to you on a 24-hour basis to provide crisis intervention services and other assistance you might need. Parents are reimbursed monthly, and the children have a medical card covering both dental and physical health care.

If you wish to pursue becoming a Treatment Foster Parent, please complete the enclosed application and return it to the Oregon Social Learning Center, attention Kathy Reid. Feel free to call if you have additional questions, 485-2711.

Sincerely,

OREGON SOCIAL LEARNING CENTER (OSLC) TREATMENT FOSTER CARE PROGRAM

Information for Prospective Treatment Foster Parents

Goals and Strategies of the Treatment Foster Care Program

The central goal of our program is to train and support treatment foster parents who are willing and able to provide special care for children with a wide range of needs and problems. Our objective is to provide children with the treatment and positive learning experiences they need in order to make a smooth and successful transition either back to their natural parents or to other permanent placements. We recognize that caring for youngsters new to a family can be challenging, and each family has a case manager who serves as the primary support person at OSLC. The case manager coordinates the child's treatment plan and communicates the child's needs to everyone with an interest in the case (school, state agencies, therapists, medical personnel, parents, etc.). This is the team treatment approach, and foster parents are key members of the treatment team. Another member of the team, the PDR (Parent Daily Report) caller, phones foster parents each day, Monday through Friday, to monitor the child's behavior and to attend to any immediate needs of the foster parents. Foster parents must attend weekly support meetings, during which they can share their joys, frustrations, and strategies with one another and with program staff. Staff are on call 24 hours a day, seven days a week, to provide support and help foster parents deal with emergencies.

The incentive system used at OSLC provides clear structure and rules for the child. This relieves foster parents of much of the burden of making rules and setting consequences for rule breaking. The system allows parents to maintain a fair and impartial attitude when taking away privileges for bad behavior and show exuberance for positive behavior. The point system is essential to the program and is the primary tool used for teaching difficult children positive social behavior.

Qualifications of Treatment Foster Parents

Basic qualifications for foster parents include being certified by Services to Children and Families or the Oregon Youth Authority (we help you with this); having the time, interest, and willingness to work with a hard-to-reach youth; having an automobile and current Oregon driver's license; and being willing to provide transportation. Also, your home must have adequate space, and you may not have a history of felonies.

Responsibilities and Relationships of Treatment Foster Parents to OSLC Staff

Treatment foster parents are responsible for providing care and supervision for one foster child. They implement and monitor the child's treatment plan and coordinate the ongoing planning and activities of the OSLC program. Parents are expected to follow OSLC policies and direct all inquiries regarding the child or the child's family to program staff. Treatment foster parents are supervised by the program director and/or case manager. Case managers, therapists, and staff at OSLC are devoted to being part of a treatment team with foster parents. Foster parents and staff work closely together to develop and implement a treatment plan that fits the specific needs of each child. Children in this program also have case workers and/or parole/probation officers who work with the team.

Some obligations come with being treatment foster parents. Welcoming a new child into an established environment can be both stressful and rewarding. The child will soon become part of your family and need nurturing, acceptance, clear limits, lots of encouragement, and daily essentials such as clothing and school supplies. All children have state-provided medical and dental coverage. Foster parents register children in school, participate in parent-teacher conferences, and keep staff informed of their child's progress in school. Children also participate in sports, day camps, arts, clubs, or any other wholesome activities that encourage positive growth. Some children have regular visits with their natural parents and, in these cases, program staff work with foster parents to set up and monitor the visits.

OREGON SOCIAL LEARNING CENTER
FOSTER PARENT APPLICATION

NAME _____
           Last   First   M.I.   Age   DOB

ADDRESS _____
                Street   City/State   Zip

PHONE: Home _____   Work _____

SSN _____   Date Married _____

Occupation _____   Employer Name _____

Net Monthly Income _____   Address _____

                               City/State _____

# of years of school completed _____   Degrees _____

HOUSEHOLD MEMBERS

Name	DOB	Age	In the Home?	Relationship
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____
_____	_____	_____	Y/N	_____

References

List the names of four people (not related to you) that have known you for at least one year.

1. Name_____   _____
         Last   First

    Address_____   _____   _____
         Street   City/State   Zip

    Phone: (Home) _____ (Work) _____

    Occupation _____

    How do you know them (friend, neighbor, employer, church, etc.):

    _____

2. Name_____   _____
         Last   First

    Address_____   _____   _____
         Street   City/State   Zip

    Phone: (Home) _____ (Work) _____

    Occupation _____

    How do you know them (friend, neighbor, employer, church, etc.):

    _____

3. Name_____   _____
         Last   First

    Address_____   _____   _____
         Street   City/State   Zip

    Phone: (Home) _____ (Work) _____

    Occupation _____

    How do you know them (friend, neighbor, employer, church, etc.):

    _____

4. Name_____   _____
         Last   First

    Address_____   _____   _____
         Street   City/State   Zip

    Phone: (Home) _____ (Work) _____

    Occupation _____

    How do you know them (friend, neighbor, employer, church, etc.):

    _____

ADDITIONAL QUESTIONS

Both parents fill this out together.

1. Why are you interested in this position?

2. Do you feel qualified to handle angry and/or rebellious adolescents?

3. What sort of events or behaviors would cause you to give up on a youth?

4. What forms of recreation do you enjoy? Especially mention ones you could include the youth in. How often?

5. How would you typically correct misbehavior? Provide your views on discipline and punishment.

6. What role would you expect the youth to assume while staying with you?

7. Are you able to provide routine and crisis transportation for the youth?

8. Have you or your spouse ever been convicted of a felony or a misdemeanor?

   YES_____   NO_____

   If yes, please note date(s) and charge(s). This information is required by Children's Services Division.

9. Have you and your spouse ever separated because of marital problems? If yes, please give the date and length of separation.

