

# Model Evidence-Based Programs for High-Risk Youth

Dan Edwards, Ph.D.

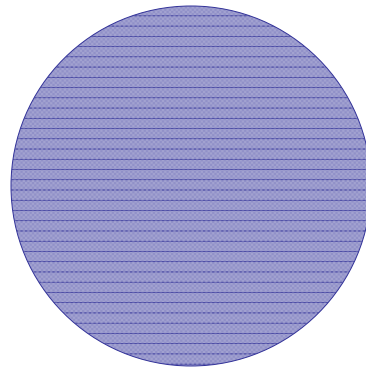
Director of Operations, Evidence-Based Associates (EBA)



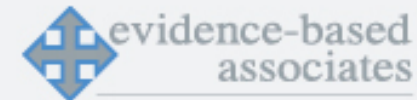
# "How we Know What isn't So"



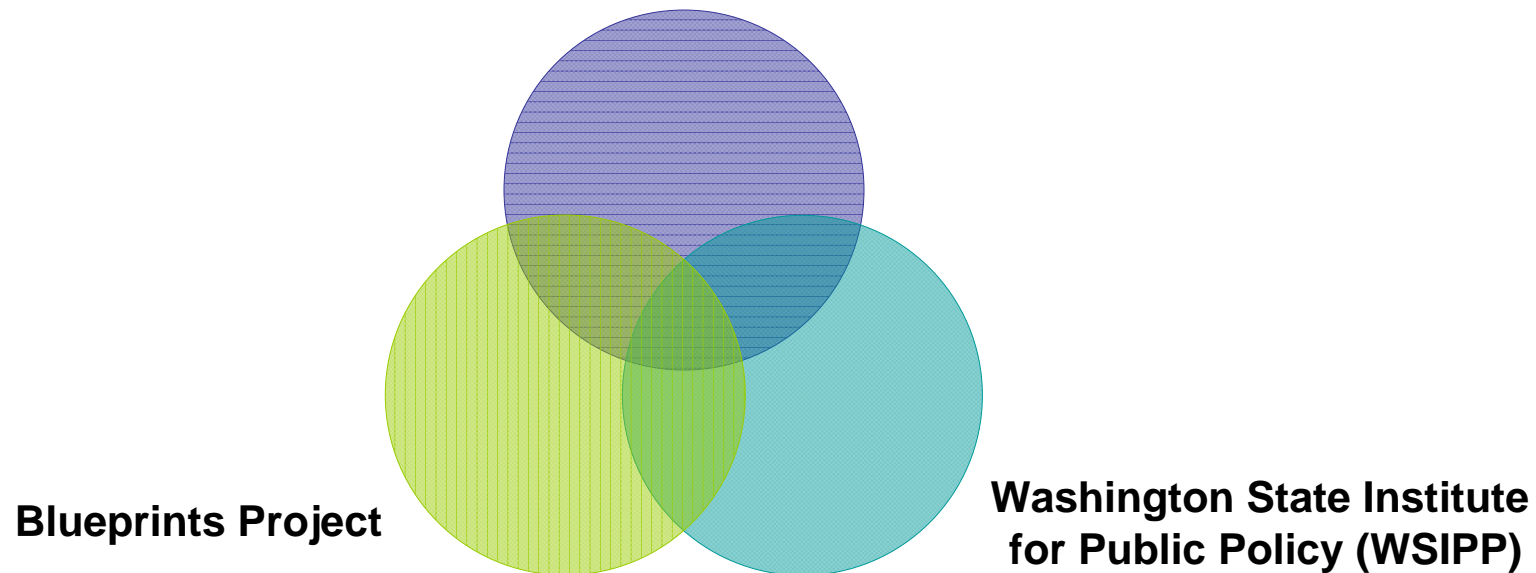
(...and why is CHANGE so difficult?)