10. Have you or your spouse ever applied for a foster care position with any other agency (including AFS, CSD, etc.)?

    YES_____   NO_____
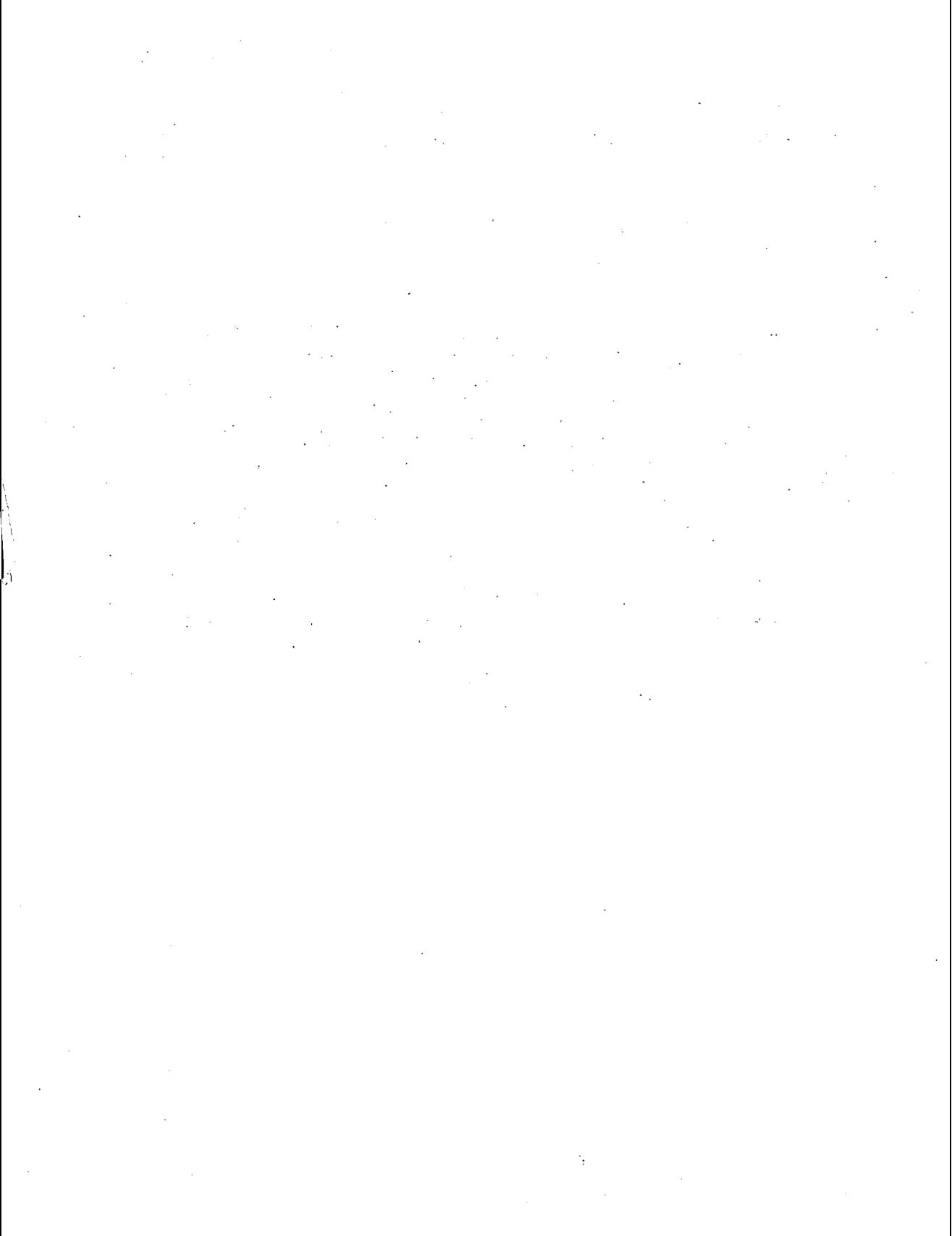
APPENDIX C

Treatment Foster Care
Training Outline

I. Overview of Treatment Foster Care
 A. Professional approach
 B. Teaching opportunities
 C. Relationship building
 D. Rules of confidentiality
 E. Treatment team
  1. Case manager
  2. Therapists
  3. Parole and probation
  4. Foster family
  5. Natural family

> **I. Skills**
>
> 1. **Understands role of treatment foster care provider**
> 2. **Can identify basic teaching opportunities**
> 3. **Knows relationship building techniques**
> 4. **Knows rules of confidentiality**
> 5. **Understands team approach**

II. Using a four step approach
 A. Knowing when a problem is a problem
  1. Identifying a behavior that puts the child at risk
  2. Is this a behavior that gets in the child's way of success
  3. Observation techniques
 B. Defining the problem behavior
  1. Describe the problem in specific detail
  2. Avoid using global terms
  3. Avoid using absolutes
 C. Examine the antecedents of the problem
  1. When does this behavior happen
  2. Where does this behavior happen
  3. With whom does this behavior happen
  4. How often does this behavior occur

> **II. Skills**
>
> 1. **Can identify problem behavior**
> 2. **Can observe behavior**
> 3. **Can give specific feedback**
> 4. **Can make effective requests**
> 5. **Knows basic techniques of encouragement**
> 6. **Knows basic techniques of setting limits**
> 7. **Can identify teaching opportunities**

 D. Change the consequences that maintain the problem
  1. Identify what motivates the problem behavior
  2. Set out consequences for inappropriate behavior
  3. Identify pro-social behavior
  4. Identify motivators for performing appropriate behavior
  5. Using consistency in tracking
  6. Provide and take advantage of teaching opportunities

III. Procedures for using a 3-level system
    A. 1. The rules of Level I
          a. Limited privileges
          b. Limited contact with family
      2. 2100 points buys Level II
    B. Level II
      1. Opportunity for child to practice skills
      2. Home visits
      3. Allowance
      4. Supervised activity time
    C. Level III
      1. Expanded privileges
      2. Planning and time management
      3. Budgeting
    D. School-home link
      1. School card
      2. Talking to teachers

IV. Working with the child's natural family
    A. Family therapist's role and goals
      1. Build a relationship with the family
      2. Teach family skills that enhance their ability to work successfully with their child upon his return
      3. Understanding the foster parent's role
          a. Little if any contact
          b. Present positive attitude about family to child
    B. Common sources of stress on the team
      1. Case Manager role
      2. Managing conflict
    C. Treatment foster care policies and procedure
      1. Communication
          a. Parole
          b. Staff
          c. Parent and/or relative
      2. Drug and Alcohol Monitoring
          a. Room search
          b. Urinalysis
          c. Alcohol in the home

III. Skills

1. Knows and understands the use of Level I

2. Can record the child's daily progress on Level I card

3. Can identify encouragement daily

4. Can identify pro-social behavior and record daily progress

5. Knows the importance of consistency in recording daily points

6. Understands the use of program structure to motivate and encourage the child

7. Has basic knowledge of the 3-level system

8. Can use the 3-level system to motivate, teach, and encourage child's success

9. Open daily communication between home and school

IV. Skills

1. Understands role of family therapist

2. Understands the importance of family relationships

3. Can support child in building a relationship with family input and decisions

4. Can support family

5. Understands the importance of open communication with team members

6. Knows procedures of the program that insure child's safety and minimize at risk behavior

3. Confidentiality
4. Protecting Self
   a. Understanding child's rights
   b. Respect of privacy
   c. Establish specific house rules that provide safety to family members

V. Putting it all together
   A. Daily support and ongoing training
      1. Daily contact through PDR calls
      2. Staff on call 24 hours, 7 days a week
   B. Foster parent support
      1. Foster parent meeting
      2. Clinical meeting
      3. Foster parent feedback
      4. Program feedback

V. Skills

1. **Knows importance of daily communicating the child's behaviors and progress**

2. **Understands staff role**

3. **Understands importance of foster parent support meeting**
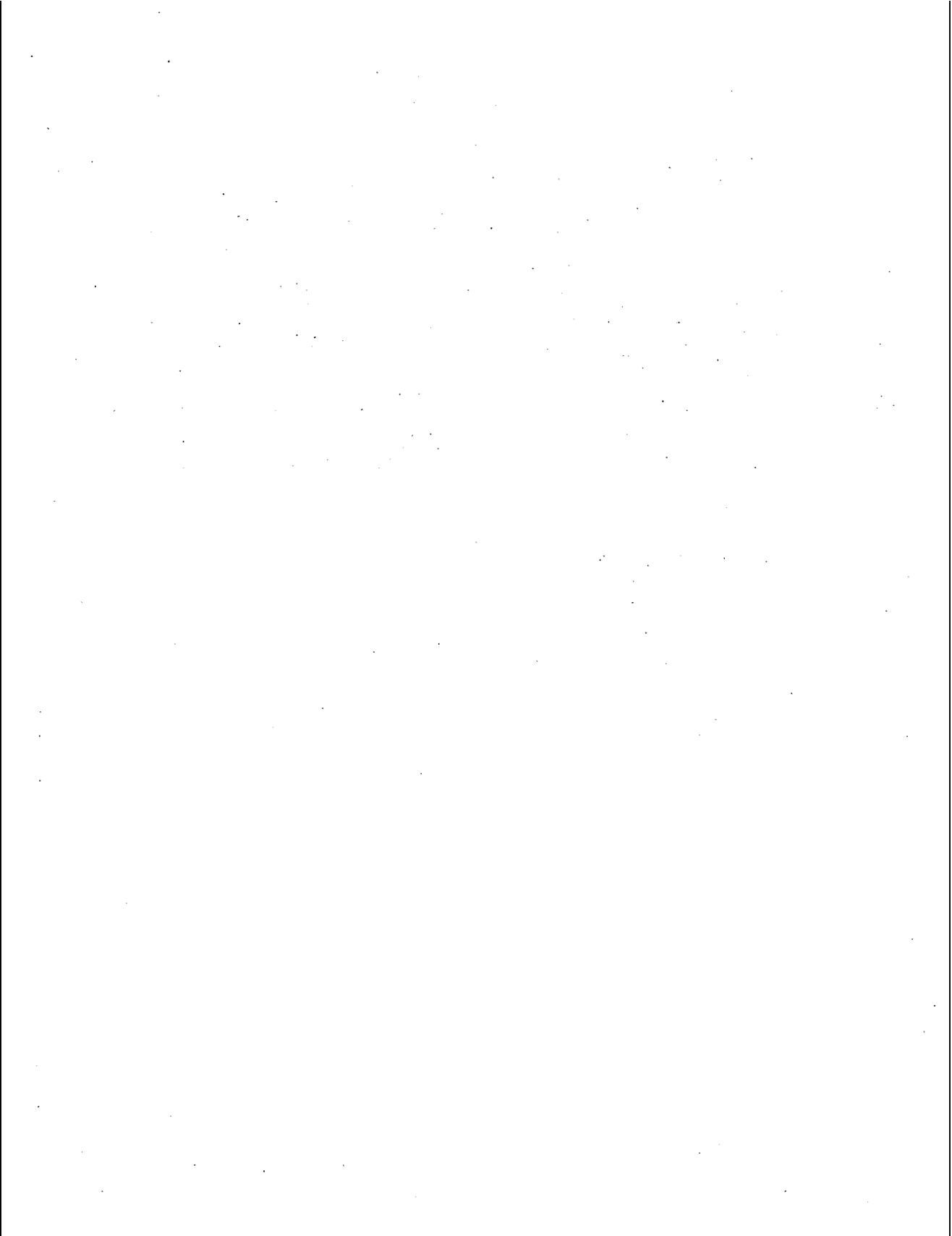
APPENDIX D

Examples of Point Programs

School Days Level II			
Name:			
BEHAVIOR	DESCRIPTION	TIME	POINTS
UP ON TIME	Out of bed.		10
READY IN MORNING	Shower, teeth brushed, hair combed, wear clean clothes, eat breakfast.		10
MORNING CLEAN-UP	Bed made, dirty clothes put away, room neat, bath towel and wash rag put away, and dishes in sink.		10
GO TO SCHOOL	Attend school each day (all classes).		5
CARRY SCHOOL CARD	Carry card to each class and get signature from each teacher.		2 cl.
BEHAVIOR IN CLASS	Pay attention to tasks in class, cooperate with the teacher, and hand homework in on time.		5 cl.
READ AND STUDY	50 minutes reading/writing each day (not including letter writing).		20
CHORE	To be explained each day.		10
ATTITUDE/MATURITY	Being helpful, taking criticism well, being pleasant, not pushing limits, not being moody, accepting NO!		15 AM 15 PM
VOLUNTEERING	Volunteering to do extra tasks (Foster Parent will decide on Points).		2-10
EXTRA CHORE	Optional (Must be approved by Foster Parents).		5-10
BED ON TIME	IF you CAN buy BASICS. IF you CAN'T buy BASICS.	9:30 8:30	10

Non-School Days Level II			
Name:			
BEHAVIOR	DESCRIPTION	TIME	POINTS
UP ON TIME	Out of bed.		10
READY IN MORNING	Shower, teeth brushed, hair combed, wear clean clothes, eat breakfast.		10
MORNING CLEAN-UP	Bed made, dirty clothes put away, room neat, bath towel and wash rag put away, and dishes in sink.		10
READ AND STUDY	50 minutes reading/writing each day (not including letter writing).		20
CHORE	To be explained each day.		10
ATTITUDE/MATURITY	Being helpful, taking criticism well, being pleasant, not pushing limits, not being moody, accepting NO!		15 AM 15 PM
VOLUNTEERING	Volunteering to do extra tasks (Foster Parent will decide on Points).		2-10
EXTRA CHORE	Optional (Must be approved by Foster Parents).		5-10
BED ON TIME	IF you CAN buy BASICS. IF you CAN'T buy BASICS.		10