# What are "Model EBPs?"



## Surgeon General's Report on Youth Violence (2001)



# Surgeon General's Report



## Report on Youth Violence

- In response to tragedy at Columbine
- Addressed youth violence as a public health risk

### What works:

- MST
- FFT
- MTFC
- Justice System Interventions (e.g., Wraparound and Intensive Protective Supervision)

### What does NOT work:

- Boot camps
- residential (milieu therapy and behavioral token) programs
- waivers to adult court
- social casework
- individual counseling
- shock programs

# Blueprints Project



1. Initially funded by OJJDP, Colorado & Pennsylvania
2. Established criteria for 'model' and 'promising' programs
3. Faculty reviewed the existing literature and update list
4. Selected model programs "that will form the nucleus of a national violence prevention initiative."

**\*\*\* Over 700 programs reviewed --- 11 selected (including MST, FFT, MTFC and NFP) \*\*\***

See [www.colorado.edu/cspv/blueprints/model/programs](http://www.colorado.edu/cspv/blueprints/model/programs)

The Institute's mission is "to carry out practical, non-partisan research—at legislative direction—on issues of importance to Washington State."

Latest report (Oct 06) highlights the most cost-effective public policy options for reducing future prison construction, criminal justice costs, and crime rates.

- Top-rated programs for juveniles:
  - MTFC
  - FIT (an adaptation of MST)
  - Adolescent Diversion Project (for lower risk adolescents)
  - FFT
  - MST

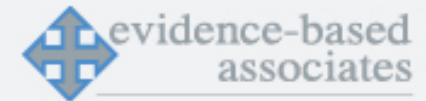
See <http://www.wsipp.wa.gov/>

## Key points:

- Prison rates have skyrocketed (despite drop in crime)
- Forecast: 23% increase based on current sentencing laws and criminal justice and demographic trends (for Washington state)
- Future demand for beds will exceed supply
- EBPs are cost-effective alternatives ... But...
- ... EBPs must be **competently** delivered (e.g., FFT study)
  
- “Incumbent to such an effort would be the policy review and management supervision necessary to hold the evidence-based programs accountable for the anticipated savings (p. 16).”

See <http://www.wsipp.wa.gov/>

# Model EBPs



## Model programs for delinquent youth share key characteristics:

1. Family-focused
2. Home- and community-based
3. Responsibility for engagement is on the provider
4. Constant focus on treatment fidelity and accountability
5. Defined length of treatment



## Functional Family Therapy ([www.fftinc.com](http://www.fftinc.com))

- Targets high-risk youth ages 11-18 and their families
- Focuses on family relations and communication; builds on youth and family strengths as motivation for change
- Cost: \$3,000-\$3,500 per youth
- Length of treatment: average 12 sessions
- Reductions in recidivism: 25-55% across studies v. control group
- Currently in over 30 states and four countries

## Multisystemic Therapy ([www.mstservices.com](http://www.mstservices.com)):

- Targets chronic and violent delinquents ages 12-18
- Focuses on the entire ecology of the youth including family, school, peer and community relations
- Cost: \$6,000-\$9,500 per youth
- Length of treatment: average 4 months (60 hours)
- Reductions in recidivism: 30-70% v. control groups
- Currently in over 35 states and eight countries

## Multidimensional Therapeutic Foster Care ([www.mtfc.com](http://www.mtfc.com)):

- Targets juveniles needing out-of-home placement age 12-17
- Recruits/supports foster families with goal of returning youth to permanency placement (e.g., biological family)
- Cost: Approx. \$5,000 per youth per month
- Length of treatment: average 10-12 months
- Reductions arrests, incarceration, and substance abuse



## Nurse-Family Partnership (NFP):

- Targets low-income, first time pregnant women
- Trained Nurses partner with clients to provide support, counseling and education from pre-natal through infancy
- Cost: \$5,000-\$6000 per client family
- Length of treatment: 2 years (through child's 2<sup>nd</sup> birthday)
- Long-term reductions for youth in arrests, incarceration, and substance abuse; improved outcomes for mothers

## Benefits (cont): Cost Savings



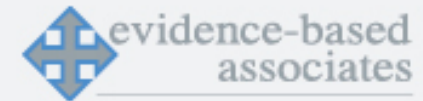
The cost of eliminating one placement can fund 6-8 youth in an evidence-based program and provide improved outcomes.

Systems save an average of \$30K per youth when evidence-based programs are utilized as an alternative to placement.