SCHOOL DAYS LEVEL II CARD				
NAME: DATE:				
THINGS TO DO TO EARN POINTS	EARNED	BONUS	TAKEN	TOTAL
10 UP ON TIME				
10 READY IN MORNING				
10 MORNING CLEAN-UP				
5 GO TO SCHOOL				
1/CL. CARRY SCHOOL CARD				
5/CL. BEHAVIOR IN CLASS				
10 SCHOOL CARD BONUS				
20 READ AND STUDY				
10 CHORE				
15 A.M. ATTITUDE/MATURITY				
15 P.M. ATTITUDE/MATURITY				
2-10 VOLUNTEERING				
5-50 EXTRA CHORE				
10 BED ON TIME				

DAILY TOTAL_____

COMMENTS:

THINGS TO DO TO EARN POINTS	EARNED	BONUS	TAKEN	TOTAL
10 UP ON TIME				
10 READY IN MORNING				
10 MORNING CLEAN-UP				
20 READ AND STUDY				
15 A.M. ATTITUDE/MATURITY				
15 P.M. ATTITUDE/MATURITY				
10 CHORE				
2-10 MINDING				
2-10 VOLUNTEERING				
10 BED ON TIME				

NON-SCHOOL DAYS LEVEL II CARD

NAME: DATE:

DAILY TOTAL_____

COMMENTS:

LEVEL II PRIVILEGES		
PRIVILEGE	DESCRIPTION	POINT COST
*BASICS	Use of telephone for 15 minutes daily, radio in your room, 9:30 P.M. bedtime.	350
TV	Can watch TV after homework and/or chores are completed.	100
LATER BEDTIME	9:00 P.M. Bedtime daily. 10:00 P.M. Bedtime on weekends and holidays with permission.	100
ACTIVITY TIME	With prior planning, permission and approval, you may plan to go skating, swimming, to a movie, school activity, etc. *If you are late or not where you said you would be you will lose 1 point per minute.	½ point per minute
BONDS	1 Bond costs 100 points. You need 6 bonds to buy Level III.	50 ea.
EXTRA TELEPHONE TIME	One 20 minute call (not long distance).	25
OTHER	Foster parents will choose if applicable.	50
ALLOWANCE	$5.00 per week. All purchases must have receipts and you must show your money to your foster parents. *Money spent at school in pop/candy machines must have JP's approval.	200
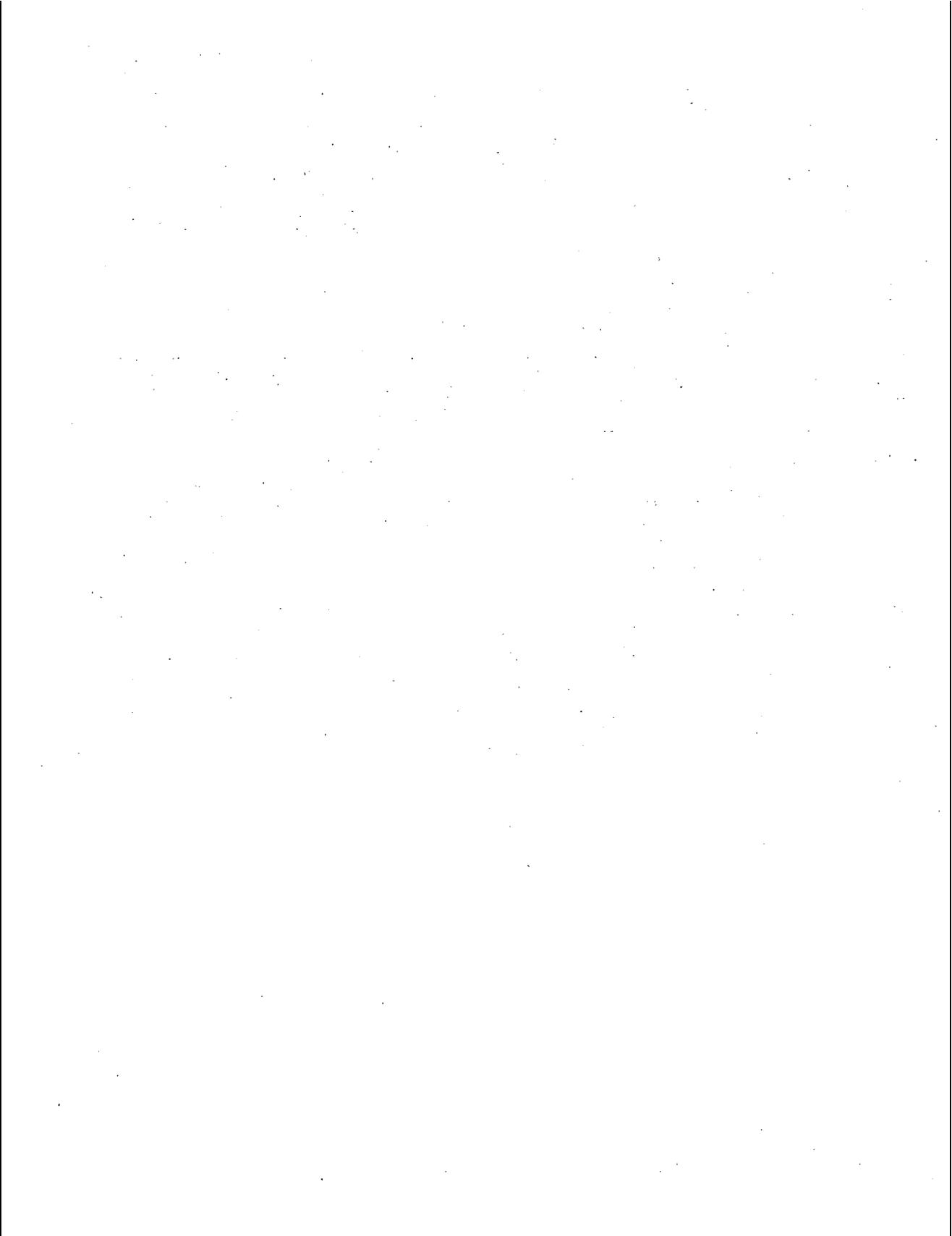
APPENDIX E

Parent Daily Report Checklist

Monitor Program___   Week of:_____ (F-Th)
YOUTH_____ (#_____) PDR CALLER_____
FOSTER PARENT_____ (#_____) PHONE_____

BEHAVIORS	SU	M	TU	W	TH	
Arguing						SUN/Rec time:
Back-talking						Unsupervised time:
Bedwetting						
Competitiveness						
Complaining						
Defiance						
Destructive, vandalism						MON/Rec time:
Encopresis						Unsupervised time:
Fighting						
Irritability						
Lying						
Negativism						
Boisterous/rowdy						TUE/Rec time:
Not minding						Unsupervised time:
Staying out late						
Skipping meals						
Running away						
Swearing/obscene lang.						
Tease/provoke						WED/Rec time:
Depression/sadness						Unsupervised time:
Sluggish						
Jealous						
Truant						
Stealing						
Nervous/jittery						THU/Rec time:
Short attention span						Unsupervised time:
Daydreaming						
Irresponsibility						
Marijuana/drugs						
Alcohol						
School problem						

TOTAL POINTS: _____ _____ _____ _____ _____   (Behaviors are on day
TOTAL POINTS LOST: _____ _____ _____ _____ _____   they occur.)

Friday: Total Points _____   Points Lost _____   Recreation Time _____
Saturday: Total Points _____   Points Lost _____   Recreation Time _____

ANYTHING POSITIVE/NEGATIVE HAPPEN?   Total Recreation Time _____
SUNDAY _____
MONDAY _____
TUESDAY _____
WEDNESDAY _____
THURSDAY _____
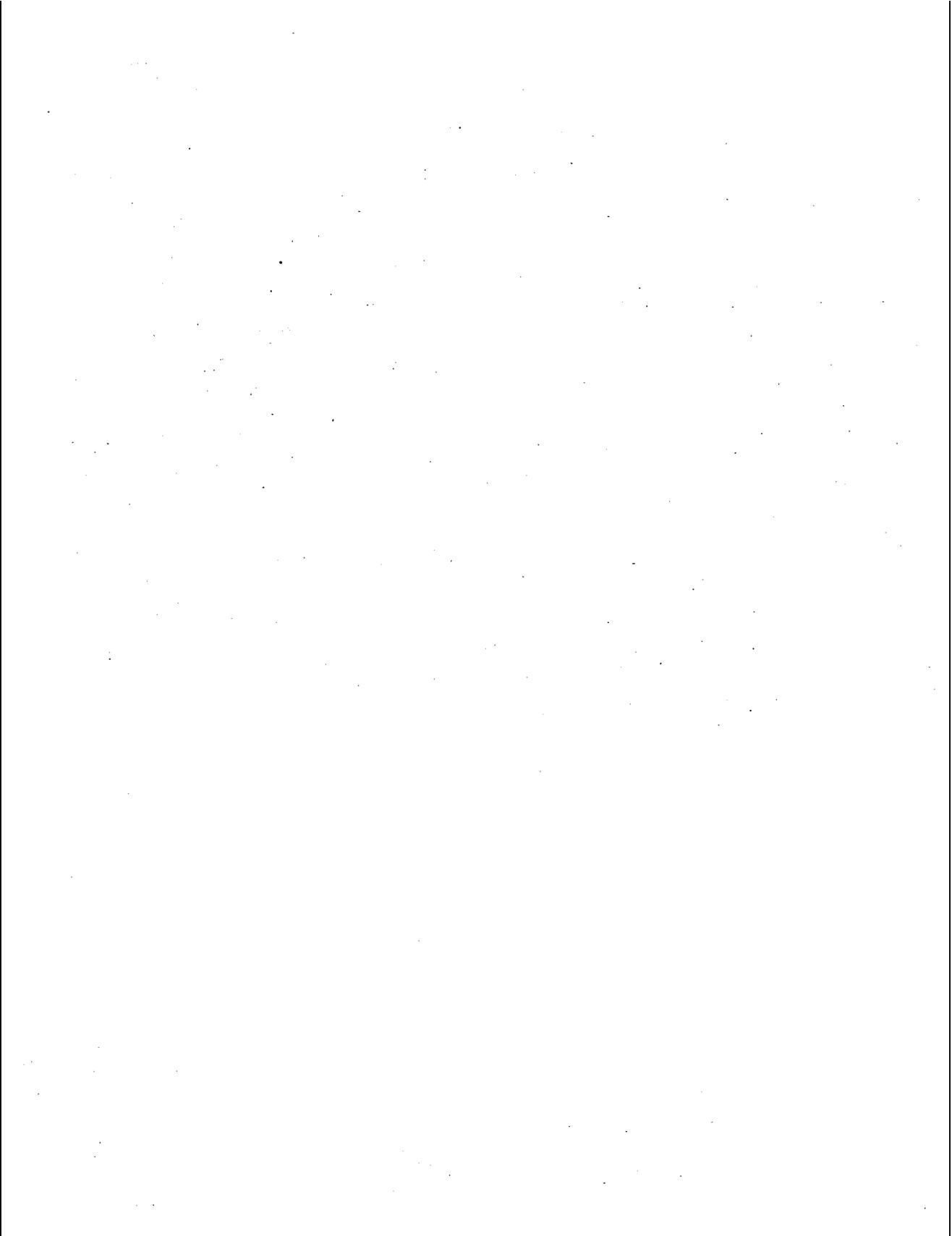
APPENDIX F

Supervision Expectations for Home Visits

During home visits, youth need to be supervised at all times by a parent or other adult living in the home. It is most helpful if you, as a parent, can stick to the schedule that your son or daughter is following in the treatment foster home. Your case manager is available to brief you on the details of that schedule.

Telephone Use: Home visits are not a time for youngsters to contact friends. Therefore, the youth's use of the telephone to talk to friends is not allowed unless approved by the case manager. Approved telephone contact with friends is to be supervised during home visits.

Going Places: Families are encouraged to do things together during home visits. You are free to take your youngster anywhere that you are going. The key is that s/he be supervised at all times. Wandering around stores presents a risk for some youth. If your child has had problems with stealing, be sure to carefully supervise him/her in settings where stealing might occur.

Having Friends Over: This is done with the prior permission of the case manager only. If the case manager has approved contact with friends, your child and his/her friends need to be supervised by an adult during home visits.

Bringing Things Back to the MTFC Home After the Home Visit: Your child may want to bring some of his/her possessions back to the MTFC home. This can be done only with prior approval of the case manager.

What to Do if Things Aren't Going Well: Many youngsters will try to test the limits and rules during home visits. Parents are key players in their child's treatment. It is important for your child to see you as cooperating with the program rules. If your child acts up during a home visit, call the case manager to talk about the situation. It is much better if you can call early in the process, when your child is just starting to misbehave, rather than waiting until there is a full-blown conflict. The most important thing to remember is to call if there is a conflict or any type of rule breaking on your child's part. It is not a failure or a bad reflection on your as a parent if you call. By calling you are playing an active and positive role in your child's treatment.