Youth served in evidence-based programs commit up to 50 percent fewer crimes.



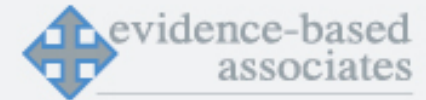
# Benefits of Model Programs



1. BETTER OUTCOMES
  - reduce recidivism
  - reduce severity of offenses
  - safer kids and communities
2. LONGER LASTING RESULTS
  - E.g., 13 yr follow-up on MST; 15 yrs for NFP
3. LOWER COSTS
  - E.g., MST costs approx \$8K per youth; residential programs for similar youth cost \$65K or more per youth



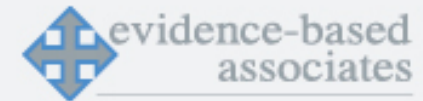
# Benefits (Continued)



4. Implementation SUPPORT: "Purveyor Organizations"
  - FFT Inc., TFC Inc., MST Services; NFP National Service
5. Clear descriptions of treatment/Quality Assurance tools
  - "you know what you're buying"
  - Parent Daily Report (MTFC); Supervisor Adherence Measure (MST)
6. **Accountability**



# Costs of Model Programs



They require that people (and systems) **change**:

- Business-as-usual thinking
- Business-as-usual feeling
- Business-as-usual behaving
  - Develop new Requests for Proposals
  - Develop new Contracts
  - Invest less in Buildings and 'bricks-and-mortar'
  - Focus on evidence-based Training
  - Shift Hiring practices
  - Reconsider Licensing requirements



# Model for Diffusion: Norway



**Innovating System:** Ministry for Children and Youth Services

**System Goals:** to identify and introduce 'state-of-the-art' behavioral health models for at-risk children and youth

**Models Selected:** Identified Incredible Years (2-6), Parent-Management Training (6-12), and MST (for highest risk youth 12-17)

**Outcomes Obtained:** In clinical trials, achieved outcomes at three of four pilot MST sites\*

**Bottom Line:** Fidelity to MST treatment model predicted outcomes

(\*Published in *Child and Adolescent Mental Health*, 11 (3), 142-149.



# Model for Diffusion: CT



**Innovating System:** Dept of Children and Families (DCF)

**System Goals:** to adopt MST as an EBP for substance-abusing and antisocial youth; later, to adapt MST to other populations

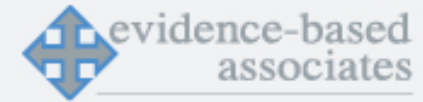
**Models Selected:** MST (recently introduced FFT, BSFT and MTFC)

**Outcomes Obtained:** Across three independent evaluations, achieved moderate-to-strong outcomes across MST sites

**Bottom Line:** Fidelity to MST treatment model predicted outcomes (Please contact presenter for details about evaluations)



# Model for Diffusion: WA



**Innovating System:** Washington State Legislature (CJAA)

**System Goals:** to adopt “research-based” programs in the state’s juvenile courts as a strategy to reduce costs, decrease recidivism

**Models Selected:** FFT, MST and ART

**Outcomes Obtained:** When competently delivered, FFT in particular reduced felony recidivism and produced significant cost savings

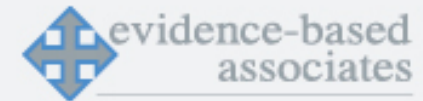
**Bottom Line:** Fidelity to FFT treatment model predicted outcomes

(See <http://www.wsipp.wa.gov/> for full results)

**FFT**  
Functional Family Therapy

**MST**  
multisystemic therapy

# Models for Diffusion: PA



**Innovating System:** Governor Ridge administration; statewide 'Children's Partnership'; PA Commission on Crime & Delinquency

**System Goals:** to implement research-based prevention programs to reduce/prevent problems among youth as public policy

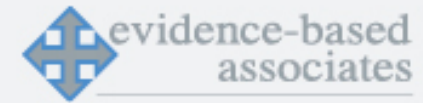
**Models Selected:** Start-up funding for NFP, FFT and MST based on community risk assessment model [Communities That Care] – local program identification and 'bottom-up' individualized approach to implementation