Will This Level of Supervision Last Forever? No. As your child becomes better at making responsible choices and decisions, s/he will get increased privileges. Your case manager will talk to you about when and how this will happen. By the time your child comes home to live with you, s/he will not need the constant level of supervision that you are being asked to provide now.

Youth_____   Date_____

Home_____

HOME VISIT ASSESSMENT

Please rate your child's behaviors using the following rating scale. Feel free to write down comments to explain your ratings.

5	Excellent
4	Very good
3	Good
2	Needs improvement
1	Showed little or no effort

1. How well has your child helped out around the house with chores?

    RATING_____Comments_____

    _____

2. Was your child where he/she was supposed to be at all times?

    RATING_____Comments_____

    _____

3. How well did your child accept your criticism without arguing or talking back?

    RATING_____Comments_____

    _____

4. How well did your child get along with you and other brothers and sisters?

    RATING_____Comments_____

    _____

5. How would you rate the quality time you spent with your child?

    RATING_____Comments_____

    _____

.6. Overall, how would you rate the success of this home visit?

    RATING_____Comments_____

    _____

APPENDIX G

Point Card for Home Visit				
Name:	Date:			
THINGS TO DO TO EARN POINTS	TIME	BONUS	TAKEN	TOTAL
10 UP ON TIME	9:00			
15 DRESS AND PICK UP AFTER SELF	9:30			
15 a.m. ATTITUDE/MATURITY	12:00			
15 p.m. ATTITUDE/MATURITY	Bedtime			
10 CHORE – To be given by parent	By 4:00			
2-10 MINDING (Doing what you asked without arguing or comment)	All day			
10 BEDTIME	10:00			

Daily Total_____

Comments: (What went well and what could be improved for the next visit)

APPENDIX H
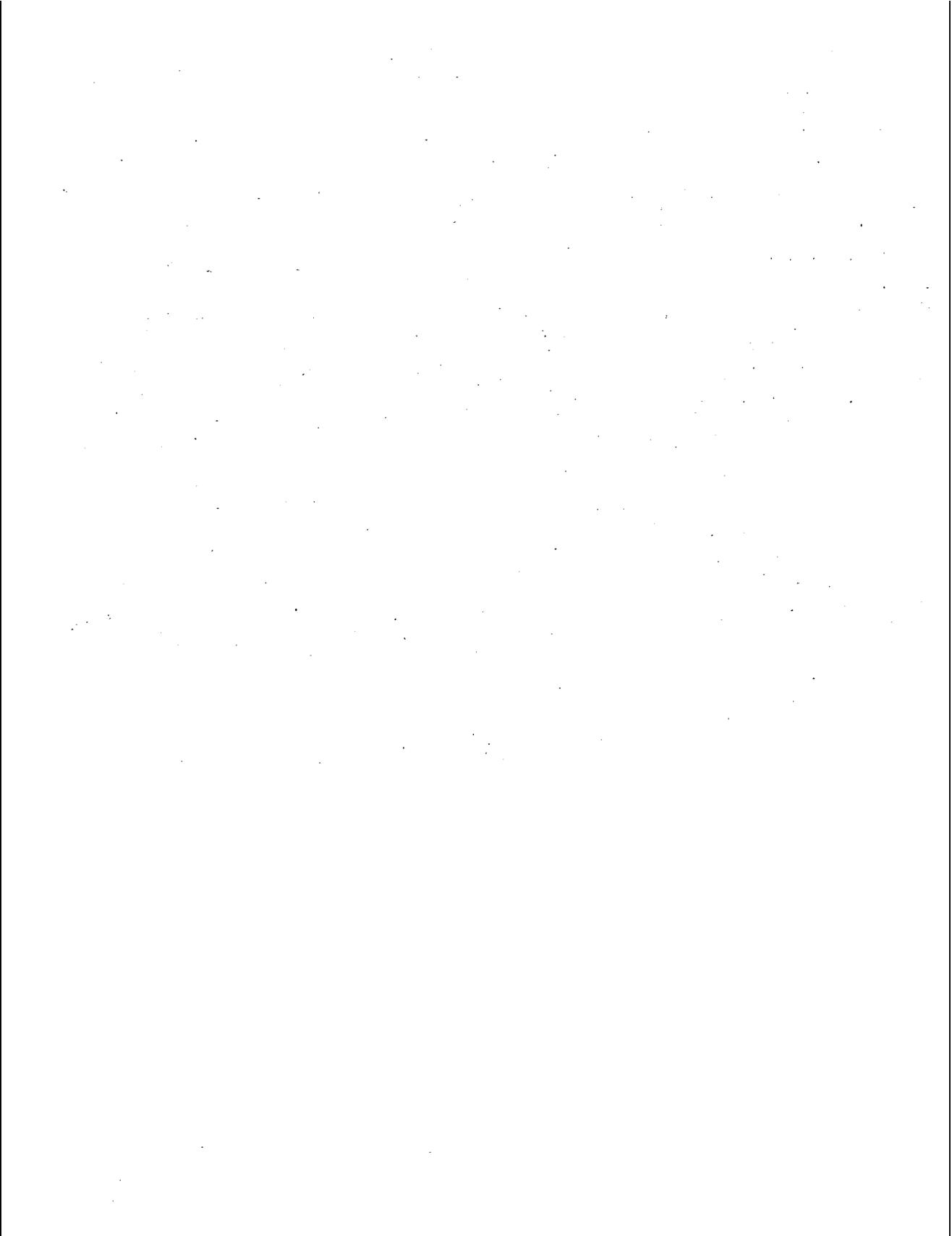
		Assignment	*Overdue Homework	Tardy	Behavior Good/Poor	Initial
Class	Today's Assignment					
		Yes/No	Yes/No	Yes/No	Good/Poor	
		Yes/No	Yes/No	Yes/No	Good/Poor	
		Yes/No	Yes/No	Yes/No	Good/Poor	
		Yes/No	Yes/No	Yes/No	Good/Poor	
		Yes/No	Yes/No	Yes/No	Good/Poor	
		Yes/No	Yes/No	Yes/No	Good/Poor	
		Yes/No	Yes/No	Yes/No	Good/Poor	

SCHOOL CARD

*Please identify overdue homework assignments on the back of this form.
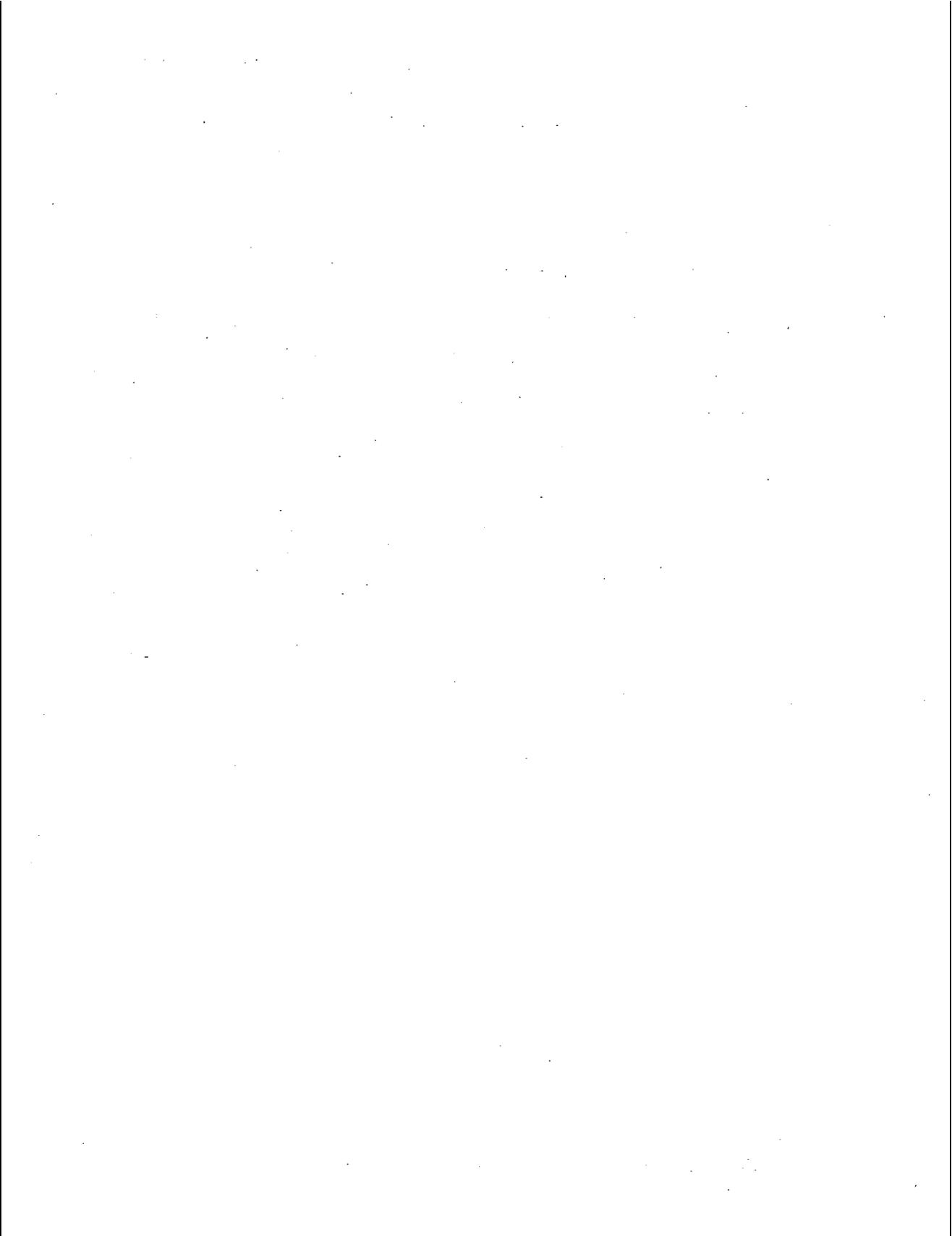
APPENDIX I

Success Begins at Home
Table of Contents

APPENDIX J

Description of the OSLC Monitor Program
207 East 5th Avenue, Suite 202
Eugene, OR 97401

The OSLC Monitor Program is designed to provide a community-based treatment alternative to institutionalization for 12- to 18-year-old youth who have a history of law violations and other problems, such as school failure, family problems, aggression, drug and alcohol use, poor peer relations, poor coping and social skills, minimal work skills, and low self-esteem.

Participating youth are placed with Oregon Youth Authority certified foster parents who are recruited, trained, and supervised by OSLC staff. Staff, foster parents, and family members together develop and implement individualized treatment programs. One or two youngsters are placed in each home. The program takes advantage of the natural parenting abilities of the foster parents, their stable and nurturing family relations, and treatment methods that have been directly developed for dealing with conduct problems and delinquency. Family members are encouraged to contact their child's case manager to obtain progress reports and to arrange home visits. Individual and family therapy are provided for all participants. Monitor Program case managers coordinate services for the youth in school, work, parole, and special interest areas to ensure an integrated approach. Case managers coordinate services for youth in school and with parole/probation officers to ensure an integrated approach. In order to evaluate the effectiveness of the program, we collect arrest records for all participating youth.

The OSLC Monitor Program focuses on helping the youth's natural family or aftercare placement family integrate the youngster after the placement period, and helping them continue to make progress in areas where positive behavior changes were achieved during placement.

The assumptions of the program are twofold: first, that the conduct of these youngsters can be altered by the circumstances that influence them, and second, that their natural or aftercare placement families can be helped to support positive social behaviors so that good community adjustment can be made, reducing the likelihood of further delinquency or institutionalization. The Monitor Program has been operating since November, 1983, and receives referrals from the state juvenile courts, attorneys, parole officers, and caseworkers.

The OSLC Monitor Program is one of thirteen statewide diversion programs funded by the Oregon Youth Authority.