**Outcomes Obtained:** Levels of funding increased from \$2M in 1998 to \$20M in 2001 through combination of state and federal dollars (then decreased)

**Bottom Line:** Fidelity to treatment model predicted outcomes



# Models for Diffusion: CA



**Innovating “System:”** Justice System (*Katie A v. Bonta, 2006*)

**System Goals:** to address a lack of adequate and appropriate treatment services available for youth in the foster care system

**Models Selected:** MTFC and Wraparound

**Outcomes Obtained:** Judgment on behalf of the plaintiffs mandated that the state of CA improve services for eligible youth

**Bottom Line:** Courts recognize the validity and availability of evidence-based programs for needy youth and families

(See <http://www.bazelon.org/incourt/docket/katieA.htm> for full story)



# Model for Diffusion: FL



**Innovating System:** Florida State Legislature

**System Goals:** to 'address a growing trend' of committing juveniles for non-law violations of probation to DJJ residential facilities

**Models Selected:** MST and FFT

**Outcomes Obtained:** At two of four pilot sites, MST and FFT reduced recidivism (at two sites there was no difference); overall, the Redirection Project produced \$5.8M cost avoidance to date

**Bottom Line:** Fidelity to treatment models predicts outcomes

(see [http://www.evidencebasedassociates.com/resources/oppaga\\_0710rpt.pdf](http://www.evidencebasedassociates.com/resources/oppaga_0710rpt.pdf))

**FFT**  
Functional Family Therapy

**MST**  
multisystemic therapy

# Model for Diffusion: FL



## Redirection Project Partners and Stakeholders:

- Department of Juvenile Justice
  - Secretary/Deputy Secretaries; Residential and Community Services (Probation Staff); Contract Monitors; Medical Services; Research and Evaluation; Executive Counsel
- Juvenile Court Judges and other court personnel (SA, PD, and admin)
- Youth and their families
- Florida Legislature
- The Media
- Provider agencies and the FL Juvenile Justice Association
- University of Florida Department of Criminal Justice
- Office of Program Policy Analysis and Government Accountability (OPPAGA)
- FFT Inc and MST Services (and associated research departments)



# EBA: Project Execution



Evidence-Based Associates (EBA) proactively promotes community-based model programs in order to create a **culture of accountability** within the mental health and juvenile justice systems:

- Functional-Family Therapy
- Multisystemic Therapy
- Multidimensional Treatment Foster Care
- Nurse-Family Partnership



# EBA's Vision

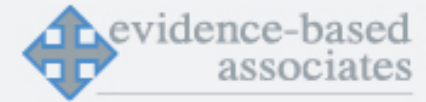


To increase the utilization of evidence-based practices for **at-risk youth and their families** in order to keep youth at home, in school and out-of-trouble.

See [www.evidencebasedassociates.com](http://www.evidencebasedassociates.com)



# EBA's Mission



- 1) To become the advocate for a "culture of accountability" in our field
- 2) To initiate positive change by promoting, collaborating with, and partnering with model evidence-based programs that serve at-risk youth, their families and their communities.



# Collaborative Approach

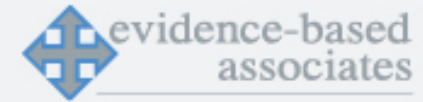


EBA helps communities, policy makers, individuals and families employ Blueprints' model violence-prevention programs in order to reduce violence, drug use and other antisocial behaviors while cultivating positive citizenship among youth in our communities.

By working together to promote the effectiveness of evidence-based programs in a coordinated fashion, we are able to influence more positive change versus going at it alone.



# Culture of Accountability



Help community decision-makers to:

- Choose new programs based on the research evidence (not on personal charisma, promises, or program novelty).
- Expect that new programs be implemented with:
  - Fidelity
  - Accountability
  - Sustainability
- Contract for services through mechanisms that support **accountability** and deliver results for each community



Coming together is a beginning.  
Keeping together is progress.  
Working together is success.

- Henry Ford

[www.evidencebasedassociates.com](http://www.evidencebasedassociates.com)

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