For further information, contact the Director, Patricia Chamberlain, Ph.D., at 485-2711, or the Program Manager, J. P. Davis, at 485-0094.
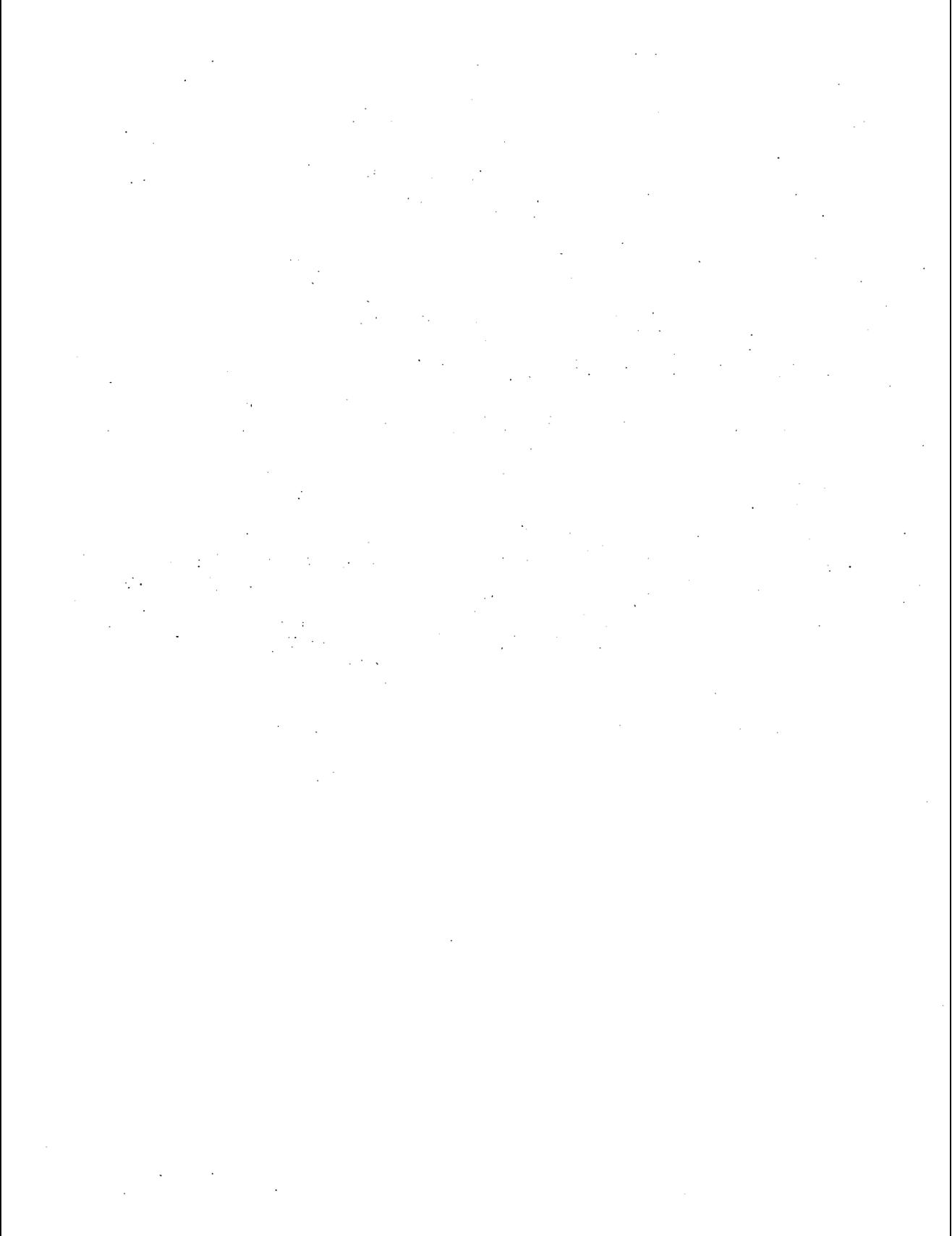
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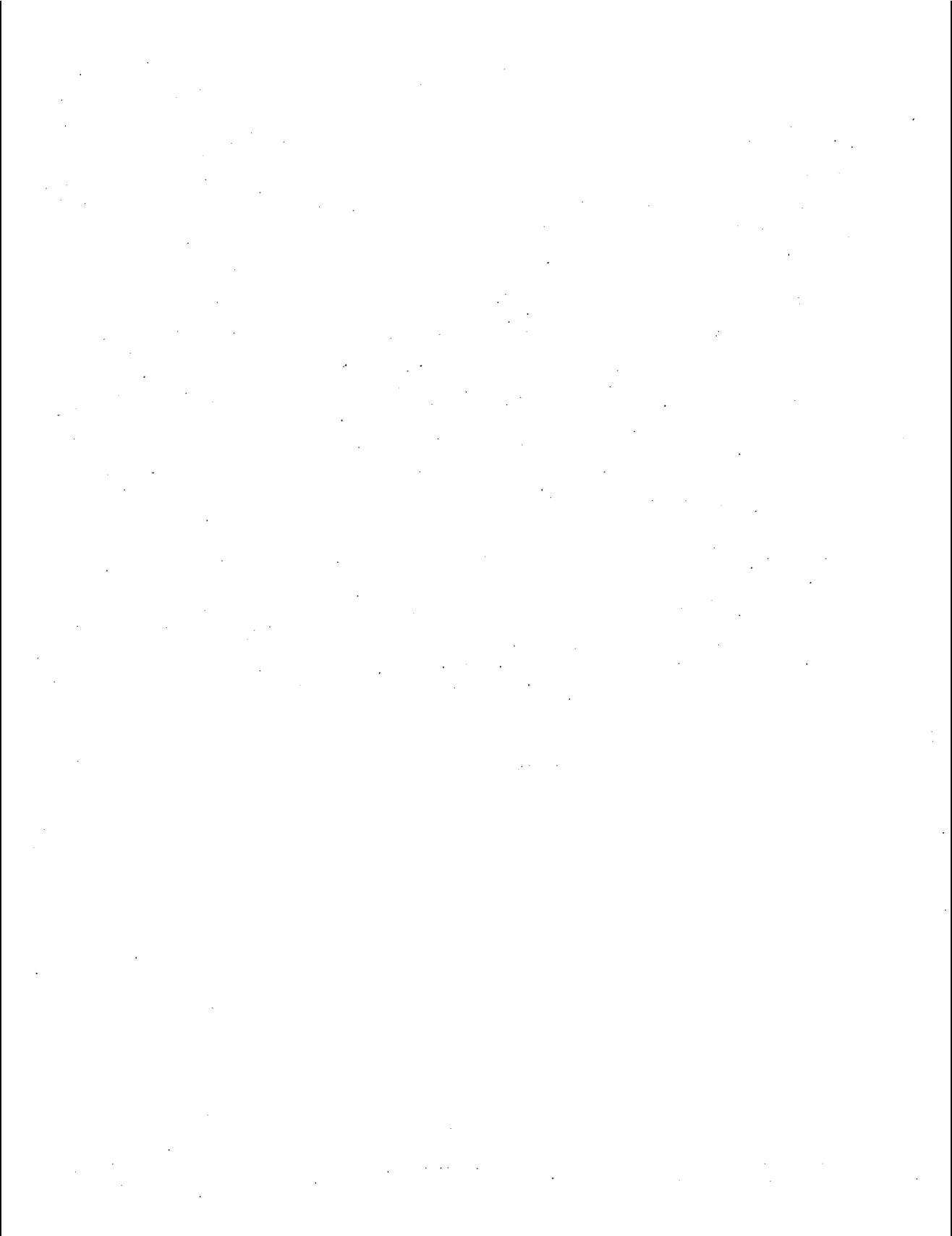
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